DOUGLAS COUNTY
COLORADO

Appendix Table of Contents

1. Board Documents
    a. Resolution
    b. Notice of intent to withdraw from TCHD
    c. TCHD proposed bylaw amendment
    d. Working group membership list
    e. Statement of purpose of the local public health working group
2. Key Documents used by working group
    a. Douglas Community Health Assessment Update 4.22.21
    b. 2021 adopted budget
    c. Department overview
    d. Colorado local health document
3. Nursing
    a. PHWG Nursing Presentation
4. Environmental Health
    a. Douglas County TCHD land use plan review fees
    b. Environmental Health resource guide -July 2018
    c. Environmental Health service delivery alternatives
    d. Environmental Health fee schedule
5. Community Health Promotion
    a. CHP IT systems and applications
    b. Strengths and opportunities
6. Emergency Preparedness and Response
    a. Narrative for the BOCC
    b. Preparedness competencies article
    c. Public Health Structure power point
7. Other TCHD Docs
    a. PHIP
    b. Strategic Plan
    c. Services Brochure
    d. Revenue Streams
    e. Landfill contract
8. CDPHE Docs
    a. Pocket guide for local boards of health
    b. CALPHO document
    c. CHAPS document
9. National Docs
    a. CDC Essential public health services
10. National Trends
    a. LA County article
    b. La Puente article
    c. Washington Post article- VA counties
    d. West Covina Public Health officer job article

e. West Covina Public Health vote article

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RESOLUTION NO. R-009- 039

THE BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF DOUGLAS, COLORADO

RESOLUTION RE-ESTABLISHING THE TRI-COUNTY HEALTH DEPARTMENT AS THE PUBLIC HEALTH AGENCY OF DOUGLAS COUNTY, AND RE-APPOINTING THE MEMBERS OF THE BOARD OF HEALTH

WHEREAS, the Douglas County Board of Commissioners recognizes the vital importance of having a public health agency to protect the health of all our people; and

WHEREAS, the Tri-County Health Department is the district health department which currently provides the public health services for Adams County, Arapahoe County and Douglas County, Colorado; and

WHEREAS, the Tri-County Health Department has been the district health department for Douglas County since 1966; and

WHEREAS, public health services in Colorado have been restructured with the passage of the Colorado Public Health Reauthorization Act, as set forth in Senate Bill 08-194, which was signed into law on June 3, 2008; and

WHEREAS, the Colorado Public Health Reauthorization Act requires the re-establishment of the Tri-County Health Department as Douglas County's public health agency, and the re-appointment of Douglas County's members serving on the re-organized Board of Health of the Tri-County Health Department; and

WHEREAS, upon re-establishment by Adams County, Arapahoe County and Douglas County, Tri-County Health Department shall function as a District Public Health Agency pursuant to §25-1-506 of the Colorado Revised Statutes.

NOW, THEREFORE, BE IT RESOLVED that the Douglas County Board of Commissioners does hereby re-establish the Tri-County Health Department as the public health agency of Douglas County, with all the powers and duties of a District Public Health Agency as set forth in the statutes of the state of Colorado, including but not being limited by, the powers and duties as set forth in §25-1-506 of the Colorado Revised Statutes, as amended, or hereafter amended;

BE IT FURTHER RESOLVED that pursuant to the provisions of §25-1-508 of the Colorado Revised Statutes, that the District Board of Health for the Tri-County Health Department shall be composed of nine members and that each County member of the Tri-County Health Department shall have the authority to appoint three members to said Board of Health

BE IT FURTHER RESOLVED that the Board of Health of the Tri-County Health Department shall have all powers and duties set forth in the statutes of the state of Colorado,

including but not being limited by, the powers and duties as set forth in §25-1-508 of the Colorado Revised Statutes, as amended, or as hereafter amended;

BE IT FURTHER RESOLVED that the re-establishment of the Tri-County Health Department pursuant to the action mandated by the provisions of §25-1-506 of the Colorado Revised Statutes shall not be deemed to be a termination of any pre-existing contract, the cessation of any existing legal obligation or the abandonment of any existing legal right of the Tri-County Health Department.

PASSED AND ADOPTED this 24th day of February, 2009, in Castle Rock, Douglas County, Colorado.

THE BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF DOUGLAS, COLORADO

BY: _____
JACK A. HILBERT, Chair

ATTEST:

_____
Melissa Pelletier, Deputy Clerk to the Board

DOUGLAS COUNTY, COLORADO SEAL EST. 1874

July 10, 2020

SENT VIA FIRST CLASS MAIL AND VIA EMAIL

Overton & Associates, LLC
Sid Overton, Esq.
6950 E. Belleview Ave, Suite 202
Greenwood Village, CO 80111

Re: Douglas County's Notice of Intent to Withdraw from the Tri-County Health Department

Dear Mr. Overton:

Please consider this letter as Douglas County's one-year written notice pursuant to C.R.S. §25-1-513(2) that Douglas County intends to withdraw from the Tri-County Health Department. While the statute requires a full year's notice, if the three member Counties wish to discuss Douglas County's withdrawal from the District at an earlier date, for example to coincide with annual budgets, Douglas County is willing to have those discussions and explore mutually acceptable options. Otherwise, this one-year notice will finalize Douglas County's withdrawal on July 11, 2021. Please let me know if you have any questions.

Sincerely,

Lance J. Ingalls
County Attorney

cc: Board of County Commissioners
County Manager

DOUGLAS COUNTY
COLORADO

Office of the County Attorney
www.douglas.co.us

November 10, 2020

SENT VIA EMAIL

Overton & Associates, LLC
Sid Overton, Esq.
6950 E. Belleview Ave, Suite 202
Greenwood Village, CO 80111

Re: TCHD proposed Bylaw Amendment-Douglas County's Notice to Withdraw

Mr. Overton,

Thank you for your and Dr. Douglas' efforts to seek a mutual resolution to extend the long-standing relationship of Tri-County Health Department (TCHD) for its three constituent counties. As a result of those efforts, the TCHD Board of Health recently adopted a policy that will increase the role of individual counties regarding public health orders, as they are being developed and before they are issued.

As previously discussed and agreed to, Douglas County is now rescinding its notice dated July 10, 2020 for withdrawal from TCHD effective July 11, 2021 and will remain in the current three-county district through at least December 31, 2022 while we collectively continue to examine our partnership.

Sincerely,

Lance J. Ingalls
County Attorney

cc: Board of County Commissioners
County Manager

Local Public Health Working Group Members

Doug DeBord-County Manager

Barbara Drake- Deputy County Manager

Planning and Information Management

Maureen Waller- Special Projects Manager.

Dan Avery -Special Projects Manager

Emergency Management

Jon Surbeck- Consultant

Veronica Moody

Tim Johnson - Director, Emergency Management

Nursing/Nutrition

Holly Carrell - Special Projects Manager

Daniel Makelky- Director, Human Services

Troy Dunning - Risk Management & Projects Coordinator

Community Health Promotion

Maggie Cooper - Special Projects Manager/CRT Coordinator

Laura Ciancone - Mental Health Initiative Coordinator

Human Resources

Laura Leary, Director of HR

Admin/Finance

Andrew Copland -Director, Finance

Martha Marshall -Director, Budget

Faye Estes, Sr. Grant Accountant

IT

Julian Spence- IT Consultant

John Huber, Chief Information Officer

Environmental Health

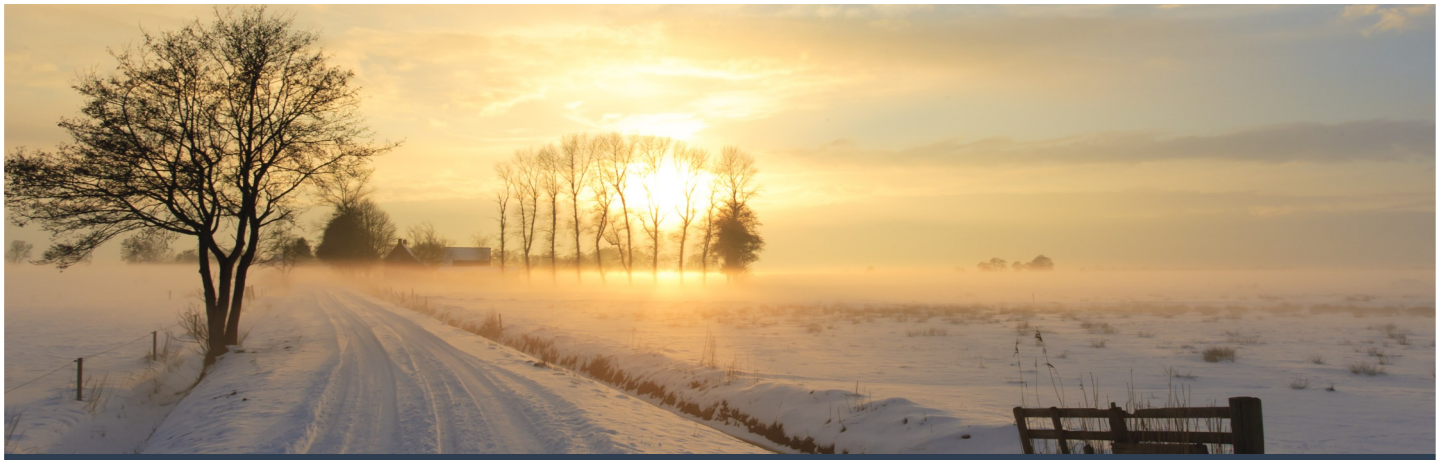
Steve Koster - Asst. Director, Planning Services

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Statement of Purpose of the Local Public Health Working Group

Douglas County has made a commitment to remain part of the Tri-county District Public Health Department through December 31, 2022. In the interim, the County is exploring options and opportunities related to the delivery of public health services for the County's residents. Those options and opportunities will be provided to the Board of County Commissioners to guide their decision on how they wish to ensure that public health services are provided to County residents.

The Working Group is charged with developing those options and opportunities through research, data gathering, analysis of Statutes, rules and regulations, best practices, economies of scale, information technology and facility requirements, budgetary and funding analyses, contracting and direct service options.



Community Health Update

April 2021

Douglas County

Purpose

The mission of Tri-County Health Department is to promote, protect, and improve the lifelong health of individuals and communities in Adams, Arapahoe, and Douglas Counties through the effective use of data, evidence-based prevention strategies, leadership, advocacy, partnerships and the promotion of health equity. The COVID-19 pandemic has changed the way people in Douglas County live, grow, work, play, and access care. Our community has made great strides in addressing one of the greatest health challenges in present memory. The purpose of this Community Health Update is to provide a snapshot of the current health status of the county, focusing on the four areas of Public Health Improvement Plan—housing, food security, mental health, and access to care—as well calling attention to social connection and economic security: key factors that influence health and wellness. We envision that this update will strategically inform the work of Tri-County Health Department as we continue to work together to navigate the pandemic and turn our collective focus toward recovery and innovation. As we are continually reminded, "Public Health is what we do together as a society to ensure the conditions in which everyone can be healthy."[1]

Process

The health behaviors and outcomes in this report reflect community priorities as developed during the public health improvement planning process in 2019. The data presented in this report were compiled from a variety of sources and include both primary (collected for local health assessment purposes) and secondary data sources (collected for another purpose, usually by another organization/institution). Public Health Improvement Plan Priority Area leads consulted on which data to include in this health update. Staff of the Planning and Information Management (PIM) Division of Tri-County Health Department completed this report. For questions or concerns, please contact Kelly Weidenbach, PIM Division Director, at 720-200-1542.

Data Limitations

While data limitations and weaknesses always exist, they are mitigated as much as possible. Timeliness may be the largest limitation to these data in that the lag between data collection and release are such that our most recent data are typically at least one-year old. Completeness, survey and recall bias, and small sample sizes all impact data. Small sample sizes or events that occur to a small portion of the population need to be displayed carefully so as not to identify an individual. It is important to measure patterns of health among subgroups of the population and to explain the context of data whenever possible.

[1]Public Health 3.0: A Call to Action to Create a 21st Century Public Health Infrastructure. (2016) Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services. Accessed November 16, 2016 at https://www.healthypeople.gov/sites/default/files/Public-Health-3.0-White-Paper.pdf

Community Characteristics: Douglas County

Population

	2019 Population		2030 Population
Population*	351,528		410,108
Population Change*	+7%	2016 to 2019	+17%	2019 to 2030

Douglas



Race/Ethnicity

White Non-Hispanic*	83%	83%
Hispanic*	8%	9%
African-American*	2%	2%
Asian*	6%	6%

Age

0-17	23%	19%
18-64*	64%	63%
65+*	12%	18%

Other Characteristics

Disability**	7%
Includes hearing, vision, cognitive, ambulatory, self-care, and independent living difficulty	
Born Outside US**	8%
Households without broadband internet**	3%

Income

Median Household Income**	$122,867
Individuals Living at or Below Poverty**	3%
Children Living at or Below Poverty**	2%
Unemployment***	6%

Households

Single Parent Households**	4%
Residents Age 65 or Older Living Alone** (of households with one member 65+)	6%
Linguistically Isolated Households** (households where all adults speak a language other than English and none speaks English "very well")	2%

Educational Attainment

Less than High School**	2%
High School (Diploma or Equivalent)**	13%
Bachelor's Degree or Higher**	58%



*Source: Colorado Department of Local Affairs, July 2019 Estimates, 2030 Population Forecast
**Source: American Community Survey 1-Year Estimate 2019
***Source: Colorado Department of Labor and Employment, December 2020

Human resilience is closely linked to the depth and strength of our interpersonal connections, including our involvement in groups and communities. In contrast, loneliness appears to be one of the greatest threats to our health, survival, and well-being.[1]

There has likely not been a time in recent memory where social connection, or its real or perceived absence, has been so noticeable or, indeed, so often discussed. The importance of connection and the effects of its opposite—isolation—have rarely been felt by so many at once. And yet, contrary to what public health would typically espouse—that connection is very important for health and wellbeing—it is for the public's health that we physically distance ourselves from others and are more likely to experience isolation and loneliness. Perhaps this collective experience better illustrates the relationship between meaningful connection and health than many of our data.

Research tells us that social connection is related to health in several ways. Simply being around other caring people who watch out for each other can reduce the risk of poor health outcomes occurring or the chance that an accident will lead to death or more serious injury. Connection and belonging can protect us from developing certain behaviors that put us at risk for poor health outcomes. Social connection has long been recognized as a factor that can reduce the chance that people will engage in less-healthy behaviors such as heavy drinking or other substance use. In Douglas County, most high school youth report having adults available to them for support (Figure 1). More youth report being able to ask parents or guardians for help with a personal problem than report having an adult to go to for help with a serious problem. Percentages were the same in 2017 and 2019.[2]

An August 2020 survey found that while most Coloradans generally consider their mental health to be excellent or very good, due to the pandemic 53% (46% in Douglas County) have experienced mental health strain, including anxiety, loneliness, or stress. Mental health strain was more commonly expressed by women (58%) compared to men (47%), by people with annual incomes below $30,000 (63%) compared to those with annual incomes above $30,000 (53%), and by people who were currently unemployed (71%) compared to people with some type of employment or retired people (51%).[3] (Figure 2)

Published research over the past year has highlighted the impact of social isolation on health: "Keep Socially (but Not Physically) Connected and Carry on: Preventing Suicide in the Age of COVID-19," "Increased Risk for Family Violence During the COVID-19 Pandemic," and "The psychological impact of quarantine and how to reduce it: rapid review of the evidence." The power of building and focusing on resiliency today is even more applicable to the population as a whole. Focusing efforts on acknowledging trauma, (re)building social connection, fostering self-efficacy, and supporting systems that create equitable access and opportunities for all people will be important parts to building our communities' resiliency as we continue in the fight of the coronavirus and begin recovery planning.

Figure 2. Connections between high school youth and their parents, Douglas County, 2017-2019[2]

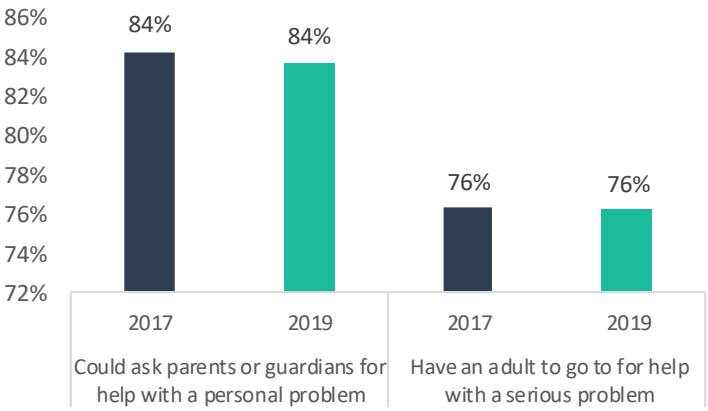
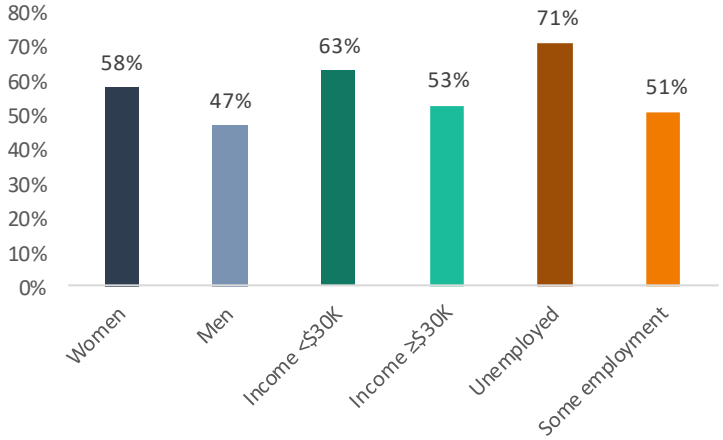


Figure 1. People experiencing mental health strain (anxiety, loneliness, or stress) from Coronavirus Pandemic, Colorado, 2020[3]



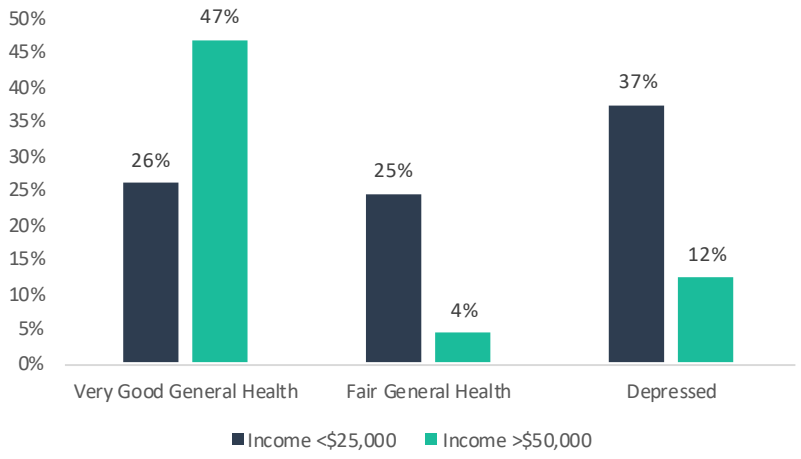
[1]Pietrabissa, G., & Simpson, S. G. (2020). Psychological Consequences of Social Isolation During COVID-19 Outbreak. *Frontiers in psychology*, *11*, 2201. https://doi.org/10.3389/ fpsyg.2020.02201
[2]Healthy Kids Colorado Survey, Colorado Dept. of Public Health and Environment, 2017, 2019
[3]The Colorado Health Foundation. Pulse Poll (2021). https://www.copulsepoll.org/ results

Health and Economic Security

Income directly influences one's ability to access and/or pay for services and resources that can affect health and wellbeing, such as healthy housing; health care services not covered by insurance, including one's deductible, for example; or high quality childcare services. Indirectly, income is a key factor in many of the choices people make every day, from the kind of food they buy, to the way they exercise or recreate, to whether or not they can take a vacation. Given the importance of income to not only meet basic needs, but also to access various services, resources, and opportunities, it is no surprise that economic security is a key to health.

Self-reported health status has a direct relationship with income: the higher the income, the more likely people are to report being healthy (Figure 3). In Douglas County, more people with incomes greater than $50,000 report their own general health as very good (47%) compared to people with incomes less than $25,000 (26%). Higher-income residents are also less likely to describe their health as fair (4%) compared to lower-income residents (25%). Lower-income residents were also more likely than higher-income residents to have ever been diagnosed with depression (37% compared to 12%).[1]

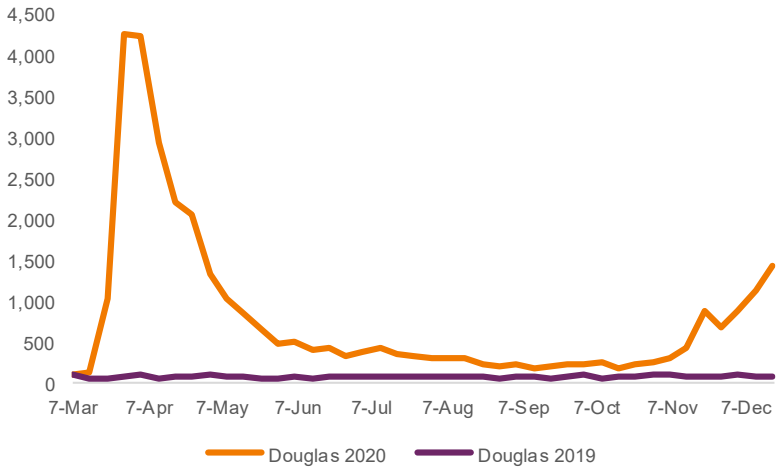
Figure 3. Self-reported health outcomes by income, Douglas County, 2019



Source: Behavioral Risk Factor Surveillance System, CDPHE

In addition to its devastating physical and mental health impacts, the coronavirus pandemic continues to strain our communities economically. Businesses navigate closures and capacity restrictions, people have lost their jobs or been forced into early retirement, and consumers have changed the way they shop and prioritize expenses. In a recent statewide survey, nearly one-third (31%) of respondents had hours cut back or wages reduced, one in five (19%) were required to go to work even though they had concerns about their health and safety, and 13% had been laid off – all due to the coronavirus pandemic.[2] Compared to the 2019 weekly average of unemployment insurance claims, the average number of weekly claims between the weeks of March 21, 2020 and December 29, 2020, increased 902% in Douglas County. Figure 4 shows weekly unemployment claims in 2020: new claims peaked the week of March 28, 2020, slowly declined in summer months, and rose again in late 2020.[3]

Figure 4. Weekly unemployment insurance claims, Douglas County, 2019 compared to 2020



Source: Colorado Dept. of Labor & Employment

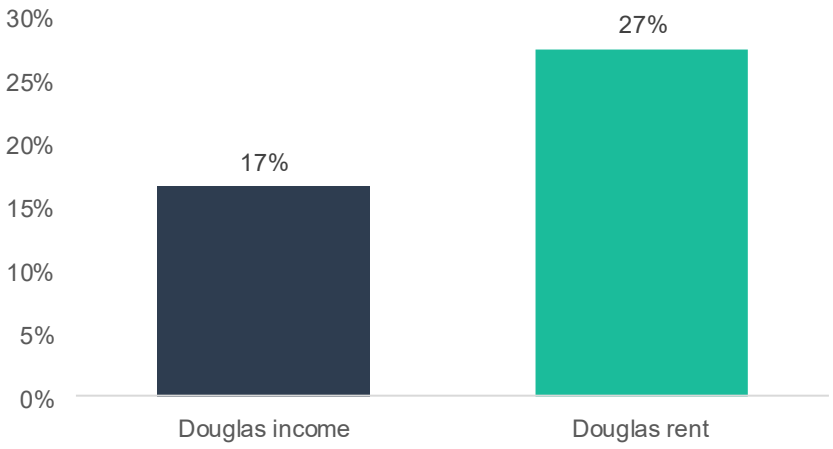
Financial security is a key determinant of health. The financial struggles of Douglas County residents precipitate difficulties they face maintaining affordable, stable housing and high quality of life. The worry and concern related to financial struggle, unemployment, and fear of uncertain situations negatively impact mental health. Improving health means improving the economic systems in which people live, learn, grow, and work, and the opportunities available for all people to be financially secure and access what they need to be healthy.

[1]Colorado Dept. of Public Health & Environment (CDPHE) (2019) Behavior Risk Factor Surveillance System (BRFSS)
[2]The Colorado Health Foundation. Pulse Poll (2021). https://www.copulsepoll.org/results
[3]Colorado Dept. of Labor & Employment (2020) Regular UI Weekly Initial Claims by Colorado County, https://www.colmigateway.com/gsipub/index.asp?docid=807

Where we live is directly connected to our health and safety. Without adequate housing, people have trouble managing their daily lives. For most people, housing is their greatest monthly expense. Quality, affordable housing is central to individual and community wellbeing. Prior to the pandemic, the growing population of the Denver Metro Area and limited housing exacerbated the affordable housing shortage. Between 2014 and 2019, the median monthly household income for residents in Douglas County increased by 17% while the median monthly rent increased by 27%; the cost of housing is outpacing the increase in wages (Figure 5).[1] These issues have only increased since the coronavirus pandemic, due in part to historic increases in unemployment, stable or even declining wages, and limited affordable housing are becoming more pronounced.

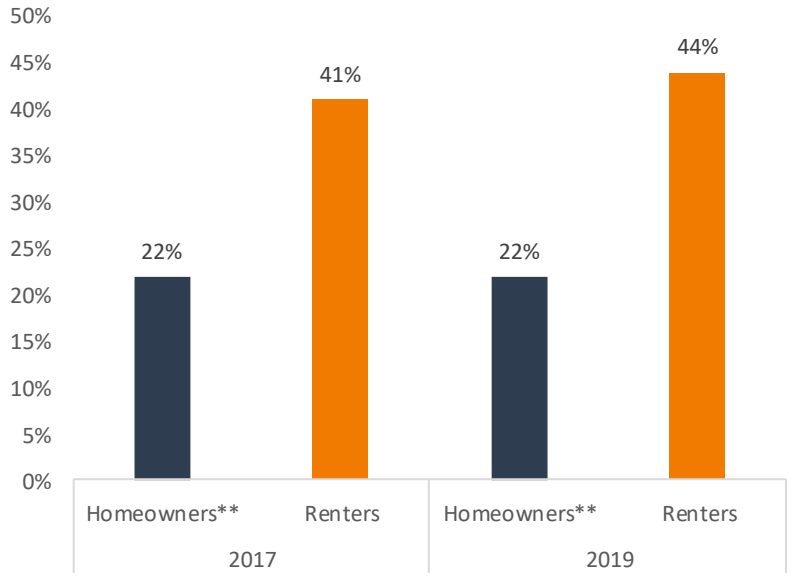
Affordable housing enables people to pay for other basic needs such as utilities, food, and medical care, which can reduce the incidence of negative health outcomes such as malnutrition, diabetes, anxiety, and depression.[3]

Figure 5. Percent change in avg monthly income and avg monthly rent costs between 2014 & 2019, Douglas County



Source: American Community Survey, U.S Census Bureau, 2019 5-year estimates

Figure 6. Percent of households paying 30% or more of household income on housing, 2019, Douglas County



As housing costs increase faster than wages, people inevitably spend a greater percentage of their income on housing, if they are able. As shown in Figure 6, 44% of renters in Douglas County spend 30% or more of their income on rent,[1] exceeding the recommendation of The United States National Housing Act of 1937, still in use today. In Douglas County, renters are more likely than homeowners to pay 30% or more of their income on housing.

Point-in-time surveys of the homeless population* in the metro estimate a 6% increase in homeless persons in the past year (from 2019 to 2020) in the metro area. Persons of color make up a higher percentage of the homeless population than they do the general population. Of the over 6,100 homeless people surveyed, 10% were veterans, 7% were families, 5% were unaccompanied youth, and 12% were people fleeing domestic violence.[2]

The coronavirus pandemic in Colorado has exacerbated problems residents face accessing affordable, safe housing in the metro area. So closely tied to economic security and other social and economic barriers to health, solutions to the housing crisis will need to be interconnected and address the many factors that contribute to accessible housing.

*Point-in-time surveys are not true counts of the home less population, but often the best existing data
**Homeowners with a mortgage

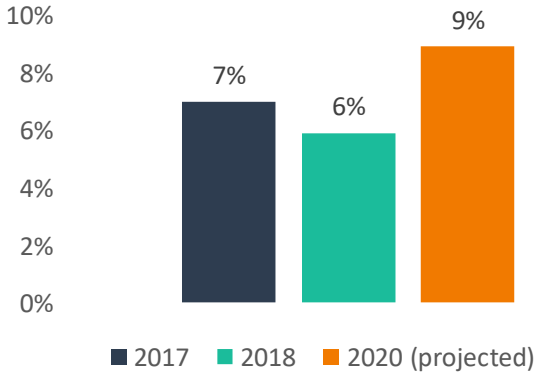
[1]American Community Survey, U.S Census Bureau, 2019 5-year estimates
[2]Metro Denver Homeless Initiative. 2020 Point in Time Survey. https://www.mdhi.org/2020_pit_reports
[3]Human Impact Project. http://www.pewtrusts.org/~/media/assets/2016/03/opportunities_for_the_housing_sector.pdf

Health and Food

Eating a nutritious diet is an important part of good overall health. It helps keep bodies functioning, improves maternal and child health, and reduces the risk of disease.[1] Eating nutritiously is a challenge for many families, and accessing healthy foods became even more difficult during the COVID-19 pandemic. Not only did lockdown restrictions make it more difficult for some families to get to the grocery store, but rising unemployment, school closures and access to in-school food, and product scarcity added additional challenges. This combination of factors increased food insecurity across the country.[2]

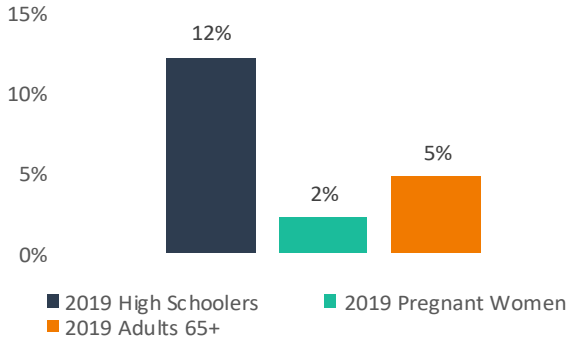
Retail food prices rose ~3.5% between 2019 and 2020.[3] The increased price of food combined with job loss, impacted many families in Douglas County. The food insecurity rate, a measurement of food access, considers both unemployment and poverty. In Douglas County, it is estimated that 9% of people (nearly one in 10) were food insecure in 2020 compared to 6% in 2018 (Figure 7).[2] Adults aged 65 and older, children, and pregnant women face unique challenges related to food insecurity (Figure 8). Mobility issues and special diets put older adults at higher risk for food insecurity and food-insecure children may not get the nutrients they need for healthy development, as well as the energy and focus necessary to fully participate in school.[2] Food insecurity in pregnant women has been linked to poor pregnancy outcomes including birth weight and gestational diabetes.[6] Luckily, few women in Douglas County report food insecurity in the year before becoming pregnant (Figure 8).

Figure 7. Food insecurity, Douglas county, 2017, 2018, & 2020 (projected)



Source: Feeding America (2020)
*The most recent release is based on data from 2018. In response to COVID-19, Feeding America also released a companion study that illustrate the projected impact of the pandemic on local food insecurity in 2020.

Figure 8. Food insecurity in vulnerable populations, Douglas County, 2019



Sources: Colorado Dept. of Public Health & Environment: Healthy Kids Colorado Survey (2019), Behavioral Risk Factor Surveillance System (2018, 2019), Pregnancy Risk Assessment Monitoring System (2016-2019)

Women were especially impacted over the past year; not only do more women work in the industries impacted by stay-at-home orders, but they experienced disproportionate job loss during the pandemic.[7] Women are also often the primary caregivers and household managers. The Supplemental Nutrition Assistance Program (SNAP) and the Supplemental Nutrition Program for Women, Infants, and Children (WIC) support families facing food insecurity; the programs supplement food budgets and help families understand nutrition and how to make healthy food choices. From 2018 to 2020, the number of Douglas County families who applied for and received SNAP assistance grew by 30%, totaling over one million dollars.[8] WIC staff also work to increase program enrollment; only 39% of eligible people were enrolled in 2017.[9]

In a healthy community, all residents can access healthy, affordable food and are able to practice healthy eating habits. Healthy children learn better and healthy adults are more productive.[1] Providing access to affordable, healthy foods helps reduce risk for many health conditions and prevent chronic diseases, putting everyone on the path for good overall health.

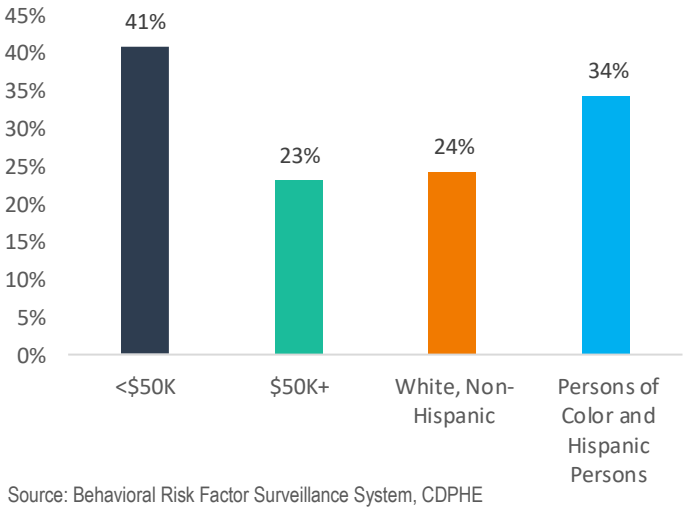
When asked about affording basic expenses — such as food — 12% of Colorado families said they were financially stable prior to the pandemic but began to struggle after it began.[4]

[1]World Health Organization (2020). Healthy diet. https://www.who.int/news-room/fact-sheets/detail/healthy-diet
[2]Feeding America (2020). Food Insecurity in the United States. https://map.feedingamerica.org/
[3]United States Department of Agriculture (2021). Consumer Price Index data
[4]Hunger Free Colorado (2020). Statewide Food Insecurity Survey
[5]Feeding America (2020). The Impact of the Coronavirus on Food Insecurity in 2020.
[6]Ivers, L. C., & Cullen, K. A. (2011). Food insecurity: special considerations for women. The American Journal of Clinical Nutrition, 94(6), 1740S–1744S.
[7]Alon, T., M. Doepke, J. Olmstead-Rumsey, & M. Tertilt. (2020). The Impact of COVID-19 on Gender Equality. National Bureau of Economic Research.
[8]Colorado Dept. of Human Services (2020). SNAP Case, Client and Issuance reports.
[9]Colorado Dept. of Public Health & Environment (2020). WIC eligibility and enrollment data

Mental health, which includes our emotional, psychological, and social wellbeing, is important at every stage of life. It affects how we think, feel, and act. Mental health helps determine how we handle stress, relate to others, and make choices. Good mental health is important for our personal well-being, our relationships, and our ability to contribute to society. Poor mental health can increase the risk for other chronic health problems such as stroke, diabetes, and heart disease.[1]

Even before the pandemic, mental health was a concern to members of our Douglas County community and one of our Public Health Improvement Plan Priority Areas.[2] In 2019, 10% of adults in Douglas County reported mental distress (poor mental health for more than 14 days), and nearly 14% of adults reported regular feelings of depression. More lower-income residents reported mental health distress than did higher-income residents; racial/ethnic groups reported similar percentages of mental health distress in 2019 (Figure 8).[3] Mothers with postpartum depressive symptoms (PDS), a mood disorder women can experience after childbirth, experience feelings of extreme sadness, anxiety, and exhaustion that may make it difficult for them to complete daily care activities for themselves or for others. In 2019, 10% of mothers in the county reported PDS.[4]

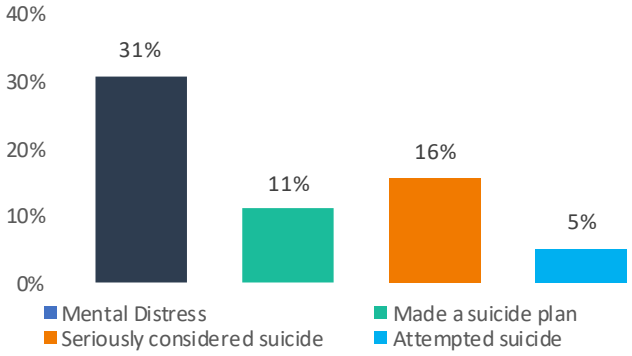
Figure 9. Mental health distress by income, race/ethnicity, Douglas County, 2019



Source: Behavioral Risk Factor Surveillance System, CDPHE

Children and youth also struggle with poor mental health. In 2020, American children reported higher stress levels than did adults and were more likely to experience common symptoms of depression.[6] In fact, about one in seven (14%) Colorado youth reported at least one major depressive episode in 2020.[6] Among Douglas County high school students, one-third (31%) stopped doing usual activities, a sign of mental distress (Figure 9).[5] In order for teenagers to achieve good mental health, they must develop skills such as coping, resilience, and good judgment. Having a trusted confidante or support can aid in the development of resilience. In Douglas County, 76% of students have someone they can go to when they are feeling sad.[5]

Figure 10. Mental health indicators among HS students, Douglas County, 2019



Source: Colorado Dept of Health & Environment, Healthy Kids CO Survey

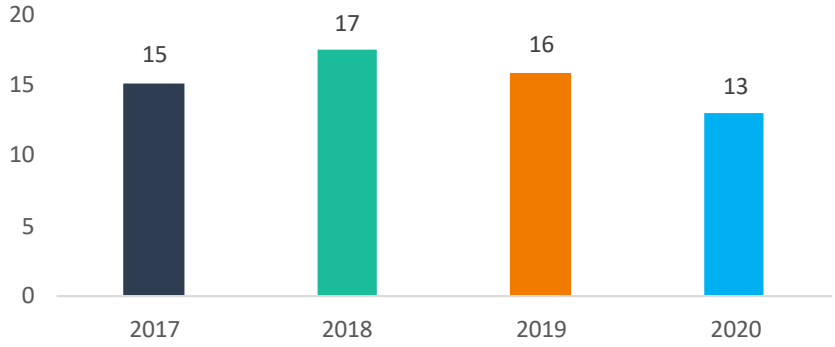
The pandemic has changed our lives, introducing new stressors and further increasing mental health concerns among community members. Growing uncertainty stemming from lockdowns and closures, economic hardship, and social isolation are associated with distress, anxiety, fear of contagion, depression, and insomnia.[7] Acknowledging the mental health burden of the coronavirus pandemic may open the doors for more widespread discussion around mental health in general and the forces that influence and amplify good mental health.

In a pandemic, fear increases anxiety and stress levels in healthy individuals and intensifies the symptoms of those with pre-existing psychiatric disorders.[8]

[1]Centers for Disease Control & Prevention (2018). Learn About Mental Health: Mental Health Basics
[2]Tri-County Health Department (2018). Community Health Assessment
[3]Behavioral Risk Factor Surveillance System (2017-2019)
[4] Colorado Dept. of Public Health & Environment (2019) Pregnancy Risk Factors Assessment System
[5] Colorado Dept. of Public Health & the Environment (2019) Healthy Kids Colorado Survey
[6]Mental Health America (2021). State of Mental Health in America
[7]Sher, L. (2020) The Impact of the COVID-19 pandemic on suicide rates
[8]F. Ornell, J.B. Schuch, A.O. Sordi, & F.H.P Kessler (2020) "Pandemic fear" and COVID-19: mental health burden and strategies

Suicide is one of the most tragic consequences of untreated mental health problems. As seen in Figure 11, the annual suicide rate in Douglas County is fairly steady.[1] However, Colorado hospitals reported an increase in both adult and adolescent emergency room visits related to mental health from March–May 2020, citing suicidal ideation and disaster-related mental health as the main reasons.[2]

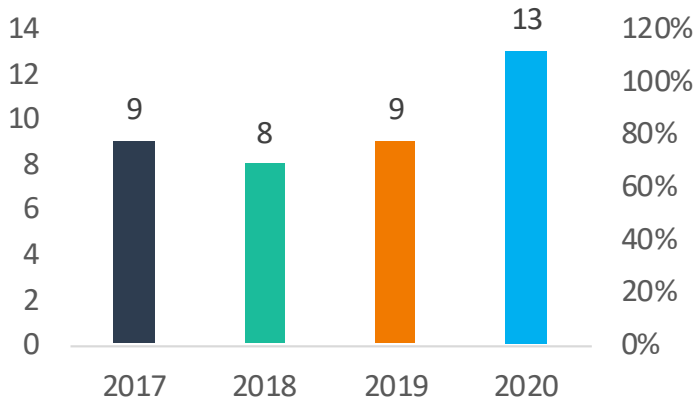
Figure 11. Annual crude suicide death rates per 100,000, Douglas County, 2017 to 2020 *(2020 data are preliminary)*



Source: CO Dept. of Public Health & Environment, Vital Statistics Program

The impacts of a public health emergency, like the coronavirus pandemic, on individuals' mental health may lead to a range of unhealthy coping mechanisms, including substance abuse.[3] In Colorado, 12% of adults reported substance use in 2018. Among Colorado youth, 5% reported substance use in the same year.[4] In Douglas County in 2019, 29% of students reported drinking alcohol at least once in the past 30 days, 13% smoked marijuana at least once, and 21% used an electronic vape product at least once.[5]

Figure 12. Yearly age-adjusted overdose death rates per 100,000, Douglas County, 2017 to 2020 *(2020 data are preliminary)*



Source: CO Dept. of Public Health & Environment, Vital Statistics Program

Anecdotally, people report increased alcohol consumption during the early months of the pandemic. Monthly liquor excise taxes* in Colorado averaged $3.8 million from 2015 to 2019, but rose to $4.2 million in 2020—an 11% increase. Since 2015, liquor excise taxes have increased by 3.5% a year on average but from 2019 to 2020, this amount grew by 12%.[6] Although we cannot look at the consumption of illegal drugs in the same way, data do show that across the state of Colorado, the number of deaths by overdose grew by 19% from 2019 to 2020 with an uptick in the spring of 2020. In Douglas County, provisional data indicate total annual overdose deaths increased by 35% from 2019 to 2020 (213 to 287). The provisional 2020 overdose death rate is higher than in previous years.[7] (Figure 12)

The events of the past year have made challenging situations even more difficult for Douglas County residents. More people report struggling with depression and poor mental health. Liquor sales have increased as have emergency room visits due to mental health distress and deaths from drug overdose. Reducing the environmental, social, and economic factors that contribute to stress, ensuring affordable access to mental health care services, and creating accepting, inclusive and supportive communities will help to bolster mental health for all, leading to higher productivity, safer communities, and optimal health and wellness.

[1]Colorado Dept of Public Health & the Environment (2021). Colorado Health Information dataset
[2]Colorado Hospital Association (2020). Hospital Utilization data.
[3]Pfefferbaum, B. & C.S. North (2020) Mental Health and the Covid-19 Pandemic. NEJM, 382: 510-512.
[4]Mental Health America (2021) State of Mental Health in America
[5]Colorado Dept of Public Health & the Environment (2019) Health Kids Colorado Survey
Colorado Dept of Revenue (2021). Colorado Dept of Revenue liquor excise tax data
[6]Colorado Department of Public Health and the Environment, Vital Statistics (2020)

In 2019, 1 in 10 adults in the United States reported symptoms of anxiety or depression. During the pandemic nearly 4 in 10 adults reported the same symptoms.[4]

*Liquor excise taxes measure taxes paid on quantities of alcohol manufactured and sold at the wholesale level. While this does not account for all retail alcohol sales, it does give an idea of the increased volume of alcohol sold by manufacturers and wholesalers.

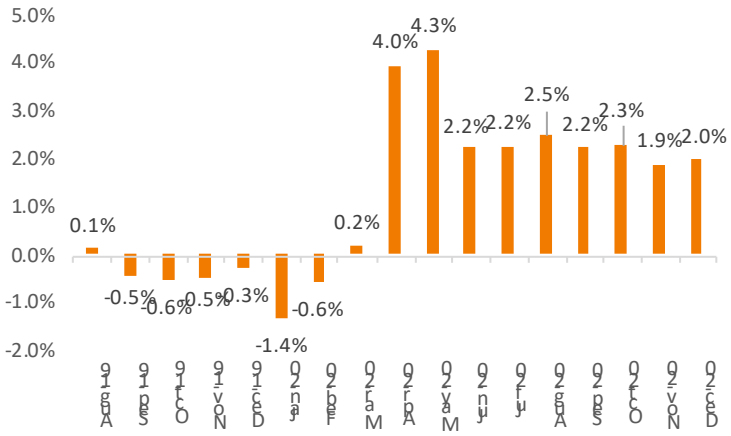
Access to Physical and Mental Health Services

The ability to access and afford the mental and physical health services needed to be healthy is one of the most important health problems identified by our community members.[1] Although many factors influence health, people need access to services for prevention, management, and treatment of various health conditions and diseases. Comprehensive access to care must include the ability to find, afford, and make an appointment within a reasonable time period, with health care providers (including specialists), therapists, counselors, and other health care providers to maintain good health. Not only do these services need to be available to community residents, they need to be able to navigate the system in which they exist.

Health insurance, public or private, is the primary way in which people pay for and afford health services. In Douglas County in 2019, 18% of people had public insurance, 79% had private insurance; and 3% were uninsured. The coronavirus pandemic resulted in both job loss and loss of employer-sponsored, private coverage.[3] Beginning in April 2020, and continuing every month through December 2020, more people enrolled in Medicaid than enrolled the month before (Figure 13).[3]

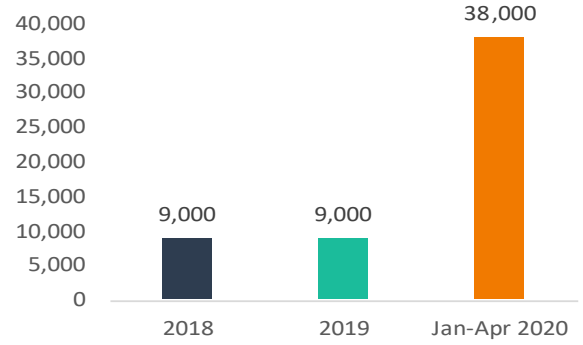
Not everyone who is eligible for public health insurance is enrolled in a plan, however. Whereas virtually all eligible adults ages 65+ are enrolled in Medicare, fewer of those who are eligible for Medicaid or CHP+ are enrolled. In 2018, 7% of Douglas County residents eligible for Medicaid were not enrolled and 6% of those eligible for CHP+ were not enrolled.[5] People with insurance coverage can struggle to locate, access, or pay for primary and mental health care services for a variety of reasons. In Douglas County, the percentage of people unable to get an appointment when needed increased from 8% to 20% between 2017 and 2019. Additionally, 13% of residents reported that finding a doctor who accepted their insurance was an issue and 10% cited cost as barriers to care. Residents looking for mental health care also faced obstacles; those who were unable to access mental health care quadrupled (from 3% to 13%) in the same timeperiod.[2]

Figure 13. Percent monthly change in Medicaid



Source: Colorado Dept. of Public Health & Financing

Figure 14. Number of Telehealth Services Utilized, Douglas County, 2018-



Source: Center for Improving Value in Healthcare

Not everyone in our communities has equal access to health services and the COVID-19 pandemic has exacerbated this problem. A shift from in-person to telehealth services offers an opportunity to reach more community members; between January and April 2020 alone, there were 322% more telehealth services utilized than in all of 2019 in Douglas County (Figure 14).[6] However, data indicate people utilized fewer preventive services in general in 2020—even with increased use of telemedicine. Additionally, people living in zip codes with 80% or more residents of color experienced smaller increases in telemedicine usage than people living in zip codes with 80% or more white people.[7] Affordable services help ensure that all people in our communities have the mental and physical energy, vitality, and resilience to obtain optimal health.

[1]TCHD (2018) Community Health Assessment
[2]Colorado Health Access Survey (2019)
[3]Center for Improving Value in Healthcare (2020) Telehealth in Colorado https://www.civhc.org/covid-19/telehealth-services-analysis/ .
[4]Kaiser Family Foundation (2021) Medicaid Expansion Enrollment and Spending Leading up to the COVID-19 Pandemic
[5]Colorado Dept of Public Health & Financing (2020) Eligible but not enrolled population
[6]Center for Improving Value in Healthcare. (2021). Telehealth Services Analysis. https://www.civhc.org/covid-19/telehealth-services-analysis/
[7]Whaley, C. M., et al (2020). Changes in Health Services Use Among Commercially Insured US Populations During the COVID-19 Pandemic. JAMA network open, 3(11), e2024984.


Tri-County
Health Department
Serving Adams, Arapahoe and Douglas Counties



2021 ADOPTED BUDGET BOOK

December 2020

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QUICK REFERENCE GUIDE

There are two tools that will help locate information in the 2021 Adopted Tri-County Health Department budget book.

1. The **Quick Reference Guide**, which shows where to find answers to commonly asked questions, along with section references and page numbers.
2. The **Table of Contents**, which outlines the entire document.

If you have this question	Refer to Tab	Page (s)
How much is in the 2021 Budget?	2021 Adopted Budget	25-37
How was the 2021 budget developed?	Budget Message	14
What is Tri-County's budget process?	Budget Message	14
What is the budget process timeline?	Budget Message	15
How much is budgeted by division?	Department Budgets	38-155
How much is budgeted by program?	Department Budgets	38-155
How are division and program budgets presented in the budget book?	Budget Message	14
What are the types of revenue?	Budget Message	11-12
What are Tri-County's financial policies?	Budget Message	12-13

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TABLE OF CONTENTS

QUICK REFERENCE GUIDE 1

TABLE OF CONTENTS 3

2021 BUDGET MESSAGE 7
INTRODUCTION 9
ABOUT TRI-COUNTY HEALTH DEPARTMENT 11
REVENUES 11
FINANCIAL POLICIES 12
BUDGET PROCESS 14
BUDGET TIMELINE 15
BASIS OF BUDGETING AND ACCOUNTING 16
FUND BALANCE 16
MISSION, VISION, VALUES, AND GUIDING PRINCIPLES 17
PUBLIC HEALTH ACCREDITATION 18
PUBLIC HEALTH IMPROVEMENT PLAN AND STRATEGIC PLAN OVERVIEW 19
TCHD BOARD OF HEALTH 21
ORGANIZATIONAL CHART 22
OFFICE LOCATIONS (MAP AND ADDRESSES) 23

2021 ADOPTED BUDGET 25
SUMMARY OF BUDGET CHANGES 2020 to 2021 – CHANGES TO REVENUE /SOURCES OF FUNDS – COUNTY PER CAPITA CONTRIBUTIONS 27
SUMMARY OF BUDGET CHANGES 2020 to 2021 – CHANGES TO REVENUES /SOURCES OF FUNDS 28
SUMMARY OF BUDGET CHANGES 2020 to 2021 – CHANGES TO EXPENDITURES 28
2021 ADOPTED SOURCES OF REVENUES CHART 29
2021 ADOPTED SOURCES OF GENERAL REVENUES CHART 30
2021 ADOPTED EXPENDITURES BY TYPE CHART 31
2021 BUDGET COMPARISON – REVENUE BY PROGRAM 32
2021 BUDGET COMPARISON – EXPENDITURE BY PROGRAM 34

1 - OFFICE OF THE EXECUTIVE DIRECTOR 38
BUDGET SUMMARY – EXECUTIVE DIRECTOR DIVISION 40
BUDGET SUMMARY – EXECUTIVE DIRECTOR 41
BUDGET SUMMARY – METRO DENVER PARTNERSHIP FOR HEALTH 42
BUDGET SUMMARY – BOARD FUND 43
BUDGET SUMMARY – COMMUNICATION 44

TABLE OF CONTENTS

2 - NUTRITION DIVISION 46
BUDGET SUMMARY – NUTRITION DIVISION 48
FUNDING SOURCES CHART – NUTRITION DIVISION 49
BUDGET SUMMARY – DIETETIC INTERNSHIP 50
BUDGET SUMMARY – WOMEN, INFANTS & CHILDREN (WIC) 51
BUDGET SUMMARY – BREASTFEEDING PEER COUNSELOR PROGRAM 53
BUDGET SUMMARY – BABY AND ME TOBACCO FREE 54
BUDGET SUMMARY – WIC CENTRAL REFERRAL PILOT 55
BUDGET SUMMARY – HUNGER FREE COLORADO OUTREACH PROGRAM 57
BUDGET SUMMARY – DRCOG ACCOUNTABLE HEALTH COMMUNITIES 58
BUDGET SUMMARY – FOOD SECURITY 60
BUDGET SUMMARY – ADMINISTRATION 61

3 - COMMUNITY HEALTH PROMOTION DIVISION 62
BUDGET SUMMARY – COMMUNITY HEALTH PROMOTION DIVISION 64
FUNDING SOURCES CHART – COMMUNITY HEALTH PROMOTION DIVISION 65
BUDGET SUMMARY – ADMINISTRATION & GENERAL 66
BUDGET SUMMARY – ADVANCING BREASTFEEDING IN COLORADO 67
BUDGET SUMMARY – AGING INITIATIVES 68
BUDGET SUMMARY – TOBACCO EDUCATION AND PREVENTION 69
BUDGET SUMMARY – COMMUNITY NUTRITION 70
BUDGET SUMMARY – DIABETES EDUCATION PROGRAM 72
BUDGET SUMMARY – HEALTHY BEVERAGE INITIATIVE 74
BUDGET SUMMARY - MATERNAL AND CHILD HEALTH (MCH) PROGRAMS 75
BUDGET SUMMARY – SUBSTANCE USE PREVENTION 77
BUDGET SUMMARY – WORKSITE WELLNESS 79
BUDGET SUMMARY – MENTAL HEALTH PROMOTION AND SUICIDE PREVENTION 80
BUDGET SUMMARY – NENS REFERRAL GRANT PROJECT 81

4 - NURSING DIVISION 82
BUDGET SUMMARY – NURSING DIVISION 84
FUNDING SOURCES CHART – NURSING DIVISION 85
BUDGET SUMMARY – DIVISION OPERATIONS 86
BUDGET SUMMARY – ARAPAHOE COUNTY SENIOR DENTAL PROGRAM 87
BUDGET SUMMARY – ADAMS COUNTY NURSE SUPPORT CONTRACTS 88
BUDGET SUMMARY – ARAPAHOE COUNTY NURSE SUPPORT CONTRACTS 89
BUDGET SUMMARY – DOUGLAS COUNTY MOTHERS FIRST 90
BUDGET SUMMARY – CHILD FATALITY PREVENTION REVIEW 91
BUDGET SUMMARY – NURSE FAMILY PARTNERSHIP 92
BUDGET SUMMARY – PUBLIC HEALTH NURSING CLINICAL EDUCATION 93
BUDGET SUMMARY – HARM REDUCTION AND HIV PREVENTION 94
BUDGET SUMMARY – IMMUNIZATION AND CLINICAL OUTBREAK RESPONSE 95

TABLE OF CONTENTS

BUDGET SUMMARY – HEALTH ENROLLMENT TEAMS AND REGIONAL HEALTH CONNECTORS 96
BUDGET SUMMARY – MATERNAL AND CHILD HEALTH (MCH) PROGRAMS 98
BUDGET SUMMARY – SEXUAL HEALTH 99

5 - EMERGENCY PREPAREDNESS, RESPONSE, AND COMMUNICABLE DISEASE SURVEILLANCE DIVISION 100
BUDGET SUMMARY – EMERGENCY PREPAREDNESS, RESPONSE, AND COMMUNICABLE DISEASE SURVEILLANCE DIVISION 102
FUNDING SOURCES CHART – EMERGENCY PREPAREDNESS, RESPONSE, AND COMMUNICABLE DISEASE SURVEILLANCE DIVISION 103
BUDGET SUMMARY – PUBLIC HEALTH EMERGENCY PREPAREDNESS PROGRAM 104
BUDGET SUMMARY – NATIONAL SYNDROMIC SURVEILLANCE PROGRAM 106
BUDGET SUMMARY – SYNDROMIC SURVEILLANCE SUICIDE PREVENTION 108
BUDGET SUMMARY – OVERDOSE DATA TO ACTION 109
BUDGET SUMMARY – CITIES READINESS INITIATIVE 110
BUDGET SUMMARY – COMMUNICABLE DISEASE 112
BUDGET SUMMARY – ADMINISTRATION 113

6 - ENVIRONMENTAL HEALTH DIVISION 114
BUDGET SUMMARY – ENVIRONMENTAL HEALTH DIVISION 116
FUNDING SOURCES CHART – ENVIRONMENTAL HEALTH DIVISION 117
BUDGET SUMMARY – DIVISION ADMINISTRATION & INFORMATICS 118
BUDGET SUMMARY – CHILD CARE PROGRAM 119
BUDGET SUMMARY – FOOD PROTECTION PROGRAM 120
BUDGET SUMMARY – GENERAL ENVIRONMENTAL SERVICES 122
BUDGET SUMMARY – INDUSTRIAL HYGIENE PROGRAM 123
BUDGET SUMMARY – LAND USE PROGRAM 124
BUDGET SUMMARY – ROCKY MOUNTAIN ARSENAL 125
BUDGET SUMMARY – SOLID & HAZARDOUS WASTE PROGRAM 126
BUDGET SUMMARY – VECTOR SURVEILLANCE PROGRAM 128
BUDGET SUMMARY – WATER PROGRAM 130

7 - HUMAN RESOURCES DIVISION 132
BUDGET SUMMARY – HUMAN RESOURCES DIVISION 134
BUDGET SUMMARY – EMPLOYEE WELLNESS 135
BUDGET SUMMARY – HUMAN RESOURCES 136

TABLE OF CONTENTS

8 - ADMINISTRATION AND FINANCE DIVISION 138
BUDGET SUMMARY – ADMINISTRATION AND FINANCE DIVISION 140
BUDGET SUMMARY – FINANCE AND OPERATIONS 141
BUDGET SUMMARY – VITAL RECORDS 143
BUDGET SUMMARY – COVID-19 144

9 - PLANNING AND INFORMATION MANAGEMENT DIVISION 146
BUDGET SUMMARY – PLANNING AND INFORMATION MANAGEMENT DIVISION 148
BUDGET SUMMARY – DATA ANALYTICS 149
BUDGET SUMMARY – DIVISION ADMINISTRATION 151
BUDGET SUMMARY – HUMAN PAPILLOMAVIRUS 152
BUDGET SUMMARY – INFORMATION TECHNOLOGY 153
BUDGET SUMMARY – MEDICAL EPIDEMIOLOGY 155

GLOSSARY 156

2021 Budget Message



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Introduction

We are pleased to present the Adopted FY 2021 Tri-County Health Department (TCHD) budget to our Board of Health and Adams, Arapahoe, and Douglas Counties. This document reflects our overall Department budget, as well as program descriptions and division-specific budgets. While it is largely based on activities by our divisions in effectively carrying out our traditional core public health functions, it also reflects our response to the unprecedented COVID-19 pandemic as well as continued efforts to address strategic priorities outlined in our new Public Health Improvement Plan. The priorities of our Plan include Access to Mental and Physical Health Care Services, Mental Health, Health and Food, and the developmental priority area, Health and Housing.

Overall, our adopted FY 2021 budget reflects an decrease of $4,289,158 (-7.18%) from our FY 2020 revised budget, largely reflecting federal support for the COVID-19 response in FY 2020 that is not currently anticipated in FY 2021. In addition, to support our budget, TCHD is requesting an increase in county funds based on population increase. Our counties have a forecasted increase in population of 1.69%. TCHD is requesting the associated $184,983 appropriation increase, maintaining the current county per capita rate of $7.10.

Due to Novel Coronavirus-19 (COVID-19) pandemic TCHD received emergency funding in the form of State and Federal dollars. Coronavirus Aid, Relief, and Economic Security (CARES) Act funding and, as noted, COVID-19 funding was the primary contributor to the increase in revenue. The Epidemiology and Laboratory Capacity (ELC) funding received totaled $11.3M. While funding to support the expected roll-out of FDA-approved vaccines may occur in the future, they are not part of our adopted budget.

As illustrated by the response to the COVID-19 pandemic, TCHD continues to strive to address ongoing challenges and to remain prepared to respond to emerging issues. Among others, these include:

- Intermittent outbreaks of serious communicable disease issues such as measles, mumps, viral hepatitis, Legionnaire's disease, West Nile virus, Tularemia, and E. coli and other foodborne illnesses,
- The impact of electronic smoking devices and vaping in our communities, especially among the youth population,
- The need to respond to the leading preventable causes of death and disability: tobacco use and obesity,
- Growing recognition of food insecurity as a challenge for many of our residents,
- Emerging recognition of the need to address mental health and substance abuse as important public health issues,
- The ongoing epidemic of opiate overdose due both to misuse of prescription opiates and increases in the use of heroin and other injectable opiates,
- Ongoing need to work with emergency preparedness and response partners to address natural disasters (i.e., wildfires, tornadoes, flooding) and epidemics,

- Increased opportunities to collaborate with other partners to improve population health through improved interactions with the health care delivery system, better analysis and dissemination of health data, and more strategically targeted communications.

In addressing these challenges, TCHD continues to rely upon and seek support from a variety of major funding streams, to include:

- Categorical state and federal funds (e.g., family planning, maternal and child health, immunizations, WIC),
- Fees for specific services that are mandated by state statute (e.g., restaurant licensing fees, individual sewage disposal system permitting fees),
- Vital Records (birth and death certificates, now available at three TCHD offices),
- Reimbursement for personal health services (e.g., family planning) generated by both client payment as well as third-party billing,
- Grants and contracts,
- State, Local Planning and Support funding,
- County per capita contributions for public health core services and categorical county funding for specific programs (e.g., Nurse home visit, Dental services for seniors).

Because over 75% of our non-county per capita funds are categorical and thus restricted in terms of the services we are able to provide, county per capita funding continues to be especially critical. It helps us maintain vital infrastructure and build organizational capacity, which allows us to respond to ever-changing local needs and emerging strategic priorities. In addition, county funding may sometimes provide a financial match for some of our outside grants and contracts, creating leverage and synergy in providing additional services that could not have been provided with county dollars alone.

In addition to the priorities outlined in our Strategic Plan, TCHD will continue to provide a wide variety of core public health services to the residents of our region. These include, but are not limited to:

- Provision of vital records
- Restaurant inspections
- Onsite waste water treatment system approvals
- Childcare center inspections
- Consultations on environmental exposures
- Land use consultation
- Methamphetamine laboratory clean-up consultation
- Emergency preparedness and response
- Disease outbreak identification and management
- Analysis of community health data
- Tobacco prevention
- Injury prevention
- Sexual health
- Immunizations

- Maternal and Child Health (MCH) services
- Women, Infants and Children (WIC) program
- Nutrition education
- Public communication

About Tri-County Health Department

Tri-County Health Department (TCHD) serves over 1.5 million people in Adams, Arapahoe and Douglas Counties, and offers over 60 programs/services ranging from birth certificates, immunizations and health care referrals, restaurant inspections, and infectious disease investigations. TCHD operates out of 11 offices in this 3,000 square mile area and has included in its jurisdiction 26 municipalities, 15 school districts with more than 360 public schools, and 12 acute care hospitals.

Tri-County District Health Department began operations on January 1, 1948 and initially served the 160,000 residents of Adams, Arapahoe and Jefferson Counties. Jefferson County separated from Tri-County in 1958 to form its own local health department and Douglas County officially joined Tri-County District Health Department on January 1, 1966, creating the current jurisdictional structure.

Revenues

Forecasted revenues for FY 2021 are estimated to be $55.5 million. This is a decrease of 7.18% as compared to the revenue projection of $59.8 million in the FY 2020 revised budget. This change in revenue is primarily CARES Act funding, in fee revenue and State contracts. Additionally, as noted above, TCHD is requesting an increase in county funds based on estimated population increase of 1.69%, maintaining the county per capita rate of $7.10. This represents an overall adopted FY 2021 county appropriation increase of $184,983 over FY 2020.

Tri-County Health Department receives revenue to fund operations from a variety of sources, which are listed below.

County Appropriations – These are the funds provided by Adams, Arapahoe, and Douglas counties for core public health services.

County Program Specific Funds – Funds provided by individual counties for specific programs. Funds are restricted to these programs.

Grants/contracts – Funding from foundations and other organizations for specific programs. Funds are generally restricted to these programs.

Fees/Donations – Fees and donations collected while performing specific public health services (e.g., restaurant inspections) for the public or private businesses.

State Funds and Federal Pass Through Funds – Funds received from the Colorado Department of Public Health and Environment (CDPHE) and other state agencies. This includes State Planning and Support for general public health services as well as program specific funding for programs in various TCHD divisions.

Medicaid Funds – Nursing funding provided through joint federal and state government cooperation. These funds are received from providing direct services to qualified patients.

Use of Fund Balance – Operational funding provided from the TCHD Fund Balance for capital improvement purposes (i.e., facility renovations, information technology updates, other capital replacements).

In-Kind Revenue – Non-cash income that takes the form of provided supplies or free rent. In-kind revenue is offset in the budget by an equal amount of in-kind expense.

Financial Policies

Tri-County Health Department has enacted financial policies to establish objectives, standards, and internal controls as well as to help frame resource allocation decisions for agency funds. The following policies are outlined below: Fund Balance Policy, Investment Policy, and Purchasing Policy.

Fund Balance Policy – The purpose of this policy, in accordance with Governmental Accounting Standards Board (GASB) Statement 54, is to ensure the financial security of TCHD through the maintenance of healthy fund balance reserves, which will guide the creation, maintenance, and use of resources for financial stabilization purposes.

The TCHD Board of Health (BOH) reviews and approves annual budgets and fund balance allocations with the authority to set aside funds to be designated for specific purposes. There are five categories comprising the fund balance, which represents the equity available to finance expenditures for routine or emergency purposes:

- Non-spendable Fund Balance includes items not expected to be converted to cash in the near term (e.g., inventories and prepaids), or funds that legally or contractually must be maintained intact.

- Restricted Fund Balance includes amounts that can be spent only for the specific purposes stipulated by constitution, external resource providers, or through enabling legislation (e.g., debt covenants reserves, TABOR reserves).

- Committed Fund Balance includes amounts that can be used only for the specific purposes (e.g., emergency operating and compensated absences) determined by a formal action of the TCHD BOH. The same formal action must be taken to remove or change the limitations placed on the funds.

- Assigned Fund Balance consists of funds intended to be used for specific purposes but do not meet the criteria to be classified as Restricted or Committed (e.g., facilities master plan projects, IT infrastructure projects, capital replacement projects).

- Unassigned Fund Balance is the residual classification of the General Fund and includes all spendable amounts not contained in the other classifications. This category also provides the resources necessary to meet unexpected expenditures and revenue shortfalls.

Investment Policy – this applies to the investment of TCHD funds, including short-term operating funds and long-term reserves. Overall, the investment policy must consider the liquidity needs for conducting daily operations as well as cash needs related to short-term needs, and long-term objectives including large information technology purchases and capital asset acquisitions. Investment activities should:

- Preserve capital and protect investment principal,

- Maintain sufficient liquidity to meet anticipated cash flows,

- Attain the market rate of return,

- Diversify to avoid incurring unreasonable market risks,

- Conform to all applicable State statutes and Federal regulations,

- Use low investment and management fees,

- Invest funds in fiscally sound, reputable banks, investment pools and brokerage firms.

Purchasing Policy – to promote maximum value and economy for TCHD through fair and competitive processes, which promotes confidence in TCHD financial practices. This applies to goods or services purchased by any person employed by TCHD for work related matters, regardless of the source of funding. All expenditures shall be made in compliance with applicable Colorado Revised Statutes, OMB Uniform Guidance (2.CFR.200) and adhere to all TCHD policies and procedures related to purchases of goods and services and the expenditures of approved budgets.

Expenditures must also comply with specific requirements as determined by specific funding sources in established agreements/contracts. Purchases are to be made in an environment of full and open competition, while ensuring the best interest of TCHD with regards to quality products and services, prompt delivery, and fair and reasonable pricing. All purchases and agreements should be free from any conflict of interest for any TCHD employee or BOH member and support ethical standards.

Budget Process

Tri-County Health Department is required to adopt an annual budget per Colorado Revised Statute (CRS) Title 29, Article 1, Section 103. The budget must include: adopted expenditures and revenues for the budget year; estimated beginning and ending fund balances; and, corresponding actual figures for the prior fiscal year and estimated figures for the current fiscal year. CRS Title 29, Article 1, Section 108 requires the TCHD BOH to hold a public hearing on the matter of adopting the adopted budget and subsequently adopt the budget after an affirmative vote of the majority of the board.

TCHD budgets annually on a calendar basis, January 1 to December 31. Budget revenues are identified by source. Expenditures are identified by agency, division, and program groups. For each of these groups, revenue and expenditures show the most recent completed and audited fiscal year, the current budget year, and the adopted budget. The budget must be balanced with expenditures not exceeding total anticipated revenue or general fund allocation.

Divisions and Programs Presented

Within each TCHD division's budget section, there are program narratives for major programs, an overall division budget report, a pie chart of divisional funding sources, and individual budget reports for significant divisional programs. The last revenue line on each budget report page displays the amount of required general funds that are used to fund that program/division. If this amount is a negative number (denoted by parenthesis), that program/division contributes to the general fund instead.

These general funds include county per capita; state, local planning and support funding; vital records fees; interest and investment income; and fund balance usage. The percentage of county and non-county general funds used is also listed at the bottom of each budget report page.

Budget Amendments

Amendments are made as new contracts or contract amendments are received during the year. These are presented to the BOH at the October meeting for approval.

Budget Timeline

The annual TCHD budget process starts each spring and is completed in December. The process for the 2021 budget is outlined below.

February

- Present Budget Calendar to BOH
- BOH Meeting – 2020 Supplemental Budget resolution presented to the BOH based on new/renewal contracts and grants

April

- Division Directors and Program Manager Budget session

May

- Meet with BOH Budget Committee to review budget
- Late May/Early June – County Leadership provides "Priorities and Policies" or Budget Guidance documents to internal department directors

June

- BOH Meeting – Present the 2021 budget dynamics document
- BOH Meeting – Rubin Brown, LLC presents 2018 year-end Audit

July

- Finalize budget data and prepare for August presentations
- Meet with BOH Budget Committee to review Budget Presentation content and approach

August

- BOH Meeting – Present the Proposed 2021 budget

September

- The Proposed 2021 Budget is presented to Adams, Arapahoe, and Douglas Board of County Commissioners

October

- BOH Meeting – 2020 Supplemental Budget resolution presented to the BOH based on new/renewal contracts and grants

November

- Finalize budget data and prepare for December presentation

December

- Tri-County Health Department BOH adopts 2021 budget

Basis of Budgeting and Accounting

Tri-County Health Department uses the modified accrual basis of accounting for both budgeting and financial statements. Revenues are recognized in the accounting period when it is earned while expenses are recognized in the period when the liability is incurred. The budget is used as a legal instrument authorizing the expenditure of public funds, as an accounting framework for allocating fiscal stewardship, and as a management tool for planning the direction for utilizing revenues.

Fund Balance

Tri-County Health Department maintains a fund balance in accordance with the TCHD Fund Balance Policy. The chart below shows the estimated fund balance at the start of 2021 and projected fund balance at the end of 2021. The change in fund balance is due to the outlined capital projects below.

Fund Title	Type	FY19 Audit Balances	Revised FY20*	Adopted FY21 Designations	Proposed Change
Inventory Reserve	Non-spendable	$ 84,671	$ 84,671	$ 84,671	$ -
Pre-paid Reserve	Non-spendable	$ 185,684	$ 185,684	$ 185,684	$ -
	Total Non-Spendable	$ 270,355	$ 270,355	$ 270,355	$ -
Emergency Operating Fund	Committed	$ 10,390,436	$ 10,390,436	$ 10,390,436	$ -
Compensated Absences	Committed	$ 1,452,347	$ 1,452,347	$ 1,452,347	$ -
	Total Committed	$ 11,842,783	$ 11,842,783	$ 11,842,783	$ -
Facilities Leasehold Improvements	Assigned	$ 979,100	$ 1,192,100	$ 979,100	$ (213,000)
Capital Equipment-IT	Assigned	$ 583,387	$ 746,387	$ 583,387	$ (163,000)
Capital Software/Systems	Assigned	$ 259,088	$ 1,084,088	$ 259,088	$ (825,000)
	Total Assigned	$ 1,821,575	$ 3,022,575	$ 1,821,575	$ (1,201,000)
TCHD Operating	Unassigned	$ 7,417,297	$ 6,855,297	$ 6,855,297	$ -
	Total Unassigned	$ 7,417,297	$ 6,855,297	$ 6,855,297	$ -
TOTAL		$ 21,352,010	$ 21,991,010	$ 20,790,010	$ (1,201,000)

* Revised to reflect FY19 Audited Financials

* Revised to reflect FY19 Audited Financials

Capital Fund Balance reduced for:	
Facilities Master Plan Projects	$ 213,000
IT Infrastructure Projects	$ 163,000
Capital Replacement Projects	$ 825,000
	$ 1,201,000

Mission, Vision, Values, and Guiding Principles

Vision
Optimal health across the lifespan for the populations we serve.

Mission
Promote, protect and improve the lifelong health of individuals and communities in Adams, Arapahoe and Douglas Counties through the effective use of data, evidence-based prevention strategies, leadership, advocacy, partnerships, and the promotion of health equity.

Values and Guiding Principles
Values for the agency are demonstrated in the behavior and decisions of all our employees and in how we conduct our efforts in the communities we serve. TCHD, its Board and its employees have adopted these eight core values that guide behavior, organizational policy, and decision-making. These values not only apply to how we interact with each other internally, but how we treat our partners and clients externally.

- Respect – We treat others with the same dignity as we wish to be treated. We honor the whole person and recognize the importance of work-life balance and diverse perspectives. We recognize the power of teamwork and appreciate the unique contributions that each member of a team can make.
- Integrity – We maintain consistency in what we say and what we do. We uphold high ethical standards and maintain accountability to each other and the communities that we serve.
- Courage – We stand up for what is right in the face of adversity. We communicate openly and welcome honest feedback. We advocate for those who cannot do it for themselves.
- Excellence – We strive for the highest quality in everything that we do. We pursue opportunities and seek creative and innovative solutions to the challenges that face us.
- Leadership – We believe that everyone can be a leader. We empower others to act; we encourage everyone to reach their fullest potential; and we model our core values.
- Collaboration – We seek to sustain and enhance the reach and impact of our efforts through the respectful engagement with community partners (local, regional and state).
- Stewardship – We maintain stewardship of public monies and facilities through active management and always striving to provide targeted, high quality, and cost-effective services for the community.
- Innovation – We seek and encourage innovative approaches to address public health issues, reach diverse communities and improve agency operation.

Public Health Accreditation

The Public Health Accreditation Board (PHAB) nationally recognized Tri-County Health Department in November 2017 for demonstrating excellence in the field of public health. Earning National Accreditation for five years means that TCHD meets or exceeds the rigorous standards established by the non-profit, non-governmental PHAB. TCHD was noted for its strong quality improvement culture, for using evidence-based practices in our programs and strategies as well as for our strong relationships with our community partners and the Board of Health.

The achievement of National Accreditation and our annual reporting to maintain accreditation continues to help guide our work to better protect, promote, and preserve the health of the people in our community.



Public Health Improvement Plan and Strategic Plan Overview

Public Health Improvement Plan Priorities

Our 2019-2024 Public Health Improvement Plan includes three primary Priority Areas and one developmental Priority Area. These include: Access to Mental and Physical Health Care Services, Mental Health, Health and Food, and the developmental priority area, Health and Housing.

Activities in each priority area shifted in 2020 to focus on the impact due to COVID-19. Housing, food, access to care, and mental health have become more critical than ever during the response to COVID-19. These key drivers of health have been central to the COVID-19 human needs response as the impacts of this virus have tested our economic and social structures in deep ways. These efforts will continue through 2021. The vision for each Priority Area is listed below.

- **Access to Mental and Physical Health Care Services**
  Vision: In a healthy community, all people across the life course, regardless of their income or other circumstances, can access high quality physical health, mental health, and substance use services.
- **Mental Health**
  Vision: In a healthy community, positive mental health and social connections allow people to have the mental and physical energy, vitality, and resilience to live joyfully and cope with the stresses of life, work productively, and make meaningful contributions to their communities.
- **Health and Food**
  Vision: In a healthy community, all residents can access safe, nutritious, affordable, and culturally relevant food and are able to practice healthy eating habits.
- **Health and Housing**
  Vision: In a healthy community, quality, attainable housing is available and people have the tools and resources to stay in their communities and feel connected to their neighborhood.

Strategic Plan

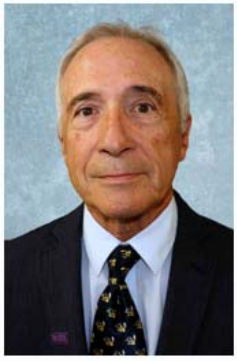
In 2019, TCHD embarked on a strategic planning process for a six-year agency-wide strategic plan. While a lot of progress was made in 2020, some of TCHD's strategic efforts were paused due to the COVID-19 response. Activities will continue, or resume, in 2021 dependent on the agency's capacity to shift resources from the COVID-19 response.

The Priority Areas include Employee Retention and Development, Excellence in Business Practices, Strengthen Organizational Culture, and Partner for Healthy Communities. The Priority Areas help support, either directly or indirectly, both our core services as well as the implementation of the Public Health Improvement Plan. The plan provides the agency with a roadmap that allows the agency to navigate changes in the complex environment of public health at the local level and further allows TCHD to take action on critical issues and to advance our mission, vision and values. The full Strategic Plan can be found here.

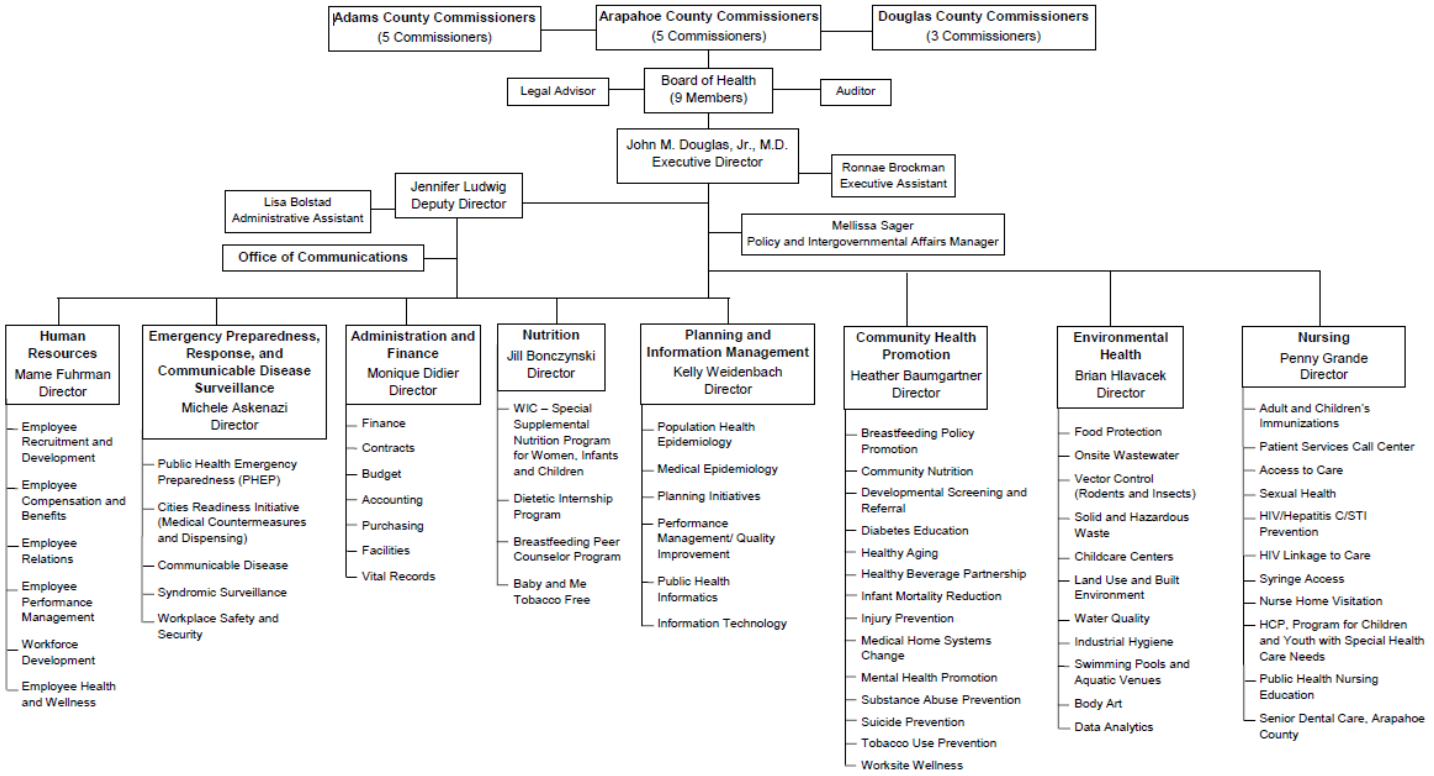


Tri-County Health Department Board of Health

The Board of Health of the Tri-County Health Department is comprised of nine members: three each from Adams, Arapahoe and Douglas Counties. Board members are appointed by their respective County Commissioners and serve five-year terms.

Adams County	Arapahoe County	Douglas County
		
Rosanna Reyes, RN Term Expires: Jan 2025 President	Jan Brainard, RN Term Expires: Feb 2023 Secretary	Zachary Nannestad, MPH Term Expires: Jan 2024 Vice President
		
Julie Mullica, MPH Term Expires: Jan 2022	Thomas Fawell, MD Term Expires: Feb 2022	Marsha Jaroch, NP Term Expires: Jan 2025
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Richard Delaney, JD, MPH Term Expires: Jan 2021	Kaia Gallagher, PhD Term Expires: Feb 2021	Paulette Joswick, RN Term Expires: Jan 2023

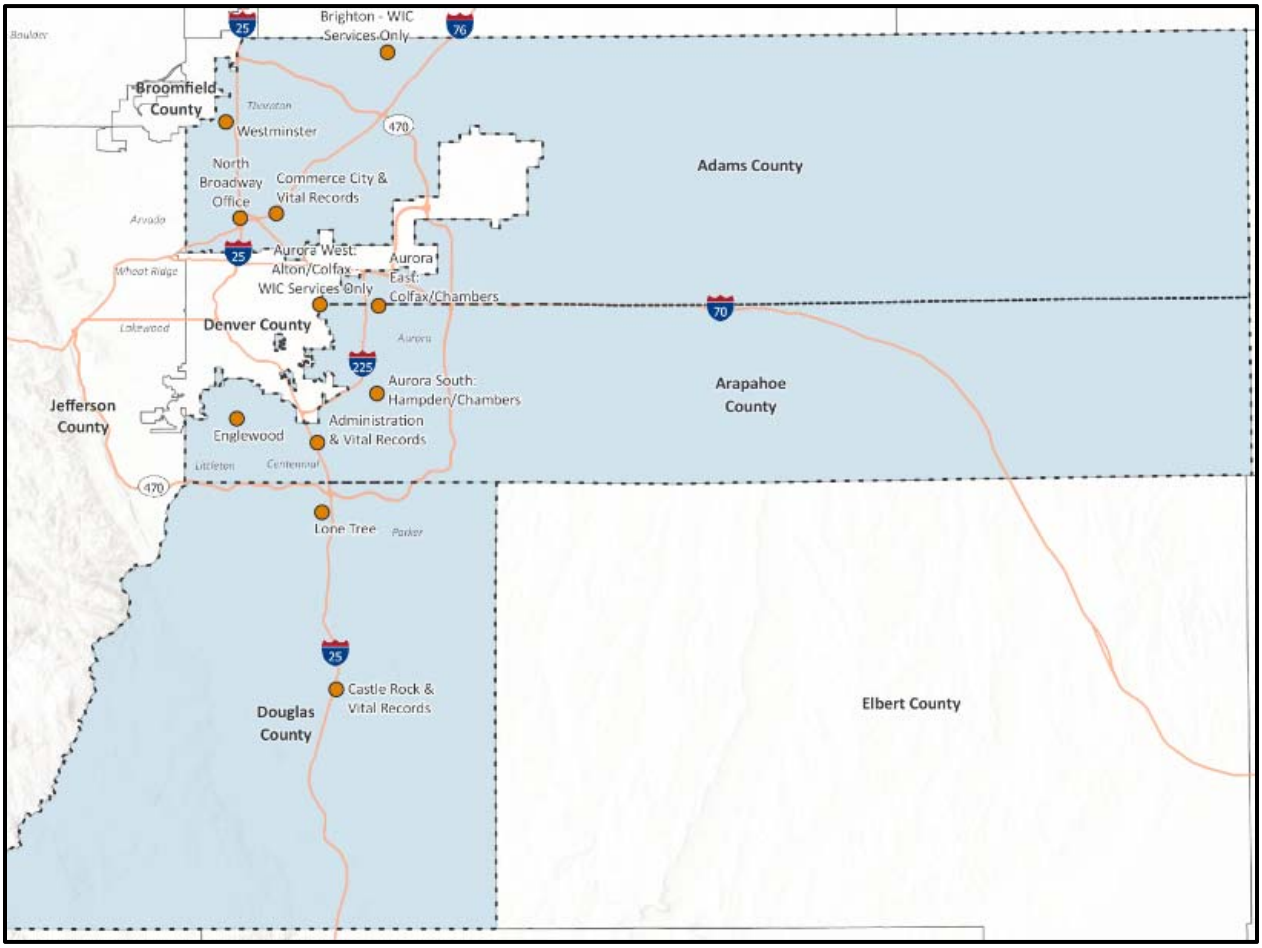
TCHD 2021 ORGANIZATIONAL CHART



Note: This is the current TCHD Organizational Chart and determines how the subsequent division budgets are organized in this budget book.

OFFICE LOCATIONS

There are currently 11 offices located throughout the Tri-County region. Each county provides at least one office for use by TCHD at no cost, but there are many expenses that are paid for by the Department to meet the needs of programs and projects located in these offices. TCHD leases the other offices, which requires the Department to negotiate the leases and pay rent out of available funding.



- Administration & Vital Records (Leased)
  6162 S. Willow Drive, Suite 100
  Greenwood Village, CO 80111
  303/220-9200

- Aurora East: Colfax/Chambers (Provided by Arapahoe County)
  15400 E. 14th Place, Suite 115
  Aurora, CO 80011-5828
  303/341-9370

- Aurora South: Hampden/Chambers (Leased)
  15192 E Hampden Avenue
  Aurora, CO 80014
  303/873-4400

- Aurora West: Alton/Colfax—WIC Services Only (Leased)
  9000 E. Colfax Avenue, Suite 105
  Aurora, CO 80010
  303/361-6010

- Brighton—WIC Services Only (Leased)
  30 S. 20th Avenue
  Brighton, CO 80601
  303/659-2335

- Castle Rock & Vital Records (Provided by Douglas County)
  410 South Wilcox
  Castle Rock, CO 80109
  303/663-7650

- Commerce City & Vital Records (Provided by Adams County)
  4201 E. 72nd Avenue, Suite D
  Commerce City, CO 80022-1488
  303/288-6816

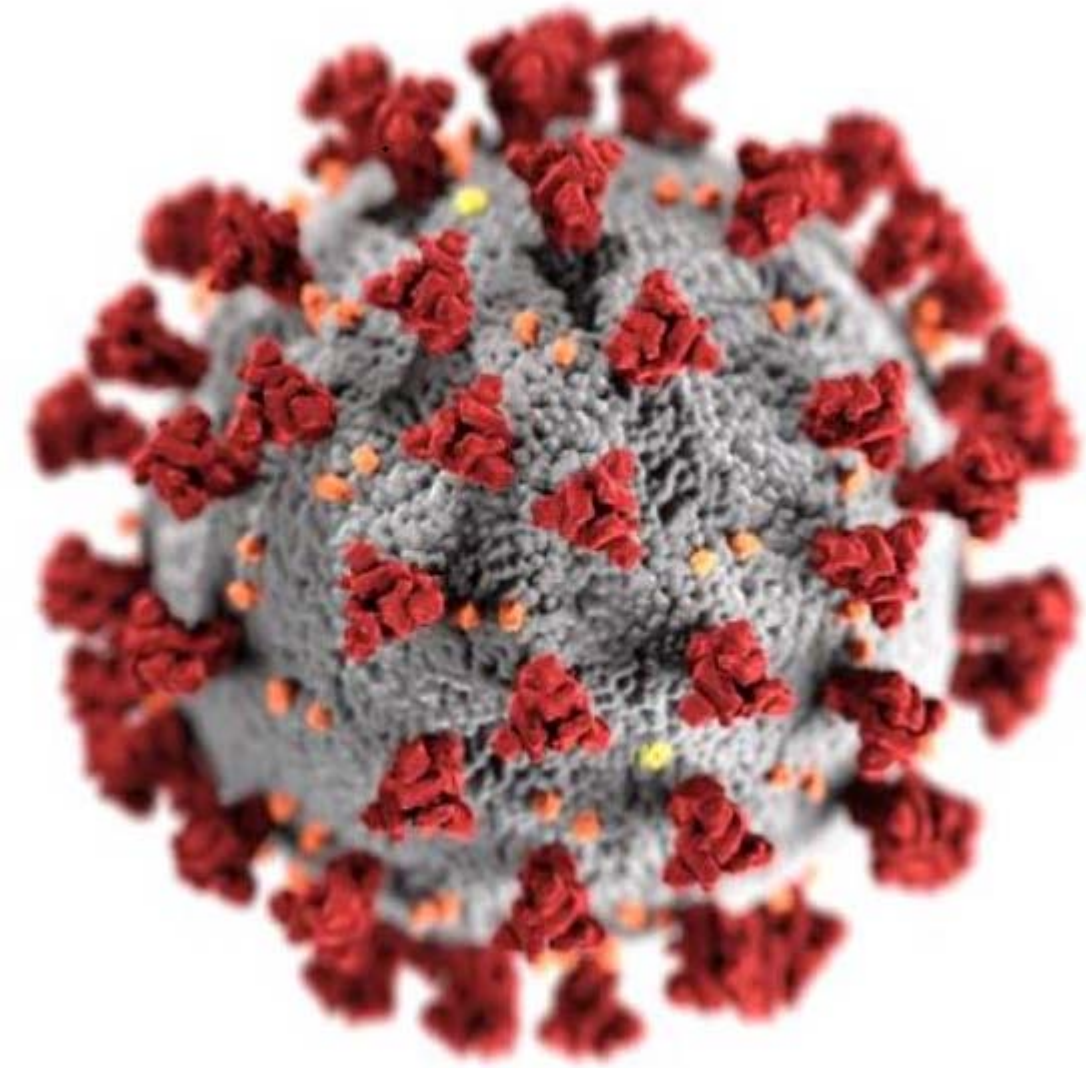
- Englewood (Provided by Arapahoe County)
  4857 S. Broadway
  Englewood, CO 80113
  303/761-1340

- Lone Tree (Provided by Douglas County)
  9350 Heritage Hills Circle
  Littleton, CO 80124
  303/784-7866

- North Broadway Office (Leased)
  7000 North Broadway #400
  Denver, CO 80221
  303/426-5232

- Westminster (Leased)
  1401 W 122nd Ave #200
  Westminster, CO 80234
  303/452-9547

2021 Adopted Budget



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SUMMARY OF BUDGET CHANGES 2020 TO 2021

Changes to Revenues/Sources of Funds - County Per Capita Contributions

	2020 Projected Population [1]	2021 Projected Population [1]	Population Inc/(Dec)	Population Inc/(Dec) Percent	3- County Population Inc/(Dec) %
Adams County	530,680	538,238	7,558	1.42%	
Arapahoe County	662,304	671,733	9,429	1.42%	
Douglas County	350,161	359,228	9,067	2.59%	
Total	1,543,145	1,569,199	26,054		1.69%

	2021 Percent of 3-County Population	2020 Adopted Appropriation	2021 Proposed Appropriation	Increase Amount [2]	2021 Adopted Per Capita Rate [3]
Adams County	34.3%	$3,767,828	$3,821,490	$53,662	$7.10
Arapahoe County	42.8%	4,702,358	4,769,304	66,946	$7.10
Douglas County	22.9%	2,486,143	2,550,519	64,376	$7.10
Total	100%	$10,956,330	$11,141,313	$184,983	

Notes:

1. Preliminary 2020/20221 population projections, based on estimates from the State Demographer's Office, increase the population base by 26,054.

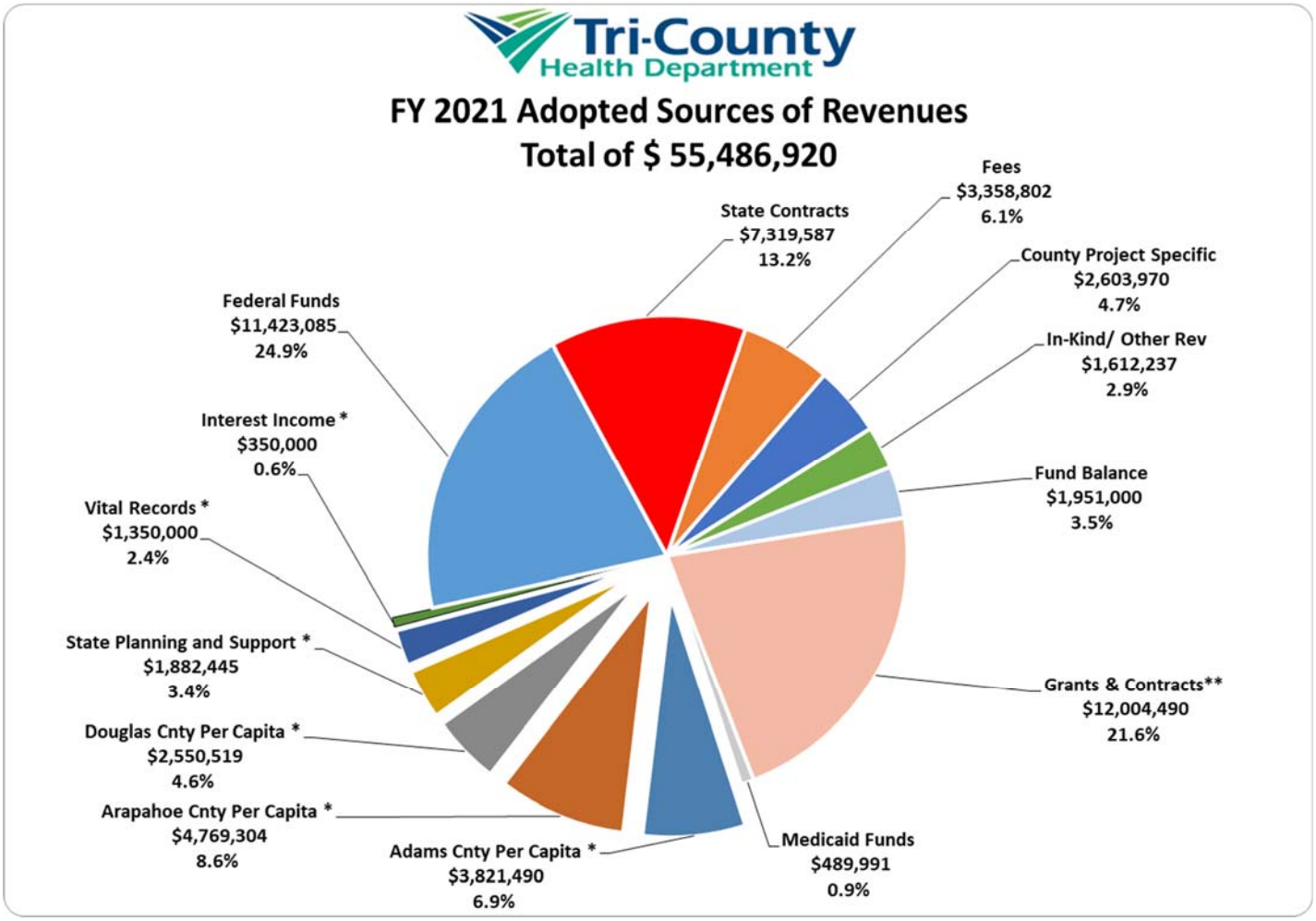
2. The FY 2021 proposed County Appropriation of $11,141,313 is a 3.8%, or $184,983, increase over the total County Appropriation amount from FY 2020. The increase related to population is 26,054, creating the $184,983 increase in the annual appropriation.

3. The FY 2021 proposed County Per Capita contribution rate of $7.10 is flat with 2020 rate of $7.10.

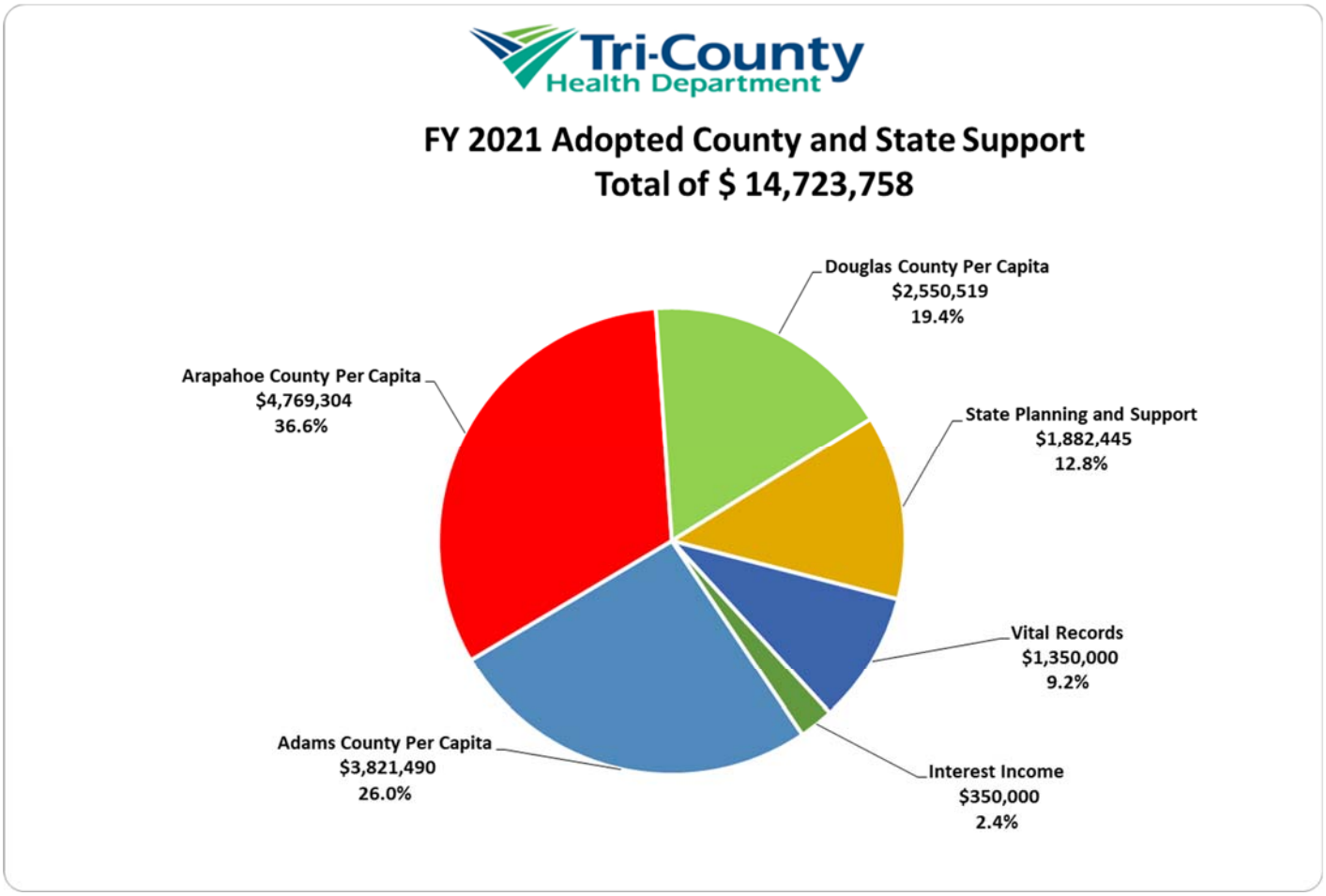
SUMMARY OF BUDGET CHANGES 2020 TO 2021

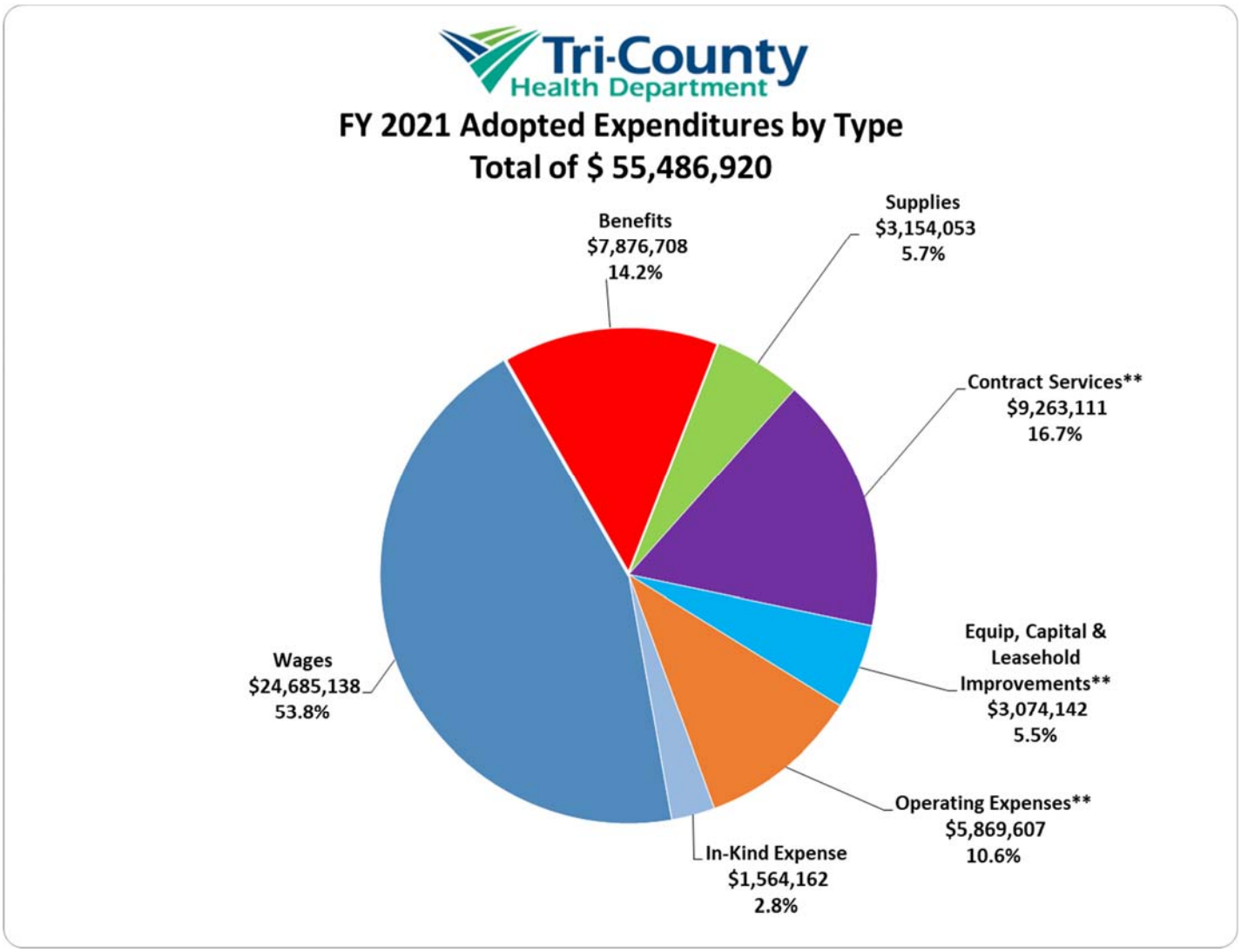
Changes to Revenues/Sources of Funds	2020 Revised Budget	2021 Adopted Budget	Increase / (Decrease) $	Increase / (Decrease) %
County Per Capita	$ 10,956,330	$ 11,141,313	$ 184,983	1.69%
County Project Specific	11,308,530	$ 2,603,970	(8,704,560)	(76.97%)
Federal Funds	336,520	407,681	71,161	21.15%
Medicaid Funds	491,491	489,991	(1,500)	(0.31%)
Fees	3,357,213	3,008,802	(348,411)	(10.38%)
Interest Income	350,000	350,000	-	0.00%
Vital Records Fees	1,463,678	1,350,000	(113,678)	(7.77%)
State Contracts	8,139,504	7,319,587	(819,917)	(10.07%)
State Planning and Support	1,882,445	1,882,445	-	0.00%
Federal Pass Through Funds	16,892,892	11,015,404	(5,877,488)	(34.79%)
Other Grants & Contracts	1,197,238	12,004,490	10,807,252	902.68%
Other Revenue *	88,075	398,075	310,000	351.97%
Fund Balance Use	1,748,000	1,951,000	203,000	11.61%
In-Kind	1,564,162	1,564,162	-	0.00%
TOTAL REVENUES	**$ 59,776,078**	**$ 55,486,920**	**$ (4,289,158)**	**(7.18%)**
	$ -			

* Other revenue includes rebates and refunds



* General Revenue


Tri-County
Health Department
FY 2021 Adopted County and State Support
Total of $ 14,723,758
Douglas County Per Capita
$2,550,519
19.4%
State Planning and Support
$1,882,445
12.8%
Vital Records
$1,350,000
9.2%
Interest Income
$350,000
2.4%
Adams County Per Capita
$3,821,490
26.0%
Arapahoe County Per Capita
$4,769,304
36.6%


Tri-County Health Department
FY 2021 Adopted Expenditures by Type
Total of $ 55,486,920
Benefits
$7,876,708
14.2%
Supplies
$3,154,053
5.7%
Contract Services**
$9,263,111
16.7%
Equip, Capital & Leasehold Improvements**
$3,074,142
5.5%
Operating Expenses**
$5,869,607
10.6%
In-Kind Expense
$1,564,162
2.8%
Wages
$24,685,138
53.8%

2021 BUDGET COMPARISON – REVENUE by PROGRAM

CODE	DESCRIPTION	2019 Actual	2020 Revised	2021 Adopted	Increase / (Decrease) $	Increase / (Decrease) %
130	EXECUTIVE *	$ -	$ 50,000	$ -	$ (50,000)	(100.00%)
131	METRO DENVER PARTNERSHIP FOR HEALTH *	41,684	50,000	50,000	$ -	0.00%
220	WIC GRANT	5,634,235	5,516,726	5,398,285	(118,441)	(2.15%)
222	WIC CENTRAL REFERRAL SYSTEM	-	100,491	99,661	(830)	(0.83%)
226	WIC PEER COUNSELOR GRANT	194,849	185,796	221,226	35,430	19.07%
238	HUNGER FREE OUTREACH	18,164	99,803	105,037	5,234	5.24%
240	DIETETIC INTERNSHIP *	60,855	59,600	63,500	3,900	6.54%
242	DRCOG AHC MODEL – CLINICAL PARTNER		60,341	164,015	103,674	171.81%
245	ADAMS CO. FOOD SECURITY		80,000	80,000	-	0.00%
270	BABY & ME - TOBACCO FREE GRANT	36,071	30,000	20,000	(10,000)	(33.33%)
290	NUTRITION ADMINISTRATION	(16)	-	-	-	0.00%
330	HEALTH PLANNING *	56,159	-	-	-	0.00%
332	WORKSITE WELLNESS - CCPD	289,483	300,300	300,300	-	0.00%
335	COMMUNITY NUTRITION *	-	-	-	-	0.00%
336	HEALTHY BEVERAGE INITIATIVE	51,655	50,250	53,395	3,145	6.26%
337	DIABETES PREVENTION	288,661	330,000	335,000	5,000	1.52%
338	ADVANCING BREASTFEEDING IN COLORADO	128,961	138,183	137,839	(344)	(0.25%)
351	TOBACCO - GRANT	1,035,462	1,328,075	1,318,077	(9,998)	(0.75%)
354	OPPI OPIOID	16,985	353,000	-	(353,000)	(100.00%)
355	SUBSTANCE ABUSE GRANT	164,347	-	-	-	0.00%
356	SAMSHA GRANT	31,565	168,881	168,881	-	0.00%
357	COMMUNITIES THAT CARE GRANT	358,281	349,690	362,852	13,162	3.76%
359	SIM/LPHA BEHAVIORAL HEALTH GRANT	333,159	-	-	-	0.00%
364	AGING INIT - MATTER OF BALANCE *	145,238	160,677	-	(160,677)	(100.00%)
371	MCH CHILD HEALTH/ADOLESCENT	129,061	259,897	267,650	7,753	2.98%
372	MCH WORA	117,902	253,073	246,397	(6,676)	(2.64%)
373	HCP MEDICAL HOME	105,926	141,566	157,743	16,177	11.43%
374	NENS REFERRAL	-	-	10,210	10,210	0.00%
390	COMMUNITY HEALTH PROMOTION ADMIN *	10,500	-	-	-	0.00%
411	CLINICAL SCHOLARS *	45,252	57,900	65,664	7,764	13.41%
415	CORE TUBERCULOSIS CONTROL *	2,100	2,100	2,100	-	0.00%
420	ADAMS MOTHERS FIRST	520,169	558,664	579,139	20,475	3.66%
424	ARAPAHOE MOTHERS FIRST	135,368	137,359	139,422	2,063	1.50%
425	CHILD FATALITY PREVENTION *	57,183	55,000	64,000	9,000	16.36%
426	ARAPAHOE NURSE SUPPORT	957,737	1,101,842	1,143,134	41,292	3.75%
427	DOUGLAS MOTHERS FIRST	-	125,000	143,967	18,967	15.17%
430	MCH CHILD HEALTH GRANT	112,511	-	-	-	0.00%
435	MCH PRENATAL GRANT	155,019	-	-	-	0.00%
440	HEALTH CARE PROGRAM FOR CHILDREN WITH SPECIAL NEEDS GRANT	662,470	651,838	637,577	(14,261)	(2.19%)
450	HEALTHY COMMUNITIES (EPSDT) *	595,013	498,624	-	(498,624)	(100.00%)
451	REGIONAL HEALTH	-	135,000	52,000	(83,000)	(61.48%)
453	2020 CENSUS OUTREACH	-	40,000	-	(40,000)	(100.00%)
455	NURSE FAMILY PARTNERSHIP CONTINUATION GRANT	2,835,765	3,146,705	3,203,712	57,007	1.81%
457	NFP MIECHVP 1 GRANT	762,085	864,676	916,801	52,125	6.03%
460	IMMUNIZATION CORE *	2,603,135	2,301,484	2,384,634	83,150	3.61%
469	HIV AND STD	799,212	588,515	764,691	176,176	29.94%
477	FAMILY PLANNING TITLE X *	1,735,729	1,709,323	1,702,256	(7,067)	(0.41%)

*Revenue codes with * indicates that General Fund Allocation is used for full or partial support of the program*

CODE	DESCRIPTION	Actual	Revised	Adopted	$	%
492	NURSING SPECIAL PROGRAMS *	2,507	-	-	-	0.00%
495	ARAPAHOE SENIOR DENTAL	436,348	511,456	443,456	(68,000)	(13.30%)
510	COMMUNICABLE DISEASE	96,191	91,373	91,373	-	0.00%
520	PUBLIC HEALTH EMERGENCY PREPAREDNESS GRANT	908,878	15,758,253	926,841	(14,831,412)	(94.12%)
530	CITIES READINESS INITIATIVE GRANT	255,517	253,537	253,537	-	0.00%
550	SYNDROMIC SURVEILLANCE GRANT	110,562	175,004	175,004	-	0.00%
551	SYNDROMIC SURVEILLANCE SUICIDE PREVENTION	17,486	201,520	201,520	-	0.00%
552	OVERDOSE DATA TO ACTION	5,178	150,000	150,000	-	0.00%
620	AIR POLLUTION GENERAL	19,613	153,674	25,337	(128,337)	(83.51%)
622	INDUSTRIAL HYGIENE - GENERAL *	1,650	12,200	12,200	-	0.00%
623	INDUSTRIAL HYGIENE - COMPLAINT - BILLABLE *	13,732	-	-	-	0.00%
627	INDUSTRIAL HYGIENE - RADON *	6,530	5,000	5,000	-	0.00%
630	RETAIL FOOD - GENERAL *	1,959,266	2,006,250	2,000,750	(5,500)	(0.27%)
640	CHILDCARE - GENERAL *	153,155	151,250	151,250	-	0.00%
643	BODY ART - GENERAL *	28,590	22,000	29,625	7,625	34.66%
645	RECREATION - GENERAL *	97,810	106,000	106,000	-	0.00%
650	LAND USE - GENERAL *	233,160	246,160	346,160	100,000	40.62%
656	WATER SUPPLIES - PRIVATE *	17,957	30,000	30,000	-	0.00%
657	WASTE WATER - GENERAL *	497,198	455,000	460,000	5,000	1.10%
658	WASTE WATER - BIO SOLIDS *	6,600	7,200	7,200	-	0.00%
668	SOLID & HAZARDOUS WASTE - GENERAL *	15,968	14,000	14,000	-	0.00%
669	SOLID & HAZARDOUS WASTE - DESIGNATED SOLID WASTE DISPOSAL *	1,660	1,660	1,660	-	0.00%
677	SHW - LOWRY SUPERFUND *	41,947	60,000	70,000	10,000	16.67%
678	SHW - TIRES *	9,617	16,237	15,945	(292)	(1.80%)
679	SOLID & HAZARDOUS WASTE - SEDALIA LANDFILL *	2,605	10,500	11,035	535	5.10%
680	SOLID & HAZARDOUS WASTE - TOWER LANDFILL *	5,388	10,000	15,742	5,742	57.42%
683	ROCKY MOUNTAIN ARSENAL MOA	92,362	135,000	206,161	71,161	52.71%
687	HOUSEHOLD CHEMICAL ROUNDUP EVENT *	221,900	253,000	216,064	(36,936)	(14.60%)
690	ENVIRONMENTAL HEALTH ADMINISTRATION *	175	-	-	-	0.00%
692	MEDICAL MARIJUANA MANUFACTURER *	1,000	1,000	3,500	2,500	250.00%
696	EH SPECIAL RESPONSE *	4,108	-	-	-	0.00%
930	DATA ANALYTICS	38,588	-	7,400	7,400	0.00%
970	HUMAN PAPILLOMAVIRUS	25,491	71,735	-	(71,735)	(100.00%)
990	PLANNING & INFORMATION MANAGEMENT ADMINISTRATION *	5,000	-	-	-	0.00%
810	FA OPERATIONS *	-	1,698,000	1,951,000	253,000	14.90%
819	COVID-19	-	-	11,000,000	11,000,000	0.00%
820	FA ADMINISTRATION *	461,764	463,162	463,162	-	0.00%
820	INTEREST INCOME	448,275	350,000	350,000	-	0.00%
840	FA FACILITIES *	2,000	-	-	-	0.00%
860	FA PURCHASING *	4,998	5,000	5,000	-	0.00%
870	FA ACCOUNTING *	4,209	8,075	8,075	-	0.00%
880	FA VITAL RECORDS	1,278,036	1,463,678	1,350,000	(113,678)	(7.77%)
895	COUNTY AND STATE PER CAPITA FUNDS					
	ADAMS COUNTY	3,635,084	3,767,828	3,821,490	53,662	1.42%
	ARAPAHOE COUNTY	4,557,246	4,702,359	4,769,304	66,945	1.42%
	DOUGLAS COUNTY	2,367,338	2,486,143	2,550,519	64,376	2.59%
	STATE PLANNING AND SUPPORT	1,914,773	1,882,445	1,882,445	-	0.00%
TOTAL REVENUE		**$41,235,397**	**$ 59,776,078**	**$ 55,486,920**	**(4,289,158)**	**(7.18%)**

*Revenue codes with * indicates that General Fund Allocation is used for full or partial support of the program*

2021 BUDGET COMPARISON – EXPENDITURE by PROGRAM

CODE	DESCRIPTION	2019 Actual	2020 Revised	2021 Adopted	Increase / (Decrease) $	Increase / (Decrease) %
130	EXECUTIVE	$ 949,423	$ 1,058,895	$ 1,048,272	$ (10,623)	(1.00%)
131	METRO DENVER PARTNERSHIP FOR HEALTH	84,000	64,000	64,000	-	0.00%
132	BOARD FUND	-	12,000	15,000	3,000	25.00%
140	COMMUNICATION	325,722	374,376	369,737	(4,639)	(1.24%)
220	WIC	4,396,833	4,220,206	4,156,881	(63,325)	(1.50%)
222	WIC CENTRAL REFERRAL SYSTEM	-	87,383	87,911	528	0.60%
226	WIC PEER COUNSELOR	150,602	142,606	171,135	28,529	20.01%
235	CHILD ADULT CARE FOOD PROGRAM - HEALTHIER MEALS INITIATIVE	-	-	-	-	0.00%
238	HUNGER FREE OUTREACH	16,549	90,730	95,489	4,759	5.24%
240	DIETETIC INTERNSHIP	125,027	131,108	136,496	5,388	4.11%
242	DRCOG AHC MODEL – CLINICAL PARTNER	-	46,086	126,521	80,435	174.53%
245	ADAMS CO. FOOD SECURITY	-	80,000	80,000	-	0.00%
270	BABY & ME - TOBACCO FREE	36,139	22,913	20,852	(2,061)	(8.99%)
290	NUTRITION ADMINISTRATION	547,700	156,093	167,408	11,315	7.25%
330	HEALTH PLANNING	197,210	98,824	147,709	48,885	49.47%
332	WORKSITE WELLNESS - CCPD	227,198	232,558	231,503	(1,055)	(0.45%)
335	COMMUNITY NUTRITION	365,879	417,788	415,951	(1,837)	(0.44%)
336	HEALTHY BEVERAGE INITIATIVE - CCPD	46,960	45,741	48,541	2,800	6.12%
337	DIABETES PREVENTION - CCPD	224,456	252,312	251,808	(504)	(0.20%)
338	ADVANCING BREASTFEEDING IN COLORADO - CCPD	100,612	105,727	106,410	683	0.65%
351	TOBACCO - 2012 GRANT	802,119	1,042,457	1,018,655	(23,802)	(2.28%)
354	OPPI OPIOID	13,336	295,996	-	(295,996)	(100.00%)
355	SUBSTANCE ABUSE PREVENTION	130,780	-	-	-	0.00%
356	SAMHSA GRANT	30,957	161,836	161,760	(76)	(0.05%)
357	COMMUNITIES THAT CARE	310,579	300,297	316,002	15,705	5.23%
358	MENTAL HEALTH PROMOTION	-	130,000	120,656	(9,344)	(7.19%)
359	SIM/LPHA BEHAVIORAL HEALTH	292,081	-	-	-	0.00%
364	AGING INIT - MOB GRANT	147,802	140,526	-	(140,526)	(100.00%)
371	MCH CHILD HEALTH/ADOLESCENT	99,577	198,856	204,578	5,722	2.88%
372	MCH WORA	92,778	196,043	190,275	(5,768)	(2.94%)
373	HCP MEDICAL HOME	87,607	108,726	120,634	11,908	10.95%
374	NENS REFERRAL GRANT PROJECT	-	-	10,411	10,411	0.00%
390	CHP ADMINISTRATION	373,095	274,845	310,027	35,182	12.80%
410	CORE NURSING	26,639	-	-	-	0.00%
411	CLINICAL SCHOLARS	34,080	57,900	65,664	7,764	13.41%
415	CORE TB CONTROL	337,872	288,692	285,811	(2,881)	(1.00%)
420	ADAMS MOTHERS FIRST	534,169	532,060	586,947	54,887	10.32%
424	ARAP MOTHERS FIRST	110,154	130,818	132,783	1,965	1.50%
425	CHILD FATALITY PREVENTION	62,116	62,553	66,984	4,431	7.08%
426	ARAP NURSE SUPPORT	887,994	1,049,372	1,088,699	39,327	3.75%
427	DOUG MOTHERS FIRST	-	119,050	137,111	18,061	15.17%
430	MCH CHILD HEALTH	86,976	-	-	-	0.00%
435	MCH PRENATAL	123,173	-	-	-	0.00%
440	HCP	513,484	499,770	487,864	(11,906)	(2.38%)
450	HEALTHY COMMUNITIES (EPSDT)	827,681	696,139	243,276	(452,863)	(65.05%)
451	REGIONAL HEALTH CONNECTORS	-	332,926	305,893	(27,033)	(8.12%)
453	2020 CENSUS OUTREACH	686	40,000	-	(40,000)	(100.00%)
455	NFP CONTINUATION	2,271,589	2,517,363	2,562,969	45,606	1.81%
457	NFP MIECHVP 1	694,594	786,068	833,455	47,387	6.03%
460	IMMUNIZATION AND CLINICAL RESPONSE	3,240,541	2,798,845	2,910,284	111,439	3.98%
461	CUSTOMER SUPPORT CENTER	-	362,335	322,299	(40,036)	(11.05%)
469	HIV AND STD	664,485	494,997	630,608	135,611	27.40%
477	SEXUAL HEALTH	3,196,541	3,420,730	3,423,688	2,958	0.09%

CODE	DESCRIPTION	2019 Actual	2020 Revised	2021 Adopted	Increase / (Decrease) $	Increase / (Decrease) %
490	NURSING ADMINISTRATION	1,658,038	1,040,219	1,210,467	170,248	16.37%
492	NURSING SPECIAL PROGRAMS	2,507	-	-	-	0.00%
495	ARAPAHOE SENIOR DENTAL	380,480	490,219	422,339	(67,880)	(13.85%)
510	COMMUNICABLE DISEASE	430,918	467,027	487,443	20,416	4.37%
520	PUBLIC HEALTH EMERGENCY PREPAREDNESS	755,744	15,555,946	731,982	(14,823,964)	(95.29%)
530	CRI	204,951	195,443	193,803	(1,640)	(0.84%)
550	NSSP	100,114	154,786	155,606	820	0.53%
551	SYNDROMIC SURVEILLANCE SUICIDE PREVENTION	13,516	159,429	159,371	(58)	(0.04%)
552	OVERDOSE DATA TO ACTION	4,002	115,364	116,467	1,103	0.96%
590	EPRCDS ADMINISTRATION	161,257	188,221	208,917	20,696	11.00%
610	ANIMAL CONTROL - BITE ACTIVITIES	7,086	8,832	5,897	(2,935)	(33.23%)
612	ANIMAL CONTROL - WILDLIFE	1,483	-	-	-	0.00%
613	VECTOR SURVEILLANCE - GENERAL	50,567	25,542	33,758	8,216	32.17%
614	VECTOR SURVEILLANCE - MOSQUITOES	24,549	52,616	31,942	(20,674)	(39.29%)
615	VECTOR SURVEILLANCE - RODENTS	29,086	-	-	-	0.00%
616	VECTOR SURVEILLANCE - BED BUGS HEAD LICE OTHER NON-DISEASE	1,666	-	-	-	0.00%
617	DISEASE PREVENTION - GENERAL	15,974	84,307	56,747	(27,560)	(32.69%)
618	DISEASE PREVENTION - FOODBORNE COMPLAINT	27,307	-	-	-	0.00%
619	DISEASE PREVENTION - OUTBREAK	22,548	-	-	-	0.00%
620	AIR POLLUTION GENERAL	49,162	153,674	31,712	(121,962)	(79.36%)
622	INDUSTRIAL HYGIENE - GENERAL	97,294	79,096	76,656	(2,440)	(3.08%)
623	INDUSTRIAL HYGIENE - COMPLAINT - BILLABLE	1,355	-	-	-	0.00%
624	INDUSTRIAL HYGIENE - COMPLAINT - NON BILLABLE	2,564	-	-	-	0.00%
627	INDUSTRIAL HYGIENE - RADON	10,773	13,397	9,721	(3,676)	(27.44%)
630	RETAIL FOOD - GENERAL	2,752,442	2,645,716	2,863,211	217,495	8.22%
640	CHILDCARE - GENERAL	184,972	263,461	267,077	3,616	1.37%
643	BODY ART - GENERAL	23,775	32,509	32,274	(235)	(0.72%)
645	RECREATION - GENERAL	95,712	135,292	140,229	4,937	3.65%
650	LAND USE - GENERAL	358,747	492,280	654,374	162,094	32.93%
651	LAND USE - APPLICATION	119,342	-	-	-	0.00%
652	LAND USE - COMP PLAN UPDATE	1,931	-	-	-	0.00%
653	WATER SUPPLIES - GENERAL	63,992	74,383	86,768	12,385	16.65%
655	WATER SUPPLIES - PUBLIC COMMUNITY SYSTEMS	686	-	-	-	0.00%
656	WATER SUPPLIES - PRIVATE	15,320	30,000	30,845	845	2.82%
657	WASTE WATER - GENERAL	531,368	629,285	563,759	(65,526)	(10.41%)
658	WASTE WATER - BIO SOLIDS	5,332	9,370	5,928	(3,442)	(36.73%)
668	SHW - GENERAL	104,598	76,927	78,764	1,837	2.39%
669	SHW - DESIGNATED SOLID WASTE DISPOSAL	6,448	9,065	9,675	610	6.73%
670	SHW - METHAMPHETAMINE	13,938	-	-	-	0.00%
671	SHW - METHANE	5,944	-	-	-	0.00%
672	SHW - SPILLS OR INCIDENTS	8,519	-	-	-	0.00%
673	SHW - CSI LANDFILL CONTRACT	369	-	-	-	0.00%
674	SHW - HIGHWAY 36 LANDFILL CONTRACT	1,181	-	-	-	0.00%
677	SHW - LOWRY SUPERFUND	34,825	51,756	54,507	2,751	5.32%
678	SHW - TIRES	7,433	12,590	12,417	(173)	(1.37%)
679	SHW - SEDALIA LANDFILL	3,588	8,587	8,640	53	0.62%
680	SHW - TOWER LANDFILL	3,847	15,250	12,386	(2,864)	(18.78%)
683	RMA MOA	62,980	103,550	157,459	53,909	52.06%
686	HCR GENERAL	99,250	93,990	91,901	(2,089)	(2.22%)
687	HCR EVENT	285,922	252,422	216,192	(36,230)	(14.35%)
690	ENVIRONMENTAL HEALTH ADMINISTRATION	787,668	747,754	1,042,241	294,487	39.38%
691	WATER SUPPLIES - PUBLIC NON-COMMUNITY SYSTEMS	103	-	-	-	0.00%
692	MARIJUANA MANUFACTURER	840	10,094	9,994	(100)	(0.99%)
695	EH INFORMATICS	259,931	389,161	329,330	(59,831)	(15.37%)
696	EH SPECIAL RESPONSE	16,865	-	-	-	0.00%

CODE	DESCRIPTION	2019 Actual	2020 Revised	2021 Adopted	Increase / (Decrease) $	Increase / (Decrease) %
710	EMPLOYEE HEALTH & WELLNESS	100,823	109,962	110,719	757	0.69%
720	HUMAN RESOURCES	571,542	535,248	557,670	22,422	4.19%
790	FRINGE BENEFITS	(915,955)	(1,089,109)	(1,374,620)	(285,511)	26.22%
810	FA OPERATIONS	-	4,324,318	5,027,996	703,678	16.27%
819	COVID-19	-	-	7,695,094	7,695,094	0.00%
820	FA ADMINISTRATION	999,545	1,070,861	953,781	(117,080)	(10.93%)
840	FA FACILITIES	1,810,005	443,163	450,846	7,683	1.73%
860	FA PURCHASING	130,969	122,762	139,045	16,283	13.26%
870	FA ACCOUNTING	714,176	747,066	751,183	4,117	0.55%
880	FA VITAL RECORDS	848,949	918,979	971,534	52,555	5.72%
890	AGENCY ADMIN SUPPORT	470,253	273,721	2,634,423	2,360,702	862.45%
910	MEDICAL EPIDEMIOLOGY	199,016	210,629	228,502	17,873	8.49%
930	DATA ANALYTICS	488,675	516,591	441,823	(74,768)	(14.47%)
950	INFORMATION TECHNOLOGY	1,478,049	1,558,002	1,504,958	(53,044)	(3.40%)
970	HPV	19,702	54,925	-	(54,925)	(100.00%)
990	PIM ADMINISTRATION	432,376	432,854	514,210	81,356	18.80%
TOTAL EXPENDITURE		**$41,046,723**	**$59,776,078**	**$55,486,920**	**(4,289,158)**	**(7.18%)**

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Office of the Executive Director



WE ACKNOWLEDGE,
RESPECT, AND CELEBRATE
OUR DIFFERENCES!

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OFFICE OF THE EXECUTIVE DIRECTOR

Division: 1	OFFICE OF THE EXECUTIVE DIRECTOR	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	41,684	50,000	50,000	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	50,000	-	(50,000)	(100.00%)
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 41,684**	**$ 100,000**	**$ 50,000**	**$ (50,000)**	**(50.00%)**
	FTE's	***7.68***	***8.01***	***8.09***	***0.08***	***0.96%***
	Benefits as a Percentage of Wages	*34.55%*	*36.17%*	*34.50%*		
EXPENDITURES:						
	WAGES	$ 809,748	$ 829,471	$ 895,428	65,957	7.95%
	BENEFITS	279,728	300,020	308,899	8,879	2.96%
	Total Personnel	***$ 1,089,476***	***$ 1,129,491***	***$ 1,204,327***	***$ 74,836***	***6.63%***
	CONTRACTS / SERVICES	149,264	231,700	165,700	(66,000)	(28.49%)
	TRAVEL	6,215	17,600	17,510	(90)	(0.51%)
	SUPPLIES	16,636	16,210	11,610	(4,600)	(28.38%)
	OPERATING	81,894	79,770	75,862	(3,908)	(4.90%)
	OTHER COSTS	13,927	32,000	22,000	(10,000)	(31.25%)
	EQUIPMENT (Non-Capital)	1,733	2,500	-	(2,500)	(100.00%)
	TOTAL DIRECT EXPENSES	***$ 1,359,144***	***$ 1,509,271***	***$ 1,497,009***	***$ (12,262)***	***(0.81%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	***-***	***-***	***-***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 1,359,144**	**$ 1,509,271**	**$ 1,497,009**	**$ (12,262)**	**(0.81%)**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***1,310,860***	***1,409,271***	***1,447,009***	***37,738***	***2.68%***
	TOTAL AGENCY NET	**$ (6,600)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		70.1%	76.5%	79.9%		
% of Total Expenses Funded by **Non-County General Funds**		26.4%	16.8%	16.7%		

Executive Director

The Executive and Deputy Director are responsible for providing strategic leadership by working with the Board of Health and the Executive Management Team to establish long-range agency goals, strategies, plans and policies. They oversee eight functional divisions: Nutrition; Community Health Promotion; Nursing; Emergency Preparedness, Response and Communicable Disease Surveillance; Environmental Health; Human Resources; Finance and Administration; and Planning and Information Management.

Funding Source(s): Required General Funds

Division: 1	**OFFICE OF THE EXECUTIVE DIRECTOR - Executive Director (130)**				**Increase / (Decrease)**	
		FY2019 ACTUAL	**FY2020 REVISED**	**FY2021 ADOPTED**	**$**	**%**
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	50,000	-	(50,000)	(100.00%)
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		$ -	$ 50,000	$ -	$ (50,000)	(100.00%)
	FTE's	***5.06***	***5.09***	***5.09***	***(0.00)***	***(0.07%)***
	Benefits as a Percentage of Wages	*34.38%*	*36.66%*	*34.30%*		
EXPENDITURES:						
	WAGES	$ 597,228	$ 584,504	$ 646,798	62,294	10.66%
	BENEFITS	205,347	214,281	221,878	7,597	3.55%
	Total Personnel	***$ 802,575***	***$ 798,785***	***$ 868,676***	***$ 69,891***	***8.75%***
	CONTRACTS / SERVICES	59,365	176,000	110,000	(66,000)	(37.50%)
	TRAVEL	5,153	13,400	10,744	(2,656)	(19.82%)
	SUPPLIES	7,075	6,210	6,610	400	6.44%
	OPERATING	61,388	44,500	42,242	(2,258)	(5.07%)
	OTHER COSTS	13,866	20,000	10,000	(10,000)	(50.00%)
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 949,423***	***$ 1,058,895***	***$ 1,048,272***	***$ (10,623)***	***(1.00%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		$ 949,423	$ 1,058,895	$ 1,048,272	$ (10,623)	(1.00%)
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***978,020***	***1,008,895***	***1,048,272***	***39,377***	***3.90%***
	TOTAL AGENCY NET	**$ 28,597**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		74.9%	78.1%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		28.1%	17.2%	17.3%		

Division: 1 OFFICE OF THE EXECUTIVE DIRECTOR - Metro Denver Partnership for Health (131)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	41,684	50,000	50,000	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 41,684**	**$ 50,000**	**$ 50,000**	**$ -**	**0.00%**
	FTE's	***0.00***	***0.00***	***0.00***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*0.00%*	*0.00%*	*0.00%*		
EXPENDITURES:						
	WAGES	$ -	$ -	$ -	-	0.00%
	BENEFITS	-	-	-	-	0.00%
	Total Personnel	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	CONTRACTS / SERVICES	84,000	50,000	50,000	-	0.00%
	TRAVEL	-	-	-	-	0.00%
	SUPPLIES	-	-	-	-	0.00%
	OPERATING	-	14,000	14,000	-	0.00%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 84,000***	***$ 64,000***	***$ 64,000***	***$ -***	***0.00%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 84,000**	**$ 64,000**	**$ 64,000**	**$ -**	**0.00%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	-	***14,000***	***14,000***	-	***0.00%***
	TOTAL AGENCY NET	**$ (42,316)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	17.9%	18.1%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	3.9%	3.8%		

Division: 1	OFFICE OF THE EXECUTIVE DIRECTOR - Board Fund (132)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		$ -	$ -	$ -	$ -	**0.00%**
	FTE's	***0.00***	***0.00***	***0.00***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*0.00%*	*0.00%*	*0.00%*		
EXPENDITURES:						
	WAGES	$ -	$ -	$ -	-	0.00%
	BENEFITS	-	-	-	-	0.00%
	Total Personnel	$ -	$ -	$ -	$ -	***0.00%***
	CONTRACTS / SERVICES	-	-	-	-	0.00%
	TRAVEL	-	-	3,000	3,000	0.00%
	SUPPLIES	-	-	-	-	0.00%
	OPERATING	-	-	-	-	0.00%
	OTHER COSTS	-	12,000	12,000	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	$ -	$ 12,000	$ 15,000	$ 3,000	***25.00%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	$ -	$ -	$ -	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		$ -	$ 12,000	$ 15,000	$ 3,000	**25.00%**
	INDIRECT ALLOCATION	$ -	$ -	$ -	$ -	***0.00%***
	GENERAL FUND USE	-	***12,000***	***15,000***	***3,000***	***25.00%***
	TOTAL AGENCY NET	$ -	$ -	$ -	$ -	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	82.0%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	18.0%	17.3%		

Communication

The Office of Communications works to promote healthy behavior and reduce public health risks as well as educating the public through proven and diverse communication and marketing strategies. It also provides media and marketing training to staff. The activities of the Communications staff include; strategic communication planning; media relations; public information; adherence to brand standards; social media; measurement and evaluation of marketing and communication campaigns; media monitoring; oversight of the TCHD website and Intranet; marketing for TCHD programs and services; graphic design and production of brochures, fact sheets, collateral materials, and reports. Communications staff also work closely with regional partners such as cities and counties, schools, community partners and state and federal government to align and share public health messages.

Funding Source(s): Required General Funds

Division: 1	OFFICE OF THE EXECUTIVE DIRECTOR - Communications (140)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		$ -	$ -	$ -	$ -	**0.00%**
	FTE's	***2.62***	***2.92***	***3.00***	***0.08***	***2.74%***
	Benefits as a Percentage of Wages	*35.00%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 212,520	$ 244,967	$ 248,630	3,663	1.50%
	BENEFITS	74,381	85,739	87,021	1,282	1.50%
	Total Personnel	***$ 286,901***	***$ 330,706***	***$ 335,651***	***$ 4,945***	***1.50%***
	CONTRACTS / SERVICES	5,899	5,700	5,700	-	0.00%
	TRAVEL	1,062	4,200	3,766	(434)	(10.33%)
	SUPPLIES	9,560	10,000	5,000	(5,000)	(50.00%)
	OPERATING	20,506	21,270	19,620	(1,650)	(7.76%)
	OTHER COSTS	61	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	1,733	2,500	-	(2,500)	(100.00%)
	TOTAL DIRECT EXPENSES	***$ 325,721***	***$ 374,376***	***$ 369,737***	***$ (4,639)***	***(1.24%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		$ 325,721	$ 374,376	$ 369,737	$ (4,639)	(1.24%)
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***332,840***	***374,376***	***369,737***	***(4,639)***	***(1.24%)***
	TOTAL AGENCY NET	**$ 7,119**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		74.3%	82.0%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		27.9%	18.0%	17.3%		

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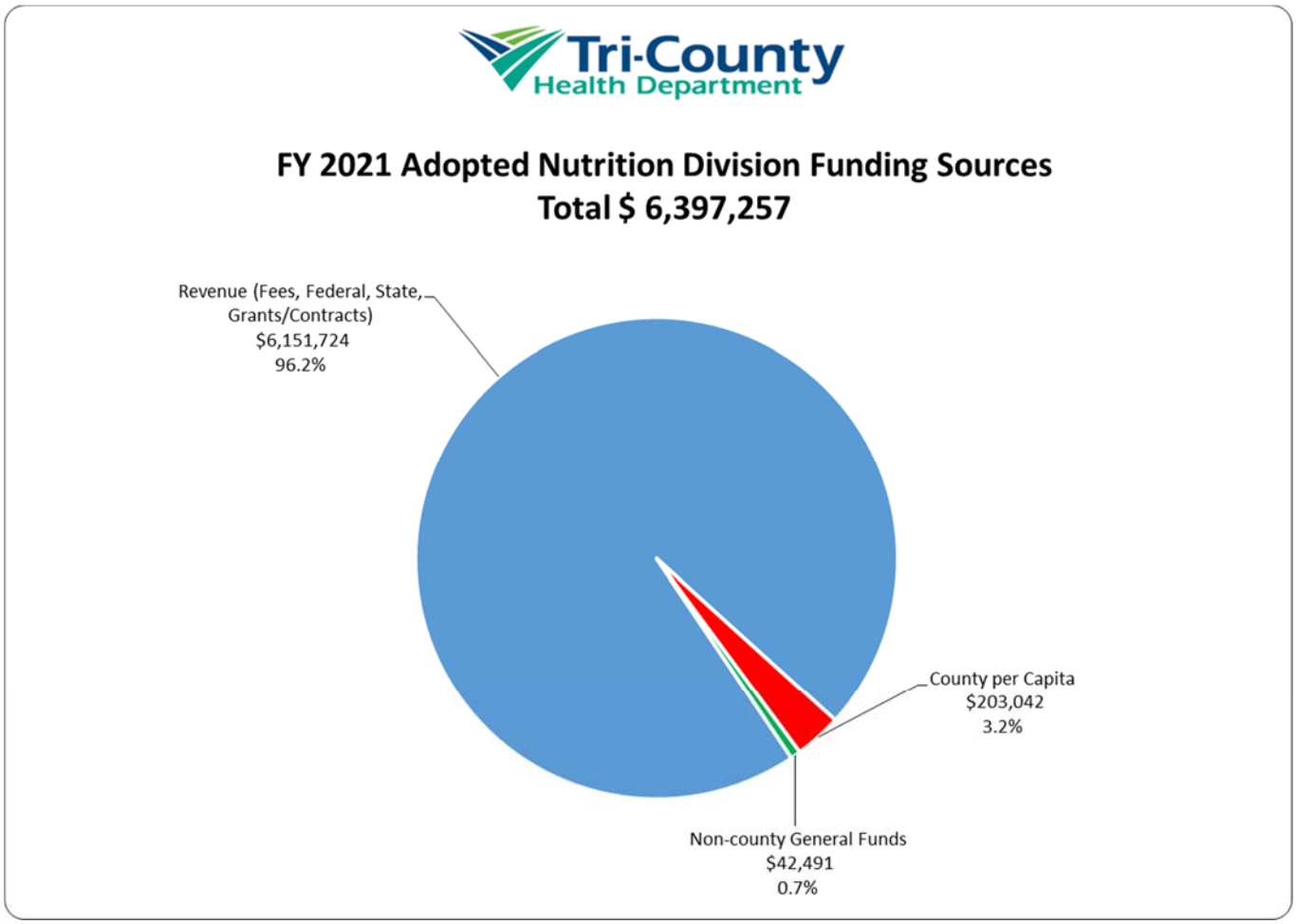
Nutrition Division



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NUTRITION DIVISION

Division: 2 NUTRITION	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:					
COUNTY	$ -	$ -	$ -	-	0.00%
COUNTY - PROJECT SPECIFIC	-	80,000	80,000	-	0.00%
FEDERAL FUNDS	-	-	-	-	0.00%
MEDICAID FUNDS	-	-	-	-	0.00%
FEES	60,855	59,600	63,500	3,900	6.54%
STATE CONTRACTS	-	-	-	-	0.00%
FEDERAL PASS THRU FUNDS	5,682,415	5,702,522	5,619,511	(83,011)	(1.46%)
OTHER GRANTS / CONTRACTS	200,888	290,635	388,713	98,078	33.75%
OTHER REVENUE	-	-	-	-	0.00%
FUND BALANCE USE	-	-	-	-	0.00%
IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE	**$ 5,944,158**	**$ 6,132,757**	**$ 6,151,724**	**$ 18,967**	**0.31%**
FTE's	***71.76***	***69.57***	***68.41***	***-1.16***	***(1.67%)***
Benefits as a Percentage of Wages	*34.72%*	*34.94%*	*34.71%*		
EXPENDITURES:					
WAGES	$ 3,437,773	$ 3,526,422	$ 3,475,492	(50,930)	(1.44%)
BENEFITS	1,193,505	1,232,061	1,206,400	(25,661)	(2.08%)
Total Personnel	***$ 4,631,279***	***$ 4,758,483***	***$ 4,681,892***	***$ (76,591)***	***(1.61%)***
CONTRACTS / SERVICES	104,312	62,775	226,153	163,378	260.26%
TRAVEL	28,651	35,295	12,447	(22,848)	(64.73%)
SUPPLIES	48,823	54,911	55,620	709	1.29%
OPERATING	456,972	59,651	60,772	1,121	1.88%
OTHER COSTS	1,063	3,010	2,006	(1,004)	(33.36%)
EQUIPMENT (Non-Capital)	1,752	3,000	3,803	803	26.77%
TOTAL DIRECT EXPENSES	***$ 5,272,851***	***$ 4,977,125***	***$ 5,042,693***	***$ 65,568***	***1.32%***
CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES	**$ 5,272,851**	**$ 4,977,125**	**$ 5,042,693**	**$ 65,568**	**1.32%**
INDIRECT ALLOCATION	***$ 1,309,252***	***$ 1,383,233***	***$ 1,354,564***	***$ (28,669)***	***(2.07%)***
GENERAL FUND USE	***585,749***	***227,601***	***245,533***	***17,932***	***7.88%***
TOTAL AGENCY NET	**$ (52,196)**	**$ -**	**$ 0**	**$ 0**	**0.00%**
(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**	6.5%	2.9%	3.2%		
% of Total Expenses Funded by **Non-County General Funds**	2.4%	0.6%	0.7%		


Tri-County
Health Department
FY 2021 Adopted Nutrition Division Funding Sources
Total $ 6,397,257
Revenue (Fees, Federal, State, Grants/Contracts)
$6,151,724
96.2%
County per Capita
$203,042
3.2%
Non-county General Funds
$42,491
0.7%

Dietetic Internship

The Dietetic Internship, started in 1980, is a public health-based program accredited by the Accreditation Council for Education in Nutrition and Dietetics of the Academy of Nutrition and Dietetics. TCHD's internship is the only program in the region to offer a public health emphasis. The ten and one half month tuition-based program trains six nutrition professionals each year, many of whom seek subsequent employment at TCHD and other Colorado health departments. Dietetic interns increase our community nutrition outreach, partnerships, and education. TCHD is proud of the 100% pass rate on the registration examination for dietitians. Graduates have career opportunities in a variety of positions in public health, community, healthcare, and business areas; hiring graduates when possible saves recruitment and training dollars. The dietetic internship has been nationally recognized for fiscal responsibility by being awarded a National Association of County and City Health Officials (NACCHO) Model Practice Award for the cost/benefit analysis of the internship and training interns on financial analysis.

Funding Source(s): Required General Funds, Tuition/Fees, In-kind Services

Division: 2	**NUTRITION - DIETETIC INTERNSHIP (240)**				Increase / (Decrease)	
		FY2019 ACTUAL	**FY2020 REVISED**	**FY2021 ADOPTED**	**$**	**%**
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	60,855	59,600	63,500	3,900	6.54%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 60,855**	**$ 59,600**	**$ 63,500**	**$ 3,900**	**6.54%**
	FTE's	***1.00***	***1.00***	***1.00***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*35.14%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 83,533	$ 86,551	$ 90,688	4,137	4.78%
	BENEFITS	29,355	30,293	31,741	1,448	4.78%
	Total Personnel	***$ 112,888***	***$ 116,844***	***$ 122,429***	***$ 5,585***	***4.78%***
	CONTRACTS / SERVICES	-	1,000	1,000	-	0.00%
	TRAVEL	1,227	2,109	2,124	15	0.71%
	SUPPLIES	1,638	2,450	2,250	(200)	(8.16%)
	OPERATING	8,464	7,699	7,687	(12)	(0.16%)
	OTHER COSTS	811	1,006	1,006	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 125,027***	***$ 131,108***	***$ 136,496***	***$ 5,388***	***4.11%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 125,027**	**$ 131,108**	**$ 136,496**	**$ 5,388**	**4.11%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***57,176***	***71,508***	***72,996***	***1,488***	***2.08%***
	TOTAL AGENCY NET	**$ (6,996)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		33.2%	44.7%	44.2%		
% of Total Expenses Funded by **Non-County General Funds**		12.5%	9.8%	9.3%		

The Special Supplemental Nutrition Program for Women Infants and Children (WIC)

The WIC program at TCHD provides monthly nutrition education, breastfeeding support, referrals and food benefits to over 20,500 women, infants, and children in our three counties through individual and group counseling sessions. There are 11 WIC clinic locations as well as a WIC presence with community partners (Children's Health Clinic and Stride), Health and Human Services, housing authorities and food pantries. Over $13.7 million is added to the local economy of TCHD's three counties each year through the foods WIC clients purchase directly, which include fresh fruits and vegetables and whole grains. It is estimated that for every WIC dollar spent, clients spend an additional four dollars while at the store. WIC increases access to fresh fruits and vegetables through three community gardens with local partners to promote healthy eating and physical activity: Adams County School District 27J in Brighton, and Amazing Meadows Garden in Thornton. TCHD also helps to host two Healthy Farmers' Markets in Adams County with Anythink Libraries, American Heart Association, City of Thornton and local farmers. The WIC program's primary focus areas are nutrition education, breastfeeding promotion and support, referrals to community partners, and obesity prevention.
Funding Source(s): Restricted Federal Funds

Division: 2 NUTRITION - WOMEN, INFANTS & CHILDREN (WIC) (220)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	5,487,566	5,516,726	5,398,285	(118,441)	(2.15%)
	OTHER GRANTS / CONTRACTS	146,669	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 5,634,235**	**$ 5,516,726**	**$ 5,398,285**	**$ (118,441)**	**(2.15%)**
	FTE's	***65.96***	***61.52***	***56.47***	***-5.05***	***(8.21%)***
	Benefits as a Percentage of Wages	*34.62%*	*35.25%*	*34.98%*		
EXPENDITURES:						
	WAGES	$ 3,131,372	$ 3,013,087	$ 2,865,087	(148,000)	(4.91%)
	BENEFITS	1,084,128	1,062,038	1,002,251	(59,787)	(5.63%)
	Total Personnel	***$ 4,215,500***	***$ 4,075,125***	***$ 3,867,338***	***$ (207,787)***	***(5.10%)***
	CONTRACTS / SERVICES	56,300	42,000	211,749	169,749	404.16%
	TRAVEL	26,076	25,964	2,500	(23,464)	(90.37%)
	SUPPLIES	38,226	44,160	42,152	(2,008)	(4.55%)
	OPERATING	58,727	30,953	32,142	1,189	3.84%
	OTHER COSTS	252	2,004	1,000	(1,004)	(50.10%)
	EQUIPMENT (Non-Capital)	1,752	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 4,396,833***	***$ 4,220,206***	***$ 4,156,881***	***$ (63,325)***	***(1.50%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 4,396,833**	**$ 4,220,206**	**$ 4,156,881**	**$ (63,325)**	**(1.50%)**
	INDIRECT ALLOCATION	***$ 1,252,773***	***$ 1,296,520***	***$ 1,241,404***	***$ (55,116)***	***(4.25%)***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ (15,371)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Breastfeeding Peer Counselor Program

Breastfeeding Peer Counselor programs have proven to be successful in providing breastfeeding support and increasing initiation and duration rates. In an effort to increase breastfeeding initiation and duration rates in the WIC program, TCHD began a Breastfeeding Peer Counselor Program in April 2005. Each of the 10 WIC clinics has at least one designated breastfeeding peer counselor. Peer counselors are available to support pregnant and breastfeeding mothers 24 hours a day by phone, text, email or in person sessions. They teach breastfeeding classes, lead support groups, organize Facebook Live presentations, find community resources, and coordinate client care with WIC educators and dietitians. Peer counselors utilize an automated texting platform to send educational texts at regular intervals throughout the prenatal and postpartum periods and allows two-way texting between the peer counselors and program participants.

Funding Source(s): Restricted Federal Funds

Division: 2 **NUTRITION - BREASTFEEDING PEER COUNSELOR PROGRAM (226)**

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	194,849	185,796	221,226	35,430	19.07%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 194,849**	**$ 185,796**	**$ 221,226**	**$ 35,430**	**19.07%**
	FTE's	***3.30***	***3.13***	***3.28***	***0.15***	***4.79%***
	Benefits as a Percentage of Wages	*22.30%*	*25.26%*	*28.98%*		
EXPENDITURES:						
	WAGES	$ 118,542	$ 105,050	$ 127,102	22,052	20.99%
	BENEFITS	26,429	26,534	36,832	10,298	38.81%
	Total Personnel	***$ 144,971***	***$ 131,584***	***$ 163,934***	***$ 32,350***	***24.59%***
	CONTRACTS / SERVICES	-	3,395	-	(3,395)	(100.00%)
	TRAVEL	827	675	1,276	601	89.04%
	SUPPLIES	380	591	580	(11)	(1.86%)
	OPERATING	4,424	6,361	5,345	(1,016)	(15.97%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 150,602***	***$ 142,606***	***$ 171,135***	***$ 28,529***	***20.01%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 150,602**	**$ 142,606**	**$ 171,135**	**$ 28,529**	**20.01%**
	INDIRECT ALLOCATION	***$ 44,247***	***$ 43,190***	***$ 52,932***	***$ 9,742***	***22.56%***
	GENERAL FUND USE	*-*	*-*	***2,841***	***2,841***	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	1.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.2%		

Baby and Me Tobacco Free

The Baby and Me Tobacco Free Program is an evidence-based, smoking cessation program created to reduce the burden of tobacco on the pregnant and postpartum population. By providing counseling support and resources to pregnant women, the program helps women quit smoking and stay quit throughout the postpartum period and beyond. Program participants receive smoking cessation information at four prenatal education sessions and take a carbon monoxide breath test to verify smoking status. If a woman quits smoking before delivery, she is eligible to take a breath test monthly and receive $50 worth of diapers each month up to six months postpartum as long as she stays quit. Participants have the option of enrolling one partner as a support person who is also eligible for $50 worth of diapers each month as long as they stay quit. Helping women quit smoking results in improved birth outcomes and long-term positive health benefits for themselves and their families.
Funding Source(s): Restricted Grant Funds

Division: 2	NUTRITION - BABY AND ME TOBACCO FREE (270)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	36,071	30,000	20,000	(10,000)	(33.33%)
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 36,071**	**$ 30,000**	**$ 20,000**	**$ (10,000)**	**(33.33%)**
	FTE's	***0.38***	***0.18***	***0.15***	***-0.03***	***(16.67%)***
	Benefits as a Percentage of Wages	*35.00%*	*35.32%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 26,719	$ 16,932	$ 14,751	(2,181)	(12.88%)
	BENEFITS	9,352	5,981	5,163	(818)	(13.68%)
	Total Personnel	***$ 36,071***	***$ 22,913***	***$ 19,914***	***$ (2,999)***	***(13.09%)***
	CONTRACTS / SERVICES	-	-	-	-	0.00%
	TRAVEL	-	-	-	-	0.00%
	SUPPLIES	68	-	938	938	0.00%
	OPERATING	-	-	-	-	0.00%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 36,139***	***$ 22,913***	***$ 20,852***	***$ (2,061)***	***(8.99%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 36,139**	**$ 22,913**	**$ 20,852**	**$ (2,061)**	**(8.99%)**
	INDIRECT ALLOCATION	***$ 10,618***	***$ 7,087***	***$ -***	***$ (7,087)***	***(100.00%)***
	GENERAL FUND USE	*-*	*-*	***852***	***852***	***0.00%***
	TOTAL AGENCY NET	**$ (10,686)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	3.4%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.7%		

WIC Central Referral Pilot

The Colorado WIC State Office at the Colorado Department of Public Health & Environment was awarded grant funding from The Colorado Health Foundation to pilot a centralized referral process. The pilot aims to improve and centralize processes for referrals from health care and community partners that screen for food insecurity to equitably maximize program access for eligible participants statewide. The State Office oversees the pilot and provides funding to the TCHD WIC Program to hire and supervise the WIC Engagement Specialist positions. This position will manage incoming WIC referrals for 8 local agencies: 1- TCHD (Westminster Clinic – 80223, 80234, 80241, 80260 & 80229), 2- Baca, 3- Clear Creek, 4- Larimer, 5- Northeast, 6- Otero, 7- Park, and 8- Summit. The Colorado WIC Program receives referrals from Colorado PEAK and WIC's online referral form (www.ColoradoWICsignup.com). Referrals are routed by zip code to Local Agency Inboxes within the WIC Referral System (WRS) at www.healthinformatics.dphe.state.co.us - a secure, online database. The WIC Engagement Specialist call all referrals and will also implement and utilize a two-way texting platform to see if it increases responses from referrals.

Funding Source: Restricted grant funds

Division: 2 NUTRITION - WIC CENTRAL REFERRAL SYSTEM (222)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	100,491	99,661	(830)	(0.83%)
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ -**	**$ 100,491**	**$ 99,661**	**$ (830)**	**(0.83%)**
	FTE's	***0.00***	***0.00***	***1.15***	***1.15***	***0.00%***
	Benefits as a Percentage of Wages	*0.00%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ -	$ 54,805	$ 57,549	2,744	5.01%
	BENEFITS	-	19,181	20,143	962	5.02%
	Total Personnel	***$ -***	***$ 73,986***	***$ 77,692***	***$ 3,706***	***5.01%***
	CONTRACTS / SERVICES	-	9,230	7,669	(1,561)	(16.91%)
	TRAVEL	-	-	-	-	0.00%
	SUPPLIES	-	1,000	-	(1,000)	(100.00%)
	OPERATING	-	1,667	2,550	883	52.97%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	1,500	-	(1,500)	(100.00%)
	TOTAL DIRECT EXPENSES	***$ -***	***$ 87,383***	***$ 87,911***	***$ 528***	***0.60%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ -**	**$ 87,383**	**$ 87,911**	**$ 528**	**0.60%**
	INDIRECT ALLOCATION	***$ -***	***$ 13,108***	***$ 13,186***	***$ 78***	***0.60%***
	GENERAL FUND USE	-	-	***1,436***	***1,436***	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	1.2%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.2%		

Hunger Free Colorado Outreach Program

Currently, only 23% of TCHD WIC participants report receiving SNAP benefits compared with the state average of 30%. TCHD's Nutrition Division has received funding from Hunger Free Colorado to cross train two WIC educators (1 FTE total) to assist individuals in completing SNAP applications. These WIC educators will provide remote and face-to-face SNAP application assistance at TCHD WIC offices, in grocery stores and, potentially in medical provider offices. TCHD's goal for this one-year grant is to complete 636 SNAP applications. This project aligns with our Public Health Improvement Plan (PHIP) Food Access priority area to increase enrollment in Federal nutrition programs in Adams, Arapahoe and Douglas counties.

Funding Sources: Restricted Grant Funds

Division: 2	**NUTRITION - HUNGER FREE OUTREACH (238)**				**Increase / (Decrease)**	
		FY2019 ACTUAL	**FY2020 REVISED**	**FY2021 ADOPTED**	**$**	**%**
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	18,164	99,803	105,037	5,234	5.24%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 18,164**	**$ 99,803**	**$ 105,037**	**$ 5,234**	**5.24%**
	FTE's	***0.24***	***1.02***	***1.31***	***0.29***	***28.43%***
	Benefits as a Percentage of Wages	*35.00%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 10,384	$ 54,596	$ 61,031	6,435	11.79%
	BENEFITS	3,635	19,109	21,361	2,252	11.79%
	Total Personnel	***$ 14,019***	***$ 73,705***	***$ 82,392***	***$ 8,687***	***11.79%***
	CONTRACTS / SERVICES	405	6,000	3,985	(2,015)	(33.59%)
	TRAVEL	416	3,547	3,547	-	0.00%
	SUPPLIES	817	2,160	1,042	(1,118)	(51.76%)
	OPERATING	892	5,318	4,523	(795)	(14.95%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 16,549***	***$ 90,730***	***$ 95,489***	***$ 4,759***	***5.24%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	***-***	***-***	***-***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 16,549**	**$ 90,730**	**$ 95,489**	**$ 4,759**	**5.24%**
	INDIRECT ALLOCATION	***$ 1,614***	***$ 9,073***	***$ 9,548***	***$ 475***	***5.24%***
	GENERAL FUND USE	***-***	***-***	***-***	***-***	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ 0**	**$ 0**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

DRCOG Accountable Health Communities (AHC)

Health-related social needs (HRSNs) matter. Convincing data demonstrates that HRSNs, sometimes referred to as social determinants of health (SDOH), affect healthcare outcomes causing illness, suffering, premature death, and increased health care costs. HRSNs need to be addressed to improve individual outcomes and community health.

The Denver Regional AHC is a regional network of health, community and public partners working to create a clinical-community continuum of care to better address individuals' HRSNs. As part of a national effort funded by the Center for Medicare and Medicaid Innovation (CMMI), the Denver Regional AHC seeks to demonstrate the value and total cost savings of meeting HRSNs through community resources. By collecting regional data on identified HRSNs, services rendered, and corresponding health impacts, the AHC hopes to acquire the evidence base needed to inform future policy, allocation of funding and services to better address HRSNs and community health moving forward.

TCHD is screening Medicaid and Medicare clients seen in our Nutrition programs for HRSNs (i.e., housing, food, utilities, transportation and safety needs). Clients are provided appropriate referrals and patient navigation services and will enter data into the AHC Portal for reimbursement.

Funding Source: Restricted Grant Funds

Division: 2 NUTRITION - DRCOG ACH MODEL (242)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	60,341	164,015	103,674	171.81%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ -**	**$ 60,341**	**$ 164,015**	**$ 103,674**	**171.81%**
	FTE's	***0.00***	***0.82***	***2.20***	***1.38***	***168.29%***
	Benefits as a Percentage of Wages	*0.00%*	*34.99%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ -	$ 34,140	$ 89,009	54,869	160.72%
	BENEFITS	-	11,946	31,154	19,208	160.79%
	Total Personnel	***$ -***	***$ 46,086***	***$ 120,163***	***$ 74,077***	***160.74%***
	CONTRACTS / SERVICES	-	-	600	600	0.00%
	TRAVEL	-	-	-	-	0.00%
	SUPPLIES	-	-	5,258	5,258	0.00%
	OPERATING	-	-	500	500	0.00%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ -***	***$ 46,086***	***$ 126,521***	***$ 80,435***	***174.53%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ -**	**$ 46,086**	**$ 126,521**	**$ 80,435**	**174.53%**
	INDIRECT ALLOCATION	***$ -***	***$ 14,255***	***$ 37,494***	***$ 23,239***	***163.02%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Food Security

This Adams County funding supports 1.0FTE and operational costs to coordinate and participate in multiple programs to increase access to food and improve coordination and systems. In 2020, the position helped to coordinate weekly produce boxes to 51 WIC families out of the North Broadway location; coordinate and market the TCHD Community Gardens; and help implement, coordinate and track data for the Healthy Farmer's Markets in coordination with American Heart Association, Anythink Libraries, City of Thornton and Lulu's Farms (including Adams County CARES dollars). This position is also helping with dual enrollment into WIC and SNAP through community hubs and begun work with local community colleges. The position will continue to coordinate across community based programs and aims to develop programming and services to reach community members who may be experiencing food insecurity.

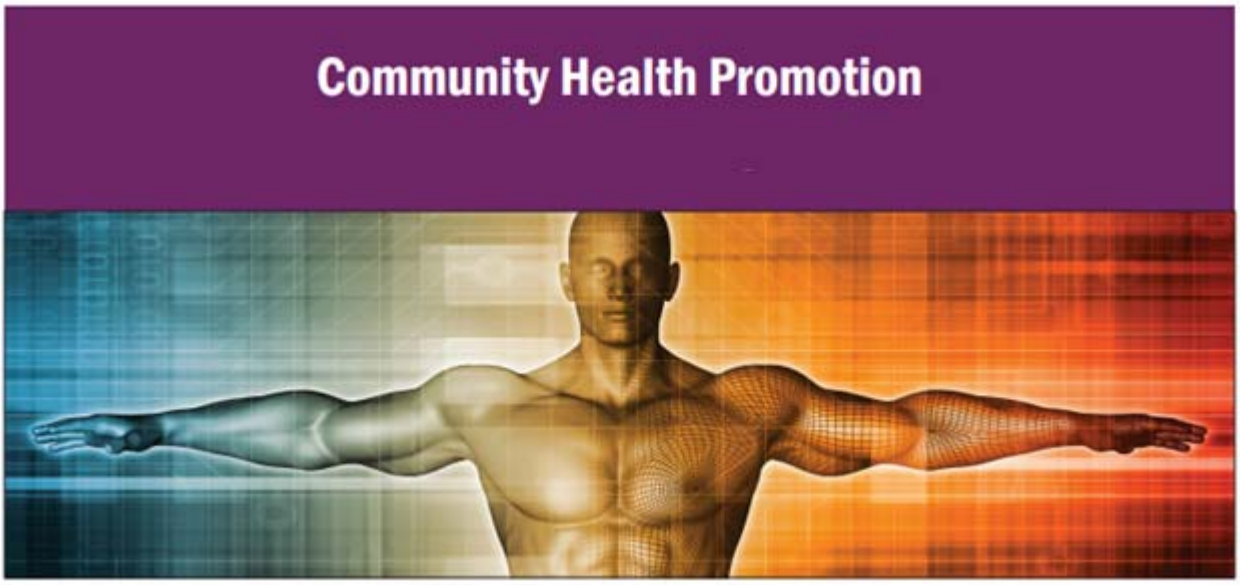
Funding Source: Restricted County Funds

Division: 2	NUTRITION - FOOD SECURITY (245)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	80,000	80,000	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ -**	**$ 80,000**	**$ 80,000**	**$ -**	**0.00%**
	FTE's	***0.00***	***0.00***	***0.95***	***0.95***	***0.00%***
	Benefits as a Percentage of Wages	*0.00%*	*34.55%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ -	$ 55,000	$ 53,109	(1,891)	(3.44%)
	BENEFITS	-	19,000	18,588	(412)	(2.17%)
	Total Personnel	***$ -***	***$ 74,000***	***$ 71,697***	***$ (2,303)***	***(3.11%)***
	CONTRACTS / SERVICES	-	-	-	-	0.00%
	TRAVEL	-	1,500	1,500	-	0.00%
	SUPPLIES	-	1,650	1,650	-	0.00%
	OPERATING	-	1,350	1,350	-	0.00%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	1,500	3,803	2,303	153.53%
	TOTAL DIRECT EXPENSES	***$ -***	***$ 80,000***	***$ 80,000***	***$ -***	***0.00%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ -**	**$ 80,000**	**$ 80,000**	**$ -**	**0.00%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Division: 2 NUTRITION - ADMINISTRATION (290)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	80,000	-	(80,000)	(100.00%)
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	18,147	200,294	-	(200,294)	(100.00%)
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 18,147**	**$ 280,294**	**$ -**	**$ (280,294)**	**(100.00%)**
	FTE's	***1.13***	***2.92***	***1.90***	***-1.02***	***(34.93%)***
	Benefits as a Percentage of Wages	*57.01%*	*35.20%*	*33.43%*		
EXPENDITURES:						
	WAGES	$ 77,606	$ 270,662	$ 117,166	(153,496)	(56.71%)
	BENEFITS	44,242	95,269	39,167	(56,102)	(58.89%)
	Total Personnel	***$ 121,848***	***$ 365,931***	***$ 156,333***	***$ (209,598)***	***(57.28%)***
	CONTRACTS / SERVICES	48,012	16,380	1,150	(15,230)	(92.98%)
	TRAVEL	521	6,547	1,500	(5,047)	(77.09%)
	SUPPLIES	8,511	7,710	1,750	(5,960)	(77.30%)
	OPERATING	385,358	14,638	6,675	(7,963)	(54.40%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	3,000	-	(3,000)	(100.00%)
	TOTAL DIRECT EXPENSES	***$ 564,249***	***$ 414,206***	***$ 167,408***	***$ (246,798)***	***(59.58%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 564,249**	**$ 414,206**	**$ 167,408**	**$ (246,798)**	**(59.58%)**
	INDIRECT ALLOCATION	***$ 1,614***	***$ 22,181***	***$ -***	***$ (22,181)***	***(100.00%)***
	GENERAL FUND USE	***528,573***	***156,093***	***167,408***	***11,315***	***7.25%***
	TOTAL AGENCY NET	**$ (19,143)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		67.9%	29.3%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		25.5%	6.4%	17.3%		

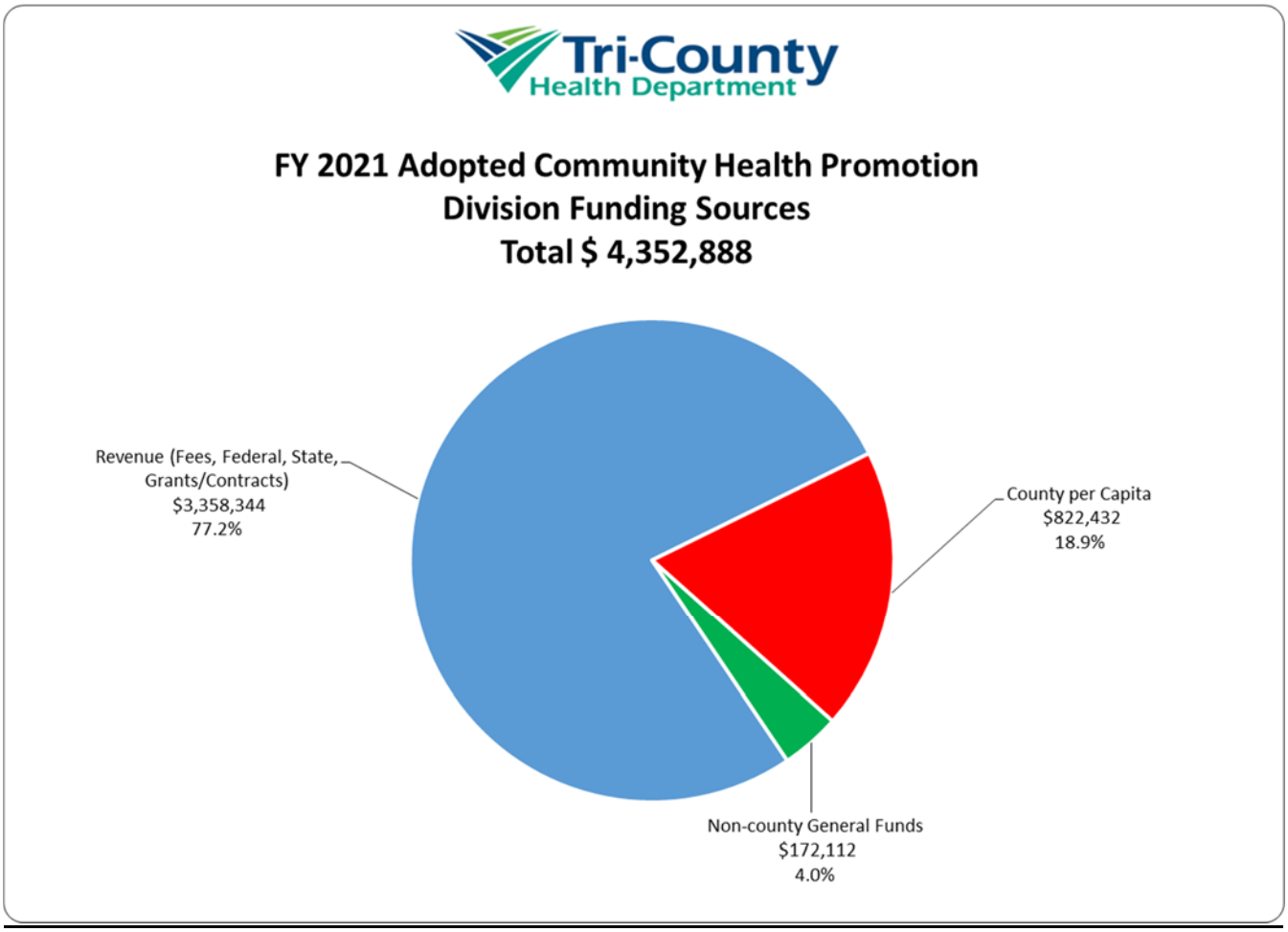
Community Health Promotion Division



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COMMUNITY HEALTH PROMOTION DIVISION

Division: 3	COMMUNITY HEALTH PROMOTION	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	31,565	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	12,392	-	-	-	0.00%
	STATE CONTRACTS	2,032,510	2,940,814	2,622,021	(318,793)	(10.84%)
	FEDERAL PASS THRU FUNDS	861,098	512,970	514,047	1,077	0.21%
	OTHER GRANTS / CONTRACTS	325,780	379,808	222,276	(157,532)	(41.48%)
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 3,263,345**	**$ 3,833,592**	**$ 3,358,344**	**$ (475,248)**	**(12.40%)**
	FTE's	***24.72***	***29.43***	***28.40***	***-1.03***	***(3.49%)***
	Benefits as a Percentage of Wages	*36.03%*	*35.07%*	*34.30%*		
EXPENDITURES:						
	WAGES	$ 1,697,751	$ 1,965,859	$ 2,021,436	55,577	2.83%
	BENEFITS	611,780	689,332	693,384	4,052	0.59%
	Total Personnel	***$ 2,309,530***	***$ 2,655,191***	***$ 2,714,820***	***$ 59,629***	***2.25%***
	CONTRACTS / SERVICES	673,614	825,147	510,072	(315,075)	(38.18%)
	TRAVEL	76,888	67,555	52,718	(14,837)	(21.96%)
	SUPPLIES	142,864	124,839	114,753	(10,086)	(8.08%)
	OPERATING	332,378	323,620	260,257	(63,363)	(19.58%)
	OTHER COSTS	693	1,780	100	(1,680)	(94.38%)
	EQUIPMENT (Non-Capital)	7,058	4,400	2,200	(2,200)	(50.00%)
	TOTAL DIRECT EXPENSES	***$ 3,543,025***	***$ 4,002,532***	***$ 3,654,920***	***$ (347,612)***	***(8.68%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 3,543,025**	**$ 4,002,532**	**$ 3,654,920**	**$ (347,612)**	**(8.68%)**
	INDIRECT ALLOCATION	***$ 626,056***	***$ 769,517***	***$ 697,968***	***$ (71,549)***	***(9.30%)***
	GENERAL FUND USE	***902,822***	***938,457***	***994,544***	***56,087***	***5.98%***
	TOTAL AGENCY NET	**$ (2,914)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		15.7%	16.1%	18.9%		
% of Total Expenses Funded by **Non-County General Funds**		5.9%	3.5%	4.0%		


Tri-County
Health Department
FY 2021 Adopted Community Health Promotion
Division Funding Sources
Total $ 4,352,888
Revenue (Fees, Federal, State, Grants/Contracts)
$3,358,344
77.2%
County per Capita
$822,432
18.9%
Non-county General Funds
$172,112
4.0%

Administration & General

The leadership and administrative team provides oversight and support for planning, implementation, performance management and quality improvement of Community Health Promotion activities and programs. Additional responsibilities include financial oversight, grants and contracts management, ensuring adherence to agency policies and processes, administrative support, and advancing prioritized efforts to support the TCHD Strategic Plan and Public Health Improvement Plan.
Funding Source(s): Required General Funds

Division: 3	COMMUNITY HEALTH PROMOTION-ADMINISTRATION & GENERAL (390)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	10,500	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 10,500**	**$ -**	**$ -**	**$ -**	**0.00%**
	FTE's	***2.62***	***2.40***	***2.40***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*41.26%*	*40.52%*	*34.17%*		
EXPENDITURES:						
	WAGES	$ 243,882	$ 181,232	$ 221,177	39,945	22.04%
	BENEFITS	100,637	73,436	75,568	2,132	2.90%
	Total Personnel	***$ 344,519***	***$ 254,668***	***$ 296,745***	***$ 42,077***	***16.52%***
	CONTRACTS / SERVICES	9,433	3,000	2,000	(1,000)	(33.33%)
	TRAVEL	5,190	500	500	-	0.00%
	SUPPLIES	4,992	6,827	5,327	(1,500)	(21.97%)
	OPERATING	8,928	9,150	5,355	(3,795)	(41.48%)
	OTHER COSTS	33	700	100	(600)	(85.71%)
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 373,095***	***$ 274,845***	***$ 310,027***	***$ 35,182***	***12.80%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 373,095**	**$ 274,845**	**$ 310,027**	**$ 35,182**	**12.80%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***389,571***	***274,845***	***310,027***	***35,182***	***12.80%***
	TOTAL AGENCY NET	**$ 26,976**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		75.9%	82.0%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		28.5%	18.0%	17.3%		

Advancing Breastfeeding in Colorado

The goal of this project is to transform communities to support health by reducing barriers to breastfeeding and promoting breastfeeding-friendly environments. This initiative is part of a regional collaborative funded through CDPHE's Cancer Cardiovascular and Pulmonary Disease Grant Program. Partners include Denver, Jefferson County, Boulder County, and Tri-County health departments. The program's target settings are childcare providers and medical offices that serve low-income families. Team members collaborate closely with staff working under TCHD's CCPD-funded worksite wellness initiative. Existing coalitions, developed under the worksite wellness initiative, are leveraged to support and facilitate the objectives of the breastfeeding initiative. The Colorado Health Institute serves as regional fiscal manager.

Funding Sources: Restricted State Funds

Division: 3	COMMUNITY HEALTH PROMOTION-ADVANCING BREASTFEEDING IN COLORADO (338)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	138,183	137,839	(344)	(0.25%)
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	128,961	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 128,961**	**$ 138,183**	**$ 137,839**	**$ (344)**	**(0.25%)**
	FTE's	***1.04***	***1.05***	***1.00***	***-0.05***	***(4.76%)***
	Benefits as a Percentage of Wages	*35.00%*	*32.13%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 67,463	$ 75,698	$ 66,618	(9,080)	(12.00%)
	BENEFITS	23,612	24,323	23,316	(1,007)	(4.14%)
	Total Personnel	***$ 91,075***	***$ 100,021***	***$ 89,934***	***$ (10,087)***	***(10.08%)***
	CONTRACTS / SERVICES	3,783	-	8,192	8,192	0.00%
	TRAVEL	830	796	1,629	833	104.65%
	SUPPLIES	3,530	3,470	5,167	1,697	48.90%
	OPERATING	1,394	1,440	1,488	48	3.33%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 100,612***	***$ 105,727***	***$ 106,410***	***$ 683***	***0.65%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 100,612**	**$ 105,727**	**$ 106,410**	**$ 683**	**0.65%**
	INDIRECT ALLOCATION	***$ 28,827***	***$ 32,456***	***$ 31,429***	***$ (1,027)***	***(3.16%)***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ (478)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Aging Initiatives

This program ended in 2020 and advanced older adult fall prevention initiatives with a variety of partners. The primary initiative is funded by a grant from the Denver Regional Council of Governments through the State Unit on Aging.

Funding Source(s): Restricted State Grant Funds, Required General Funds

Division: 3	COMMUNITY HEALTH PROMOTION-AGING INITIATIVES (364)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	75	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	145,163	160,677	-	(160,677)	(100.00%)
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 145,238**	**$ 160,677**	**$ -**	**$ (160,677)**	**(100.00%)**
	FTE's	***1.06***	***1.35***	***0.00***	***-1.35***	***(100.00%)***
	Benefits as a Percentage of Wages	*26.00%*	*25.30%*	*0.00%*		
EXPENDITURES:						
	WAGES	$ 67,268	$ 80,978	$ -	(80,978)	(100.00%)
	BENEFITS	17,488	20,490	-	(20,490)	(100.00%)
	Total Personnel	***$ 84,756***	***$ 101,468***	***$ -***	***$ (101,468)***	***(100.00%)***
	CONTRACTS / SERVICES	26,153	27,000	-	(27,000)	(100.00%)
	TRAVEL	5,017	2,143	-	(2,143)	(100.00%)
	SUPPLIES	21,556	1,300	-	(1,300)	(100.00%)
	OPERATING	10,057	7,535	-	(7,535)	(100.00%)
	OTHER COSTS	263	1,080	-	(1,080)	(100.00%)
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 147,802***	***$ 140,526***	***$ -***	***$ (140,526)***	***(100.00%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 147,802**	**$ 140,526**	**$ -**	**$ (140,526)**	**(100.00%)**
	INDIRECT ALLOCATION	***$ 38,356***	***$ 37,151***	***$ -***	***$ (37,151)***	***(100.00%)***
	GENERAL FUND USE	***21,990***	***17,000***	*-*	***(17,000)***	***(100.00%)***
	TOTAL AGENCY NET	**$ (18,929)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		8.6%	7.8%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		3.2%	1.7%	0.0%		

Tobacco Education and Prevention

Tobacco Education and Prevention Partnership team members focus on evidence-based policy, systems, and environmental change strategies as well as community engagement and education for decreasing youth and adult tobacco and nicotine use. Efforts focus on policy changes to prevent youth access to and initiation of nicotine products and the elimination of secondhand smoke and nicotine aerosol exposure. Staff work through strategic partnerships to promote smoking cessation among target populations and support school districts, public housing authorities, detention facilities, youth-serving organizations, healthcare providers, and municipal governments and other community agencies. In addition, staff collaborate with and help coordinate agency-wide chronic disease and injury prevention activities through multi divisional work groups. They also continually seek to build and nurture partnerships with community organizations that promote chronic disease, injury, and tobacco prevention.

Funding Source(s): Restricted State Grant Funds, Required General Funds

Division: 3 COMMUNITY HEALTH PROMOTION- TOBACCO EDUCATION AND PREVENTION (351)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	1,035,462	1,328,075	1,318,077	(9,998)	(0.75%)
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 1,035,462**	**$ 1,328,075**	**$ 1,318,077**	**$ (9,998)**	**(0.75%)**
	FTE's	***4.75***	***7.23***	***7.00***	***-0.23***	***(3.18%)***
	Benefits as a Percentage of Wages	*34.97%*	*34.98%*	*34.98%*		
EXPENDITURES:						
	WAGES	$ 316,048	$ 461,890	$ 457,662	(4,228)	(0.92%)
	BENEFITS	110,534	161,581	160,097	(1,484)	(0.92%)
	Total Personnel	***$ 426,581***	***$ 623,471***	***$ 617,759***	***$ (5,712)***	***(0.92%)***
	CONTRACTS / SERVICES	104,858	155,355	142,356	(12,999)	(8.37%)
	TRAVEL	9,639	13,901	14,094	193	1.39%
	SUPPLIES	33,498	25,200	40,800	15,600	61.90%
	OPERATING	223,636	220,130	201,446	(18,684)	(8.49%)
	OTHER COSTS	186	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	3,721	4,400	2,200	(2,200)	(50.00%)
	TOTAL DIRECT EXPENSES	***$ 802,119***	***$ 1,042,457***	***$ 1,018,655***	***$ (23,802)***	***(2.28%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 802,119**	**$ 1,042,457**	**$ 1,018,655**	**$ (23,802)**	**(2.28%)**
	INDIRECT ALLOCATION	***$ 215,341***	***$ 285,618***	***$ 299,422***	***$ 13,804***	***4.83%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ 18,002**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Community Nutrition—Policy and Systems Change Through Advocacy and Education

Staff collaborate with early childhood, school district, and workplace partners to promote sustainable, evidence-based healthy eating and active living policies and practices. Technical assistance is provided to assist organizations with assessing current practices, adopting and implementing long-term changes, and connecting with additional resources to meet identified needs, which leverages and extends grant-funded efforts. Education includes coordination of TCHD participation in community events, provision of train-the-trainer sessions, and production of communication tools and educational materials that increase TCHD's visibility and provide value to partners. Registered dietitians bring a public health lens to community organization boards and committees, actively collaborate on Healthy Eating and Active Living messaging campaigns, and provide data and subject matter expertise to inform public policy and proposed regulations. Examples include serving on early childhood councils, school wellness committees, chamber of commerce committees, parks and recreation collaboratives, and other community coalitions. Staff convene external partners and internal cross-program workgroups to enhance planning and coordination of TCHD's advocacy and education with childcare and school sectors.

Funding Source(s): Required General Funds

Division: 3 COMMUNITY HEALTH PROMOTION-COMMUNITY NUTRITION (335)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	FTE's	***3.14***	***3.50***	***3.50***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*37.90%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 260,801	$ 299,704	$ 301,114	1,410	0.47%
	BENEFITS	98,835	104,900	105,389	489	0.47%
	Total Personnel	***$ 359,636***	***$ 404,604***	***$ 406,503***	***$ 1,899***	***0.47%***
	CONTRACTS / SERVICES	-	750	-	(750)	(100.00%)
	TRAVEL	1,881	5,200	2,748	(2,452)	(47.15%)
	SUPPLIES	865	1,744	1,800	56	3.21%
	OPERATING	3,497	5,490	4,900	(590)	(10.75%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 365,879***	***$ 417,788***	***$ 415,951***	***$ (1,837)***	***(0.44%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 365,879**	**$ 417,788**	**$ 415,951**	**$ (1,837)**	**(0.44%)**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***369,611***	***417,788***	***415,951***	***(1,837)***	***(0.44%)***
	TOTAL AGENCY NET	**$ 3,732**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		73.4%	82.0%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		27.6%	18.0%	17.3%		

Diabetes Education Program

The Diabetes Education Program has implemented programming with funding through CDPHE's Cancer, Cardiovascular, and Chronic Pulmonary Disease Grants Program since 2015. TCHD partners with primary care practices, community based organizations, recreational centers, businesses, and churches to outreach, recruit, and offer Diabetes Self-Management Education (DSME) and the Centers for Disease Control and Prevention's evidenced based National Diabetes Prevention Program (NDPP) – Journey to Wellness. TCHD is a recognized DSME site with the American Diabetes Association and has full recognition for the NDPP through CDC indicating attainment of all program benchmarks and provision of evidenced based education to the community. Residents in the prioritized neighborhood clusters of southwest Adams County and northwest Aurora experience higher diabetes burden and health inequities. The program also screens for food security and housing barriers, and assists clients with navigating the health system. Program staff conduct outreach to educate the public on the importance of NDPP and DSME and to enroll eligible clients, including through targeted outreach to eligible WIC clients. TCHD has increased access to the Spanish-speaking community by providing the NDPP in Spanish and connects clients with resources and information on navigating the health system. This program work supports the Food and Health priority in the TCHD Public Health Improvement Plan.
Funding Source: Restricted State Funds

Division: 3 COMMUNITY HEALTH PROMOTION-DIABETES PREVENTION (337)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	288,661	330,000	335,000	5,000	1.52%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 288,661**	**$ 330,000**	**$ 335,000**	**$ 5,000**	**1.52%**
	FTE's	***2.55***	***2.55***	***2.95***	***0.40***	***15.69%***
	Benefits as a Percentage of Wages	*34.95%*	*34.38%*	*28.46%*		
EXPENDITURES:						
	WAGES	$ 156,282	$ 172,847	$ 173,635	788	0.46%
	BENEFITS	54,615	59,424	49,422	(10,002)	(16.83%)
	Total Personnel	***$ 210,897***	***$ 232,271***	***$ 223,057***	***$ (9,214)***	***(3.97%)***
	CONTRACTS / SERVICES	-	9,200	6,680	(2,520)	(27.39%)
	TRAVEL	7,925	1,140	7,162	6,022	528.25%
	SUPPLIES	2,051	4,560	6,846	2,286	50.13%
	OPERATING	3,518	5,141	8,063	2,922	56.84%
	OTHER COSTS	65	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 224,456***	***$ 252,312***	***$ 251,808***	***$ (504)***	***(0.20%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 224,456**	**$ 252,312**	**$ 251,808**	**$ (504)**	**(0.20%)**
	INDIRECT ALLOCATION	***$ 65,945***	***$ 77,688***	***$ 83,192***	***$ 5,504***	***7.08%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ (1,740)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Healthy Beverage Initiative

The Healthy Beverage Partnership (HBP) has conducted efforts with funding through CDPHE's Cancer, Cardiovascular, and Chronic Pulmonary Disease grants program since 2015. TCHD is one of four metro area public health agencies collaborating regionally as the HBP to increase access to healthy food and beverages and to decrease consumption of unhealthy food and beverages. Sugary drinks are the largest source of added sugar in the U.S. diet and the single largest contributor to daily caloric intake, contributing to type 2 diabetes, obesity, heart disease, and tooth decay. Health implications of sugary drinks disproportionately impact low-income communities and people of color. HBP is building on the organizational policy work and Hidden Sugar media campaign by increasing community knowledge and capacity around municipal policy change supporting healthy restaurant children's meals. This program advances goals of the Food and Health priority of the TCHD Public Health Improvement Plan.
Funding Source(s): Restricted State Funds

Division: 3	COMMUNITY HEALTH PROMOTION-HEALTHY BEVERAGE INITIATIVE (336)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	$ -	-	0.00%
	OTHER GRANTS / CONTRACTS	51,655	50,250	53,395	3,145	6.26%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 51,655**	**$ 50,250**	**$ 53,395**	**$ 3,145**	**6.26%**
	FTE's	***0.52***	***0.50***	***0.50***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*35.00%*	*33.95%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 30,516	$ 30,852	$ 31,145	293	0.95%
	BENEFITS	10,681	10,474	10,901	427	4.08%
	Total Personnel	***$ 41,197***	***$ 41,326***	***$ 42,046***	***$ 720***	***1.74%***
	CONTRACTS / SERVICES	-	1,900	300	(1,600)	(84.21%)
	TRAVEL	1,336	651	2,132	1,481	227.50%
	SUPPLIES	2,826	100	2,669	2,569	2569.00%
	OPERATING	1,601	1,764	1,394	(370)	(20.98%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 46,960***	***$ 45,741***	***$ 48,541***	***$ 2,800***	***6.12%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 46,960**	**$ 45,741**	**$ 48,541**	**$ 2,800**	**6.12%**
	INDIRECT ALLOCATION	***$ 4,696***	***$ 4,509***	***$ 4,854***	***$ 345***	***7.65%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Maternal and Child Health (MCH) Block Grant

Child and Adolescent Health

TCHD leverages funding from the Maternal and Child Health Block Grant to support a variety of efforts focused on improving child and adolescent health. Work in this area includes a focus on early childhood developmental screening and referral and reducing bullying and suicide in youth. TCHD staff work with partners across the early childhood and youth systems in all three counties to identify gaps, and improve and align support and services, for children, youth and families. The majority of the program is supported financially by the Federal Maternal Child Health Block grant (Title V), administered by CDPHE. This program work supports the Mental Health priority in the TCHD Public Health Improvement Plan.

Funding Source(s): Restricted Federal Funds, Restricted State Funds

Medical Home for Children and Youth with Special Healthcare Needs

TCHD leverages funding from the Maternal and Child Health Block Grant to support efforts aimed at improving access to and coordination across medical care and community resources for children and youth with special healthcare needs. TCHD staff work with partners across the system of care for children and youth to remove barriers to quality care. The majority of the program is supported financially by the Federal Maternal Child Health Block grant (Title V), administered by CDPHE.

Funding Sources: Restricted Federal Funds, Restricted State Funds

Perinatal Health

TCHD leverages funding from the Maternal and Child Health Block Grant to support initiatives to improve the health of women of reproductive age. Current priorities include increasing identification, screening and referrals for women experiencing maternal mood disorders, increasing support and services for women who misuse substances in the perinatal period and decreasing the disparity of infant mortality. The majority of the program is supported financially by the Federal Maternal Child Health Block grant (Title V), administered by CDPHE. This program work supports the Mental Health priority in the TCHD Public Health Improvement plan.

Funding Source(s): Restricted Federal Funds, Restricted State Funds

Division: 3 COMMUNITY HEALTH PROMOTION-MCH (371,372,373)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	43,639	141,566	157,743	16,177	11.43%
	FEDERAL PASS THRU FUNDS	309,250	512,970	514,047	1,077	0.21%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 352,889**	**$ 654,536**	**$ 671,790**	**$ 17,254**	**2.64%**
	FTE's	***1.97***	***4.05***	***4.31***	***0.26***	***6.38%***
	Benefits as a Percentage of Wages	*34.89%*	*35.07%*	*34.77%*		
EXPENDITURES:						
	WAGES	$ 157,103	$ 324,909	$ 358,164	33,255	10.24%
	BENEFITS	54,806	113,955	124,518	10,563	9.27%
	Total Personnel	***$ 211,909***	***$ 438,864***	***$ 482,682***	***$ 43,818***	***9.98%***
	CONTRACTS / SERVICES	49,418	23,229	14,995	(8,234)	(35.45%)
	TRAVEL	7,098	14,204	8,584	(5,620)	(39.57%)
	SUPPLIES	1,700	9,750	4,242	(5,508)	(56.49%)
	OPERATING	9,773	17,578	4,984	(12,594)	(71.65%)
	OTHER COSTS	65	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 279,962***	***$ 503,625***	***$ 515,487***	***$ 11,862***	***2.36%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 279,962**	**$ 503,625**	**$ 515,487**	**$ 11,862**	**2.36%**
	INDIRECT ALLOCATION	***$ 72,676***	***$ 150,911***	***$ 156,303***	***$ 5,392***	***3.57%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ 251**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Substance Use Prevention

At the request of the County Commissioners, TCHD facilitates the Tri-County Overdose Prevention Partnership (TCOPP), comprised of partners across the three counties coming together to address opiate use, prevent initial use, reduce and prevent deaths, and provide for a supportive community. This partnership looks at multiple levels of prevention including intervention and treatment. TCHD supports a community coalition facilitated by Douglas County Schools utilizing SAMHSA's Strategic Prevention Framework to assess the community, plan evidence-based interventions, and evaluate success. TCHD also administers a grant to work with community coalitions in Western Arapahoe County and along the I-70 Corridor using the Communities That Care model with the goal of reducing youth use, misuse, and abuse of substances. This program work supports the Mental Health and Access to Care priorities of the TCHD Public Health Improvement Plan.

Funding Source(s): General Funds, Restricted State Grant Funds, Restricted Federal Funds

Division: 3	**COMMUNITY HEALTH PROMOTION-MENTAL/BEHAVIORAL HEALTH PROMOTION, SUBSTANCE USE PREVENTION (354, 355, 357, 359, 330-334, 330-339)**				**Increase / (Decrease)**	
		FY2019 ACTUAL	**FY2020 REVISED**	**FY2021 ADOPTED**	**$**	**%**
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	1,817	-	-	-	0.00%
	STATE CONTRACTS	375,266	702,690	362,852	(339,838)	(48.36%)
	FEDERAL PASS THRU FUNDS	551,848	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 928,930**	**$ 702,690**	**$ 362,852**	**$ (339,838)**	**(48.36%)**
	FTE's	***5.21***	***4.60***	***3.65***	***-0.95***	***(20.65%)***
	Benefits as a Percentage of Wages	*35.42%*	*36.33%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 278,586	$ 190,192	$ 198,798	8,606	4.52%
	BENEFITS	98,662	69,103	69,579	476	0.69%
	Total Personnel	***$ 377,248***	***$ 259,295***	***$ 268,377***	***$ 9,082***	***3.50%***
	CONTRACTS / SERVICES	444,949	346,065	166,992	(179,073)	(51.75%)
	TRAVEL	35,828	20,426	8,765	(11,661)	(57.09%)
	SUPPLIES	21,388	38,400	2,400	(36,000)	(93.75%)
	OPERATING	62,833	40,916	17,177	(23,739)	(58.02%)
	OTHER COSTS	83	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	1,657	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 943,986***	***$ 705,102***	***$ 463,711***	***$ (241,391)***	***(34.23%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 943,986**	**$ 705,102**	**$ 463,711**	**$ (241,391)**	**(34.23%)**
	INDIRECT ALLOCATION	***$ 132,856***	***$ 106,397***	***$ 46,850***	***$ (59,547)***	***(55.97%)***
	GENERAL FUND USE	***121,650***	***108,809***	***147,709***	***38,900***	***35.75%***
	TOTAL AGENCY NET	**$ (26,262)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		8.2%	11.0%	23.9%		
% of Total Expenses Funded by **Non-County General Funds**		3.1%	2.4%	5.0%		

Division: 3 COMMUNITY HEALTH PROMOTION-SAMSHA GRANT (356)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	31,565	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	168,881	168,881	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 31,565**	**$ 168,881**	**$ 168,881**	**$ -**	**0.00%**
	FTE's	***0.07***	***0.30***	***0.29***	***-0.01***	***(2.12%)***
	Benefits as a Percentage of Wages	*35.00%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 4,509	$ 20,084	$ 20,362	278	1.38%
	BENEFITS	1,578	7,029	7,127	98	1.39%
	Total Personnel	***$ 6,087***	***$ 27,113***	***$ 27,489***	***$ 376***	***1.39%***
	CONTRACTS / SERVICES	24,869	126,383	126,428	45	0.04%
	TRAVEL	-	3,340	2,493	(847)	(25.36%)
	SUPPLIES	-	2,200	1,700	(500)	(22.73%)
	OPERATING	-	2,800	3,650	850	30.36%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 30,957***	***$ 161,836***	***$ 161,760***	***$ (76)***	***(0.05%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 30,957**	**$ 161,836**	**$ 161,760**	**$ (76)**	**(0.05%)**
	INDIRECT ALLOCATION	***$ 609***	***$ 7,045***	***$ 7,121***	***$ 76***	***1.08%***
	GENERAL FUND USE	*-*	*-*	*-*	*-*	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Worksite Wellness

TCHD enhances worksite policies and practices through outreach to local and regional employers with funding provided by CDPHE's Cancer Cardiovascular and Pulmonary Disease Grant Program. Through active facilitation of five coalitions, TCHD provides training, technical advising and financial opportunities to support employers in the process of implementing breastfeeding and healthy food and beverage-friendly policies and programs. Project partners include local chambers of commerce, the American Heart Association, Kaiser Permanente, Aetna, Health Links, and many other local and regional stakeholders. Coalitions include public and private employers from the greater Metro area including Jefferson, Boulder, Broomfield, and Denver counties.

Funding Sources: Restricted State Funds

Division: 3	COMMUNITY HEALTH PROMOTION-CCPD WORKSITE WELLNESS (332)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	289,483	300,300	300,300	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 289,483**	**$ 300,300**	**$ 300,300**	**$ -**	**0.00%**
	FTE's	***1.79***	***1.90***	***1.70***	***-0.20***	***(10.53%)***
	Benefits as a Percentage of Wages	*34.98%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 115,293	$ 127,473	$ 118,808	(8,665)	(6.80%)
	BENEFITS	40,332	44,617	41,583	(3,034)	(6.80%)
	Total Personnel	***$ 155,625***	***$ 172,090***	***$ 160,391***	***$ (11,699)***	***(6.80%)***
	CONTRACTS / SERVICES	10,150	12,250	11,016	(1,234)	(10.07%)
	TRAVEL	2,145	5,254	4,611	(643)	(12.24%)
	SUPPLIES	50,457	31,288	43,685	12,397	39.62%
	OPERATING	7,141	11,676	11,800	124	1.06%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	1,680	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 227,198***	***$ 232,558***	***$ 231,503***	***$ (1,055)***	***(0.45%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 227,198**	**$ 232,558**	**$ 231,503**	**$ (1,055)**	**(0.45%)**
	INDIRECT ALLOCATION	***$ 66,751***	***$ 67,742***	***$ 68,797***	***$ 1,055***	***1.56%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ (4,465)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Mental Health Promotion and Suicide Prevention

TCHD will serve as a convener and backbone to collective work where appropriate, uniting efforts across sectors to implement the TCHD-area Mental Health Promotion Framework and the TCHD-area Suicide Prevention Framework. Staff will assess and communicate community needs, gaps, and solutions; share data, trends, and evidence-based practices; and lead identification of barriers and implementation of effective strategies. A priority will be placed on reducing stigma; increasing access to and utilization of services; and building capacity within other sectors, including school districts. Throughout implementation, community members will influence the work and strategies will aim to reduce inequities.

Funding Source(s): General Funds

Division: 3	COMMUNITY HEALTH PROMOTION-MENTAL HEALTH PROGRAM (358)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
z	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		$ -	$ -	$ -	$ -	**0.00%**
	FTE's	***0.00***	***0.00***	***1.00***	***1.00***	***0.00%***
	Benefits as a Percentage of Wages	*0.00%*	*0.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ -	$ -	$ 66,328	66,328	0.00%
	BENEFITS	-	-	23,215	23,215	0.00%
	Total Personnel	***$ -***	***$ -***	***$ 89,543***	***$ 89,543***	***0.00%***
	CONTRACTS / SERVICES	-	120,015	31,113	(88,902)	(74.08%)
	TRAVEL	-	-	-	-	0.00%
	SUPPLIES	-	-	-	-	0.00%
	OPERATING	-	-	-	-	0.00%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ -***	***$ 120,015***	***$ 120,656***	***$ 641***	***0.53%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		$ -	$ 120,015	$ 120,656	$ 641	**0.53%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	$ -	***0.00%***
	GENERAL FUND USE	-	***120,015***	***120,656***	***641***	***0.53%***
	TOTAL AGENCY NET	$ -	$ -	$ -	$ -	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	82.0%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	18.0%	17.3%		

NENS Referral Grant Project

This grant from the Denver Health and Hospitals Foundation addresses a need to navigate the Early Intervention System. This system is primarily built for English speakers, and is not easy to navigate if a family speaks another language. The Non-English, Non-Spanish (NENS) project assists patients 0-5 years through the use of linguistically and culturally responsive multilingual care navigation, by ensuring NENS children and adults screened and referred for specialty care and services are able to access that care, and connecting NENS child and adult patients without a medical home. The goal is for TCHD to create a streamlined referral to evaluation process for NENS children who are referred from the Denver Health Lowry clinic.

Funding Source(s): Restricted State Funds

Division: 3	COMMUNITY HEALTH PROMOTION-NENS REFERRAL GRANT PROJECT (374)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
z	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	10,210	10,210	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		$ -	$ -	$ 10,210	$ 10,210	**0.00%**
	FTE's	***0.00***	***0.00***	***0.10***	***0.10***	***0.00%***
	Benefits as a Percentage of Wages	*0.00%*	*0.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ -	$ -	$ 7,625	7,625	0.00%
	BENEFITS	-	-	2,669	2,669	0.00%
	Total Personnel	***$ -***	***$ -***	***$ 10,294***	***$ 10,294***	***0.00%***
	CONTRACTS / SERVICES	-	-	-	-	0.00%
	TRAVEL	-	-	-	-	0.00%
	SUPPLIES	-	-	117	117	0.00%
	OPERATING	-	-	-	-	0.00%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ -***	***$ -***	***$ 10,411***	***$ 10,411***	***0.00%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		$ -	$ -	$ 10,411	$ 10,411	**0.00%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	-	-	***201***	***201***	***0.00%***
	TOTAL AGENCY NET	$ -	$ -	$ -	$ -	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	1.6%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.3%		

Nursing Division

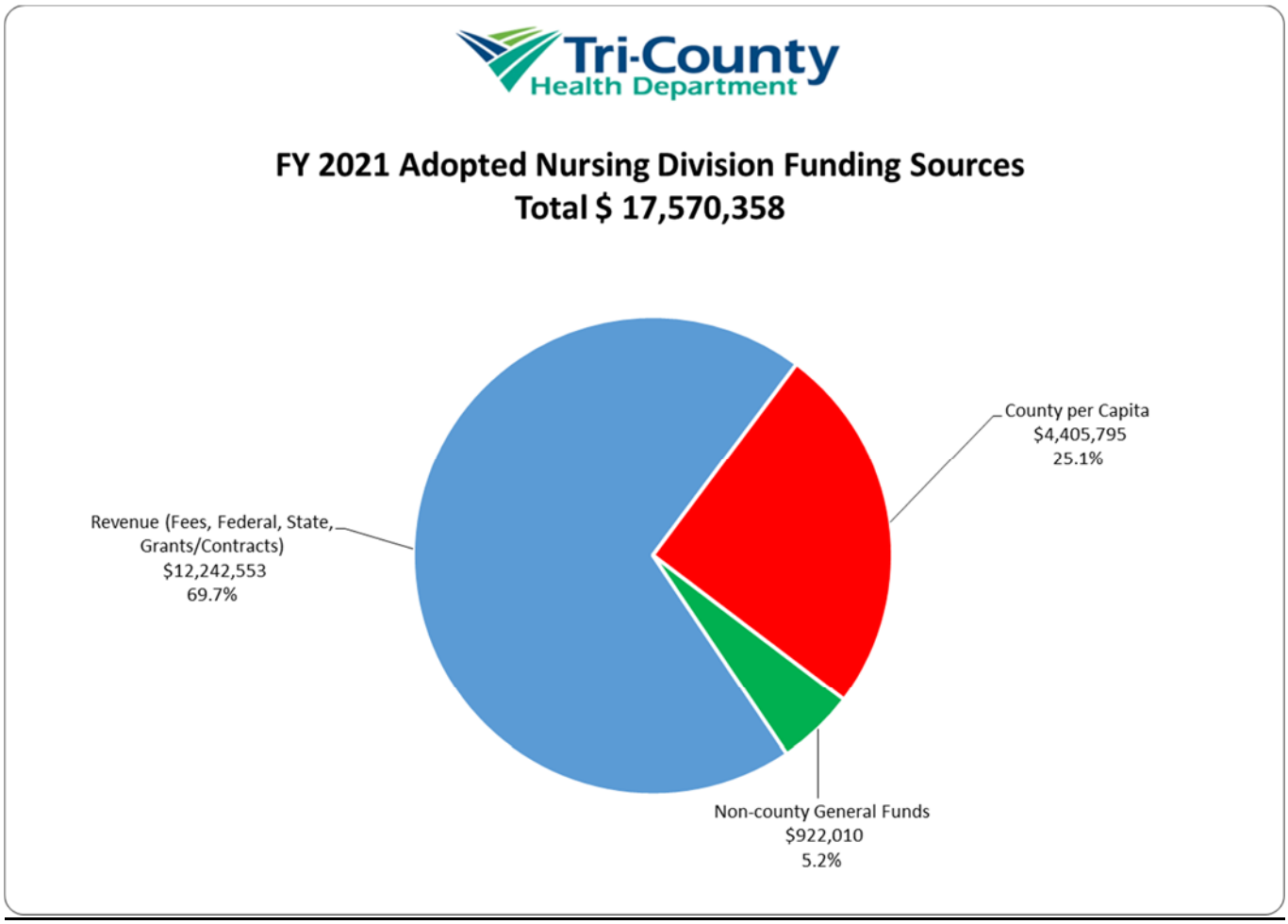


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NURSING DIVISION

Division: 4 NURSING DIVISION

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	2,001,583	2,311,173	2,393,970	82,797	3.58%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	437,085	491,491	489,991	(1,500)	(0.31%)
	FEES	514,424	463,513	463,513	-	0.00%
	STATE CONTRACTS	5,700,070	4,939,093	4,438,261	(500,832)	(10.14%)
	FEDERAL PASS THRU FUNDS	2,399,234	2,966,316	$ 3,203,154	236,838	7.98%
	OTHER GRANTS / CONTRACTS	48,252	177,900	117,664	(60,236)	(33.86%)
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	1,316,958	1,136,000	1,136,000	-	0.00%
TOTAL DIVISION REVENUE		**$ 12,417,605**	**$ 12,485,486**	**$ 12,242,553**	**$ (242,933)**	**(1.95%)**
	FTE's	***135.23***	***140.02***	***136.11***	***-3.91***	***(2.79%)***
	Benefits as a Percentage of Wages	*34.87%*	*36.55%*	*34.48%*		
EXPENDITURES:						
	WAGES	$ 8,688,096	$ 9,093,539	$ 9,482,123	388,584	4.27%
	BENEFITS	3,029,880	3,323,378	3,269,039	(54,339)	(1.64%)
	Total Personnel	***$ 11,717,977***	***$ 12,416,917***	***$ 12,751,162***	***$ 334,245***	***2.69%***
	CONTRACTS / SERVICES	869,624	572,504	545,112	(27,392)	(4.78%)
	TRAVEL	235,600	256,451	257,939	1,488	0.58%
	SUPPLIES	798,950	903,165	786,135	(117,030)	(12.96%)
	OPERATING	695,760	343,199	227,852	(115,347)	(33.61%)
	OTHER COSTS	10,909	10,300	8,941	(1,359)	(13.19%)
	EQUIPMENT (Non-Capital)	8,019	16,520	4,000	(12,520)	(75.79%)
	TOTAL DIRECT EXPENSES	***$ 14,336,839***	***$ 14,519,056***	***$ 14,581,141***	***$ 62,085***	***0.43%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ 65,000***	***$ -***	$ (65,000)	(100.00%)
	IN-KIND EXPENSE	***1,316,958***	***1,136,000***	***1,136,000***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 15,653,796**	**$ 15,720,056**	**$ 15,717,141**	**$ (2,915)**	**(0.02%)**
	INDIRECT ALLOCATION	***$ 2,577,218***	***$ 1,659,948***	***$ 1,853,217***	***$ 193,269***	***11.64%***
	GENERAL FUND USE	***5,518,776***	***4,894,518***	***5,327,805***	***433,287***	***8.85%***
	TOTAL AGENCY NET	**$ (294,632)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		22.0%	23.1%	25.1%		
% of Total Expenses Funded by **Non-County General Funds**		8.3%	5.1%	5.2%		


Tri-County
Health Department
FY 2021 Adopted Nursing Division Funding Sources
Total $ 17,570,358
County per Capita
$4,405,795
25.1%
Revenue (Fees, Federal, State, Grants/Contracts)
$12,242,553
69.7%
Non-county General Funds
$922,010
5.2%

Division Operations

This core leadership team is responsible for oversight, planning, implementation, and evaluation of all nursing activities and programs. This division operations team is also responsible for financial oversight, data collection and management, grant and contract management, and program evaluation. This team also assists with quality assurance and improvement processes.

Funding Source(s): Required General Funds

Division: 4	NURSING - DIVISION OPERATIONS (490)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	2,507	-	-	-	0.00%
	STATE CONTRACTS	-	40,000	-	(40,000)	(100.00%)
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 2,507**	**$ 40,000**	**$ -**	**$ (40,000)**	**(100.00%)**
	FTE's	***9.35***	***9.19***	***8.29***	***-0.90***	***(9.79%)***
	Benefits as a Percentage of Wages	*37.04%*	*48.37%*	*34.57%*		
EXPENDITURES:						
	WAGES	$ 751,457	$ 560,425	$ 790,556	230,131	41.06%
	BENEFITS	278,348	271,090	273,299	2,209	0.81%
	Total Personnel	***$ 1,029,805***	***$ 831,515***	***$ 1,063,855***	***$ 232,340***	***27.94%***
	CONTRACTS / SERVICES	97,079	46,117	15,000	(31,117)	(67.47%)
	TRAVEL	13,599	13,000	13,000	-	0.00%
	SUPPLIES	22,102	19,600	17,700	(1,900)	(9.69%)
	OPERATING	516,512	161,463	93,271	(68,192)	(42.23%)
	OTHER COSTS	8,773	8,524	7,641	(883)	(10.36%)
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 1,687,869***	***$ 1,080,219***	***$ 1,210,467***	***$ 130,248***	***12.06%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	***-***	***-***	***-***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 1,687,869**	**$ 1,080,219**	**$ 1,210,467**	**$ 130,248**	**12.06%**
	INDIRECT ALLOCATION	***$ 201***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***2,040,459***	***1,040,219***	***1,210,467***	***170,248***	***16.37%***
	TOTAL AGENCY NET	**$ 354,895**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		87.8%	78.9%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		33.0%	17.4%	17.3%		

Arapahoe County Senior Dental Program

The Senior Dental program provides preventative, some restorative, and maintenance dental services to income-eligible seniors residing in Arapahoe County. Qualifying adults over 55 can receive care on a sliding fee scale with the majority of funding provided by Arapahoe County. Routine dental care improves the quality of life, general health, and well-being for senior citizens.

Funding Source(s): Fees, Restricted County Funds, Restricted State Funds, Medicaid Reimbursement

Division: 4	NURSING - ARAPAHOE COUNTY SENIOR DENTAL (495)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	311,943	311,943	311,943	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	28,180	30,000	30,000	-	0.00%
	FEES	93,225	101,513	101,513	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	3,000	68,000	-	(68,000)	(100.00%)
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 436,348**	**$ 511,456**	**$ 443,456**	**$ (68,000)**	**(13.30%)**
	FTE's	***3.42***	***3.60***	***3.00***	***-0.60***	***(16.67%)***
	Benefits as a Percentage of Wages	*28.82%*	*35.62%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 240,747	$ 263,933	$ 249,241	(14,692)	(5.57%)
	BENEFITS	69,375	94,023	87,235	(6,788)	(7.22%)
	Total Personnel	***$ 310,122***	***$ 357,956***	***$ 336,476***	***$ (21,480)***	***(6.00%)***
	CONTRACTS / SERVICES	41,134	42,565	45,435	2,870	6.74%
	TRAVEL	1,573	498	895	397	79.72%
	SUPPLIES	20,660	22,500	38,533	16,033	71.26%
	OPERATING	2,799	1,700	1,000	(700)	(41.18%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	4,193	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 380,480***	***$ 425,219***	***$ 422,339***	***$ (2,880)***	***(0.68%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ 65,000***	***$ -***	$ (65,000)	(100.00%)
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 380,480**	**$ 490,219**	**$ 422,339**	**$ (67,880)**	**(13.85%)**
	INDIRECT ALLOCATION	***$ 19,024***	***$ 21,237***	***$ 21,117***	***$ (120)***	***(0.57%)***
	GENERAL FUND USE	*-*	*-*	*-*	*-*	***0.00%***
	TOTAL AGENCY NET	**$ 36,844**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Nurse Home Visiting Program – Adams County Nurse Support Contract Programs

This program is a longstanding contract with the Adams County Human Services Department (ACHSD). ACHSD recognizes that public health nursing intervention can result in improved pregnancy outcomes, parenting knowledge, and enhanced self-sufficiency for families receiving benefits or involved with child welfare.

Funding Source(s): Restricted County Funds.

Division: 4 NURSING - ADAMS COUNTY NURSE SUPPORT CONTRACT PROGRAMS (420)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	520,169	558,664	579,139	20,475	3.66%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 520,169**	**$ 558,664**	**$ 579,139**	**$ 20,475**	**3.66%**
	FTE's	***6.12***	***6.10***	***6.60***	***0.50***	***8.20%***
	Benefits as a Percentage of Wages	*35.18%*	*35.64%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 376,403	$ 377,503	$ 413,916	36,413	9.65%
	BENEFITS	132,401	134,541	144,870	10,329	7.68%
	Total Personnel	***$ 508,804***	***$ 512,044***	***$ 558,786***	***$ 46,742***	***9.13%***
	CONTRACTS / SERVICES	684	-	-	-	0.00%
	TRAVEL	13,912	11,700	18,500	6,800	58.12%
	SUPPLIES	6,127	2,300	2,421	121	5.26%
	OPERATING	4,548	6,016	7,240	1,224	20.35%
	OTHER COSTS	93	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 534,169***	***$ 532,060***	***$ 586,947***	***$ 54,887***	***10.32%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 534,169**	**$ 532,060**	**$ 586,947**	**$ 54,887**	**10.32%**
	INDIRECT ALLOCATION	***$ 37,372***	***$ 26,604***	***$ 29,347***	***$ 2,743***	***10.31%***
	GENERAL FUND USE	*-*	*-*	***37,155***	***37,155***	***0.00%***
	TOTAL AGENCY NET	**$ (51,372)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	5.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	1.0%		

Nurse Home Visiting Program – Arapahoe County Nurse Support Contract Programs

The Arapahoe County Department of Human Services (ACDHS) recognizes that public health nursing intervention can result in improved pregnancy outcomes, parenting knowledge, and enhanced family self-sufficiency. The County also provides funds for public health nurses to work with child and adult welfare units, to provide professional assessments, and to act as liaison for families referred to human services.

Funding Source(s): Restricted County Funds

Division: 4	NURSING - ARAPAHOE COUNTY NURSE SUPPORT CONTRACT PROGRAMS (424, 426)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	1,093,105	1,239,201	1,282,556	43,355	3.50%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 1,093,105**	**$ 1,239,201**	**$ 1,282,556**	**$ 43,355**	**3.50%**
	FTE's	***11.29***	***13.11***	***13.16***	***0.05***	***0.38%***
	Benefits as a Percentage of Wages	*35.24%*	*36.28%*	*34.94%*		
EXPENDITURES:						
	WAGES	$ 708,284	$ 821,065	$ 854,080	33,015	4.02%
	BENEFITS	249,622	297,893	298,447	554	0.19%
	Total Personnel	***$ 957,906***	***$ 1,118,958***	***$ 1,152,527***	***$ 33,569***	***3.00%***
	CONTRACTS / SERVICES	3,605	-	1,039	1,039	0.00%
	TRAVEL	20,999	24,590	28,976	4,386	17.84%
	SUPPLIES	4,649	20,300	23,464	3,164	15.59%
	OPERATING	10,641	16,342	15,476	(866)	(5.30%)
	OTHER COSTS	350	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 998,148***	***$ 1,180,190***	***$ 1,221,482***	***$ 41,292***	***3.50%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 998,148**	**$ 1,180,190**	**$ 1,221,482**	**$ 41,292**	**3.50%**
	INDIRECT ALLOCATION	***$ 49,904***	***$ 59,011***	***$ 61,074***	***$ 2,063***	***3.50%***
	GENERAL FUND USE	*-*	*-*	*-*	*-*	***0.00%***
	TOTAL AGENCY NET	**$ 45,054**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Nurse Home Visiting Program – Douglas County Mothers First Program

This program is the result of a new contract with the Douglas County Department of Human Services (DCDHS) to provide public health nursing intervention resulting in supporting and helping families stay together, prevention of out-of-home placements, reduction of unintended pregnancies, and provisioning of prenatal education and psychosocial support for pregnant women and their families
Funding Source(s): Restricted County Funds

Division: 4	NURSING - DOUGLAS MOTHERS FIRST PROGRAM (427)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	125,000	143,967	18,967	15.17%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ -**	**$ 125,000**	**$ 143,967**	**$ 18,967**	**15.17%**
	FTE's	***0.00***	***0.00***	***1.54***	***1.54***	***0.00%***
	Benefits as a Percentage of Wages	*0.00%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ -	$ 83,759	$ 99,101	15,342	18.32%
	BENEFITS	-	29,315	34,685	5,370	18.32%
	Total Personnel	***$ -***	***$ 113,074***	***$ 133,786***	***$ 20,712***	***18.32%***
	CONTRACTS / SERVICES	-	-	-	-	0.00%
	TRAVEL	-	3,600	1,499	(2,101)	(58.36%)
	SUPPLIES	-	1,000	1,000	-	0.00%
	OPERATING	-	1,376	826	(550)	(39.97%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ -***	***$ 119,050***	***$ 137,111***	***$ 18,061***	***15.17%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	***-***	***-***	***-***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ -**	**$ 119,050**	**$ 137,111**	**$ 18,061**	**15.17%**
	INDIRECT ALLOCATION	***$ -***	***$ 5,950***	***$ 6,856***	***$ 906***	***15.23%***
	GENERAL FUND USE	***-***	***-***	***-***	***-***	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Child Fatality Prevention Review

The Child Fatality Prevention Review program works with community partners, law enforcement and county officials in all three counties to facilitate case reviews of all preventable child deaths. The goal of each county review team is to improve the health and safety of children by examining individual fatalities, exploring fatality trends and documenting population-based recommendations.

Funding Source(s): Restricted State Funds, Required General Funds

Division: 4	NURSING - CHILD FATALITY PREVENTION REVIEW (425)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	57,183	55,000	64,000	9,000	16.36%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 57,183**	**$ 55,000**	**$ 64,000**	**$ 9,000**	**16.36%**
	FTE's	***0.75***	***0.75***	***0.75***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*35.00%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 44,237	$ 45,705	$ 48,052	2,347	5.14%
	BENEFITS	15,483	15,998	16,818	820	5.13%
	Total Personnel	***$ 59,720***	***$ 61,703***	***$ 64,870***	***$ 3,167***	***5.13%***
	CONTRACTS / SERVICES	695	-	-	-	0.00%
	TRAVEL	774	300	814	514	171.33%
	SUPPLIES	48	400	400	-	0.00%
	OPERATING	880	150	900	750	500.00%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 62,116***	***$ 62,553***	***$ 66,984***	***$ 4,431***	***7.08%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	***-***	***-***	***-***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 62,116**	**$ 62,553**	**$ 66,984**	**$ 4,431**	**7.08%**
	INDIRECT ALLOCATION	***$ 18,115***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***13,813***	***7,553***	***2,984***	***(4,569)***	***(60.49%)***
	TOTAL AGENCY NET	**$ (9,235)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		12.5%	9.9%	3.7%		
% of Total Expenses Funded by **Non-County General Funds**		4.7%	2.2%	0.8%		

Nurse Home Visiting Program – Nurse Family Partnership

The Nurse Family Partnership is a research-based primary prevention nursing case management program targeting first time, low-income women. The program begins home visits during the client's pregnancy. The mom and baby receive home visits weekly or bi-monthly until the child's second birthday. The goal of the program is to improve pregnancy outcomes, enhance family interactions, expand parenting skills, and increase parental self-sufficiency. Another long-term goal of the program is to limit the time that families receive entitlement family support or welfare programs.
Funding Source(s): Restricted Federal Funds, Restricted State Funds, Medicaid Reimbursement

Division: 4	NURSING - NURSE FAMILY PARTNERSHIP (455, 457)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	7,443	17,806	17,806	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	2,828,322	3,128,899	3,185,906	57,007	1.82%
	FEDERAL PASS THRU FUNDS	762,085	864,676	916,801	52,125	6.03%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 3,597,850**	**$ 4,011,381**	**$ 4,120,513**	**$ 109,132**	**2.72%**
	FTE's	***28.27***	***31.10***	***31.16***	***0.06***	***0.19%***
	Benefits as a Percentage of Wages	*35.30%*	*36.57%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 1,980,551	$ 2,174,394	$ 2,323,853	149,459	6.87%
	BENEFITS	699,080	795,168	813,351	18,183	2.29%
	Total Personnel	***$ 2,679,631***	***$ 2,969,562***	***$ 3,137,204***	***$ 167,642***	***5.65%***
	CONTRACTS / SERVICES	55,521	64,730	51,698	(13,032)	(20.13%)
	TRAVEL	87,163	111,347	108,058	(3,289)	(2.95%)
	SUPPLIES	54,200	59,690	55,724	(3,966)	(6.64%)
	OPERATING	85,272	83,782	38,940	(44,842)	(53.52%)
	OTHER COSTS	568	800	800	-	0.00%
	EQUIPMENT (Non-Capital)	3,827	13,520	4,000	(9,520)	(70.41%)
	TOTAL DIRECT EXPENSES	***$ 2,966,183***	***$ 3,303,431***	***$ 3,396,424***	***$ 92,993***	***2.82%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 2,966,183**	**$ 3,303,431**	**$ 3,396,424**	**$ 92,993**	**2.82%**
	INDIRECT ALLOCATION	***$ 637,357***	***$ 707,950***	***$ 724,089***	***$ 16,139***	***2.28%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ (5,689)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Public Health Nursing Clinical Education

TCHD's Public Health Nursing Clinical Education Program is primarily responsible for providing a wide variety of clinical education to nursing students and assisting in the coordination of professional development for division staff. This program leads student placements for contracted schools of nursing, provides latent tuberculosis case management to referred clients, coordinates ancillary nursing student placements, and participates on internal work groups including the Disease Intervention Field Team and the Public Health Incident Management Team.

Funding Sources: Restricted Contracts, Required General Funds

Division: 4	NURSING - PUBLIC HEALTH NURSING CLINICAL EDUCATION (411, 415)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	2,100	2,100	2,100	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	45,252	57,900	65,664	7,764	13.41%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 47,352**	**$ 60,000**	**$ 67,764**	**$ 7,764**	**12.94%**
	FTE's	***0.38***	***0.62***	***0.64***	***0.02***	***3.23%***
	Benefits as a Percentage of Wages	*35.00%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 25,791	$ 41,284	$ 47,513	6,229	15.09%
	BENEFITS	9,027	14,451	16,630	2,179	15.08%
	Total Personnel	***$ 34,818***	***$ 55,735***	***$ 64,143***	***$ 8,408***	***15.09%***
	CONTRACTS / SERVICES	335,811	286,592	285,811	(781)	(0.27%)
	TRAVEL	414	1,225	420	(805)	(65.71%)
	SUPPLIES	113	684	273	(411)	(60.09%)
	OPERATING	797	2,356	828	(1,528)	(64.86%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 371,952***	***$ 346,592***	***$ 351,475***	***$ 4,883***	***1.41%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 371,952**	**$ 346,592**	**$ 351,475**	**$ 4,883**	**1.41%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***334,492***	***286,592***	***283,711***	***(2,881)***	***(1.01%)***
	TOTAL AGENCY NET	**$ 9,892**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		65.4%	67.8%	66.8%		
% of Total Expenses Funded by **Non-County General Funds**		24.6%	14.9%	14.0%		

Disease Prevention and Clinical Services Program – Harm Reduction and HIV Prevention Program

This program focuses on the prevention and education of Human Immunodeficiency Virus (HIV), Hepatitis C Virus, and sexually transmitted illnesses (STI). Providers in this program focus on individual screening, community education, and outreach to individuals affected by these infections. Linkage to care services are provided for individuals who have been newly diagnosed or have fallen out of HIV care. The Aurora Syringe Access Services provide sterile syringes, safe injection supplies, wound care education, and Naloxone for individuals that use intravenous drugs who are at risk for HIV and Hepatitis C infection and overdose death.

Funding Source(s): Restricted Federal Funds, Restricted State Funds, Required General Funds

Division: 4	**NURSING - HARM REDUCTION AND HIV PREVENTION PROGRAM (469)**				**Increase / (Decrease)**	
		FY2019 ACTUAL	**FY2020 REVISED**	**FY2021 ADOPTED**	**$**	**%**
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	799,212	280,563	277,618	(2,945)	(1.05%)
	FEDERAL PASS THRU FUNDS	-	307,952	487,073	179,121	58.17%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 799,212**	**$ 588,515**	**$ 764,691**	**$ 176,176**	**29.94%**
	FTE's	***7.45***	***5.80***	***7.10***	***1.30***	***22.41%***
	Benefits as a Percentage of Wages	*35.10%*	*35.23%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 407,459	$ 324,545	$ 414,629	90,084	27.76%
	BENEFITS	143,002	114,351	145,122	30,771	26.91%
	Total Personnel	***$ 550,461***	***$ 438,896***	***$ 559,751***	***$ 120,855***	***27.54%***
	CONTRACTS / SERVICES	72,304	15,400	27,951	12,551	81.50%
	TRAVEL	15,655	13,000	13,969	969	7.45%
	SUPPLIES	8,683	16,208	18,105	1,897	11.70%
	OPERATING	17,261	11,100	10,832	(268)	(2.41%)
	OTHER COSTS	121	393	-	(393)	(100.00%)
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 664,485***	***$ 494,997***	***$ 630,608***	***$ 135,611***	***27.40%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 664,485**	**$ 494,997**	**$ 630,608**	**$ 135,611**	**27.40%**
	INDIRECT ALLOCATION	***$ 134,186***	***$ 93,518***	***$ 134,083***	***$ 40,565***	***43.38%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ 541**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Disease Prevention and Clinical Services Program – Immunization and Clinical Outbreak Response

This program provides immunizations to individual of all ages to protect them from vaccine-preventable diseases. Immunizations are available every weekday and one Saturday per month. Clinics are held in TCHD offices and at community-based sites around the three-county region and appointments are coordinated through our Patient Services Call Center. The immunization program targets persons who are uninsured or underinsured. There is no residency or income requirement; although a $22 administration fee is requested for each immunization, nobody is turned away for inability to pay.

Funding Source(s): Restricted Federal Funds, Restricted State Funds, Required General Funds, Medicaid Reimbursement, Patient Fees, Patient Donations, Private Insurance Billing

Division: 4	NURSING - IMMUNIZATION AND CLINICAL OUTBREAK RESPONSE (460, 461)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	192,309	175,000	175,000	-	0.00%
	FEES	197,187	175,000	175,000	-	0.00%
	STATE CONTRACTS	530,694	490,396	530,693	40,297	8.22%
	FEDERAL PASS THRU FUNDS	463,943	421,088	463,941	42,853	10.18%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	1,219,004	1,040,000	1,040,000	-	0.00%
TOTAL DIVISION REVENUE		**$ 2,603,135**	**$ 2,301,484**	**$ 2,384,634**	**$ 83,150**	**3.61%**
	FTE's	***21.07***	***22.50***	***23.70***	***1.20***	***5.33%***
	Benefits as a Percentage of Wages	*34.99%*	*35.38%*	*34.71%*		
EXPENDITURES:						
	WAGES	$ 1,195,854	$ 1,357,645	$ 1,446,153	88,508	6.52%
	BENEFITS	418,391	480,385	501,897	21,512	4.48%
	Total Personnel	***$ 1,614,245***	***$ 1,838,030***	***$ 1,948,050***	***$ 110,020***	***5.99%***
	CONTRACTS / SERVICES	92,491	8,100	8,100	-	0.00%
	TRAVEL	26,003	36,200	23,500	(12,700)	(35.08%)
	SUPPLIES	275,285	221,650	200,733	(20,917)	(9.44%)
	OPERATING	13,201	13,900	11,900	(2,000)	(14.39%)
	OTHER COSTS	313	300	300	-	0.00%
	EQUIPMENT (Non-Capital)	-	3,000	-	(3,000)	(100.00%)
	TOTAL DIRECT EXPENSES	***$ 2,021,537***	***$ 2,121,180***	***$ 2,192,583***	***$ 71,403***	***3.37%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	***1,219,004***	***1,040,000***	***1,040,000***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 3,240,541**	**$ 3,161,180**	**$ 3,232,583**	**$ 71,403**	**2.26%**
	INDIRECT ALLOCATION	***$ 576,003***	***$ 256,664***	***$ 324,107***	***$ 67,443***	***26.28%***
	GENERAL FUND USE	***1,070,870***	***1,116,360***	***1,172,056***	***55,696***	***4.99%***
	TOTAL AGENCY NET	**$ (142,538)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		20.4%	26.8%	27.3%		
% of Total Expenses Funded by **Non-County General Funds**		7.7%	5.9%	5.7%		

Access to Healthcare Program – Health Enrollment Team

The Health Enrollment (HE) Team works to improve access for children and pregnant women enrolled in Health First Colorado, Colorado's Medicaid Program, and Child Health Plan Plus (CHP+). The HE program directly aligns with TCHD's strategic goal to increase interactions with the health care delivery system.

Funding Source(s): Restricted Federal Funds, Restricted State Funds, Required General Funds, Medicaid Reimbursement

Access to Healthcare Program – Regional Health Connectors

The goal of the Regional Health Connectors (RHC) Program is to improve health in communities by connecting the systems that keep communities healthy- including primary care, public health, social services and other community resources. The RHC program supports TCHD's strategic goals by interacting directly with primary care providers and with clinical Quality Improvement teams.

Funding Source(s): Required General Funds

Division: 4	NURSING - HEALTH ENROLLMENT TEAM AND REGIONAL HEALTH CONNECTIONS (440-999,450, 451)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	466	1,500	-	(1,500)	(100.00%)
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	781,214	497,124	-	(497,124)	(100.00%)
	FEDERAL PASS THRU FUNDS	475,803	734,838	637,577	(97,261)	(13.24%)
	OTHER GRANTS / CONTRACTS	-	52,000	52,000	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 1,257,483**	**$ 1,285,462**	**$ 689,577**	**$ (595,885)**	**(46.36%)**
	FTE's	***16.31***	***17.70***	***10.76***	***-6.94***	***(39.21%)***
	Benefits as a Percentage of Wages	*36.72%*	*35.45%*	*34.99%*		
EXPENDITURES:						
	WAGES	$ 940,640	$ 1,081,117	$ 733,484	(347,633)	(32.15%)
	BENEFITS	345,385	383,260	256,635	(126,625)	(33.04%)
	Total Personnel	***$ 1,286,025***	***$ 1,464,377***	***$ 990,119***	***$ (474,258)***	***(32.39%)***
	CONTRACTS / SERVICES	23,256	29,500	17,178	(12,322)	(41.77%)
	TRAVEL	16,049	13,491	12,408	(1,083)	(8.03%)
	SUPPLIES	5,105	7,900	1,739	(6,161)	(77.99%)
	OPERATING	10,605	13,484	15,589	2,105	15.61%
	OTHER COSTS	126	83	-	(83)	(100.00%)
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 1,341,165***	***$ 1,528,835***	***$ 1,037,033***	***$ (491,802)***	***(32.17%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 1,341,165**	**$ 1,528,835**	**$ 1,037,033**	**$ (491,802)**	**(32.17%)**
	INDIRECT ALLOCATION	***$ 165,598***	***$ 152,068***	***$ 149,713***	***$ (2,355)***	***(1.55%)***
	GENERAL FUND USE	***65,006***	***395,441***	***497,169***	***101,728***	***25.73%***
	TOTAL AGENCY NET	**$ (184,273)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		3.1%	19.3%	34.6%		
% of Total Expenses Funded by **Non-County General Funds**		1.2%	4.2%	7.2%		

MCH Child, MCH HCP, MCH Prenatal

The Maternal and Child Health (MCH) Block Grant programs moved to the CHP Division, programs 371-373 in 2020.

Funding Source(s): Restricted State Funds

Division: 4	NURSING - MCH CHILD, MCH HCP, MCH PRENATAL (430, 435, 440-444)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	267,531	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 267,531**	**$ -**	**$ -**	**$ -**	**0.00%**
	FTE's	***1.70***	***0.00***	***0.00***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*35.00%*	*0.00%*	*0.00%*		
EXPENDITURES:						
	WAGES	$ 129,339	$ -	$ -	-	0.00%
	BENEFITS	45,269	-	-	-	0.00%
	Total Personnel	***$ 174,607***	***$ -***	***$ -***	***$ -***	***0.00%***
	CONTRACTS / SERVICES	22,499	-	-	-	0.00%
	TRAVEL	4,488	-	-	-	0.00%
	SUPPLIES	4,528	-	-	-	0.00%
	OPERATING	4,026	-	-	-	0.00%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 210,149***	***$ -***	***$ -***	***$ -***	***0.00%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 210,149**	**$ -**	**$ -**	**$ -**	**0.00%**
	INDIRECT ALLOCATION	***$ 57,382***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Disease Prevention and Clinical Services Program – Sexual Health

The goal of this program is to provide sexual health services and prevent unintended pregnancies. The Sexual Health program sees women and men and targets at-risk populations, including those who are under-served, low-income and adolescents. The program offers reproductive health exams, contraceptive counseling and supplies, cervical cancer screening, pregnancy testing, HIV testing and sexually transmitted infection (STI) testing and treatment. The program also offers pre-conception counseling for clients planning a pregnancy. Annually this program also helps to educate thousands of high school students within our community about sexual health.

Funding Source(s): Restricted Federal Funds, Restricted State Funds, Required General Funds, Medicaid Reimbursement, Patient Fees, Patient Donation

Division: 4 NURSING - SEXUAL HEALTH (477)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	74,265	74,265	74,265	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	208,687	267,185	267,185	-	0.00%
	FEES	221,505	187,000	187,000	-	0.00%
	STATE CONTRACTS	435,916	447,111	380,044	(67,067)	(15.00%)
	FEDERAL PASS THRU FUNDS	697,402	637,762	697,762	60,000	9.41%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	97,954	96,000	96,000	-	0.00%
TOTAL DIVISION REVENUE		**$ 1,735,729**	**$ 1,709,323**	**$ 1,702,256**	**$ (7,067)**	**(0.41%)**
	FTE's	***29.13***	***29.55***	***29.41***	***-0.14***	***(0.47%)***
	Benefits as a Percentage of Wages	*33.09%*	*35.31%*	*32.99%*		
EXPENDITURES:						
	WAGES	$ 1,887,336	$ 1,962,164	$ 2,061,545	99,381	5.06%
	BENEFITS	624,498	692,903	680,050	(12,853)	(1.85%)
	Total Personnel	***$ 2,511,834***	***$ 2,655,067***	***$ 2,741,595***	***$ 86,528***	***3.26%***
	CONTRACTS / SERVICES	124,546	79,500	92,900	13,400	16.86%
	TRAVEL	34,971	27,500	35,900	8,400	30.55%
	SUPPLIES	397,452	530,933	426,043	(104,890)	(19.76%)
	OPERATING	29,220	31,530	31,050	(480)	(1.52%)
	OTHER COSTS	565	200	200	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 3,098,587***	***$ 3,324,730***	***$ 3,327,688***	***$ 2,958***	***0.09%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	***97,954***	***96,000***	***96,000***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 3,196,541**	**$ 3,420,730**	**$ 3,423,688**	**$ 2,958**	**0.09%**
	INDIRECT ALLOCATION	***$ 882,076***	***$ 336,946***	***$ 402,831***	***$ 65,885***	***19.55%***
	GENERAL FUND USE	***1,994,136***	***2,048,353***	***2,124,263***	***75,910***	***3.71%***
	TOTAL AGENCY NET	**$ (348,752)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		35.5%	44.7%	45.9%		
% of Total Expenses Funded by **Non-County General Funds**		13.4%	9.8%	9.6%		

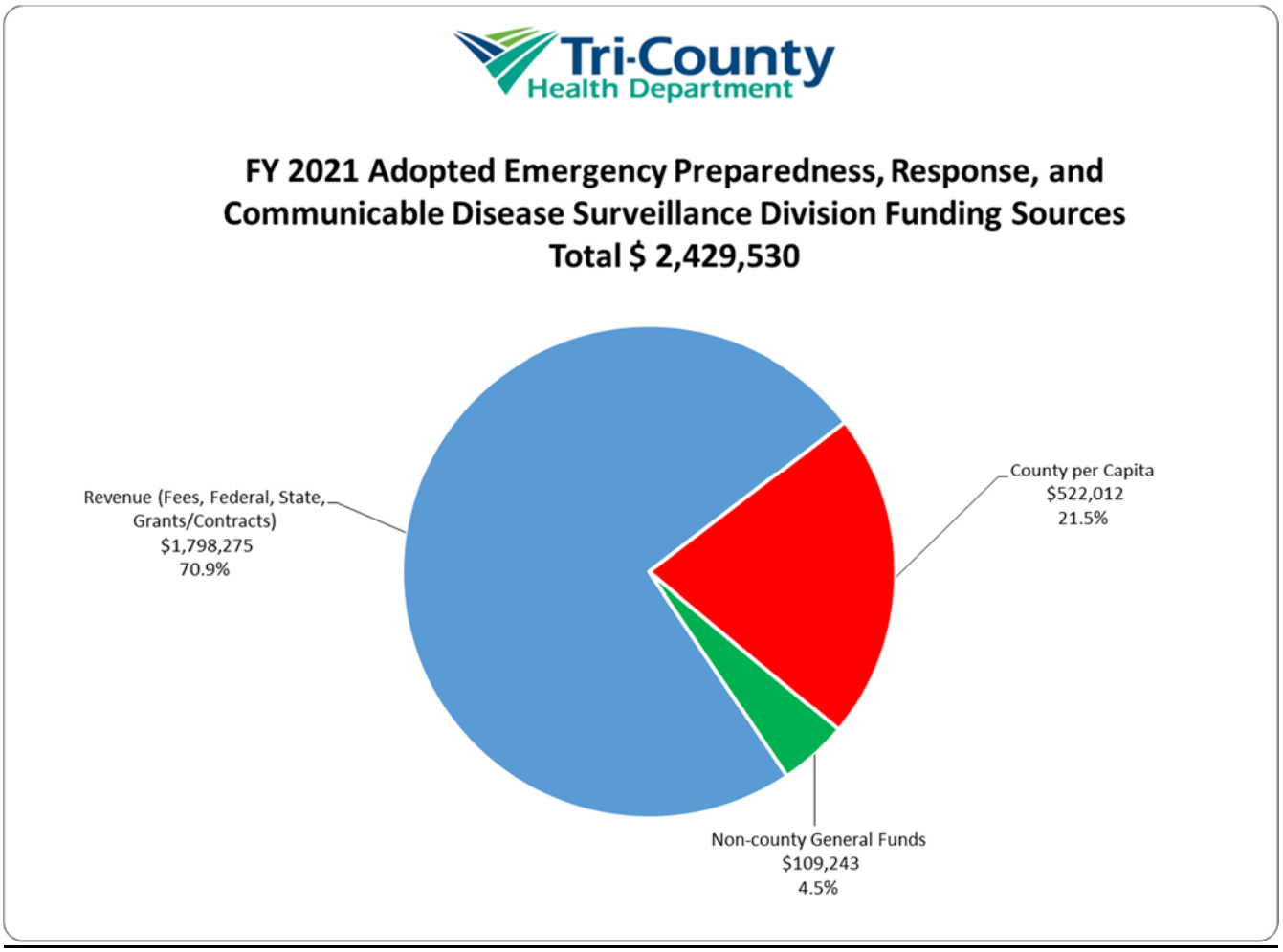
Emergency Preparedness, Response, and Communicable Disease Surveillance Division



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EMERGENCY PREPAREDNESS, RESPONSE, AND COMMUNICABLE DISEASE SURVEILLANCE DIVISION

Division: 5	EMERGENCY PREPARENESS, RESPONSE, and COMMUNICABLE DISEASE SURVEILLANCE	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	8,784,357	-	(8,784,357)	(100.00%)
	FEDERAL FUNDS	-	201,520	201,520	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	1,393,812	7,603,810	$ 1,596,755	(6,007,055)	(79.00%)
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	40,000	-	(40,000)	(100.00%)
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 1,393,812**	**$ 16,629,687**	**$ 1,798,275**	**$ (14,831,412)**	**(89.19%)**
	FTE's	***15.20***	***17.70***	***17.63***	***-0.07***	***(0.40%)***
	Benefits as a Percentage of Wages	*35.83%*	*35.09%*	*34.70%*		
EXPENDITURES:						
	WAGES	$ 1,039,922	$ 7,494,718	$ 1,285,879	(6,208,839)	(82.84%)
	BENEFITS	372,626	2,630,192	446,225	(2,183,967)	(83.03%)
	Total Personnel	***$ 1,412,548***	***$ 10,124,910***	***$ 1,732,104***	***$ (8,392,806)***	***(82.89%)***
	CONTRACTS / SERVICES	36,676	5,143,730	163,329	(4,980,401)	(96.82%)
	TRAVEL	29,695	51,671	17,206	(34,465)	(66.70%)
	SUPPLIES	43,117	348,859	20,266	(328,593)	(94.19%)
	OPERATING	106,056	139,668	111,161	(28,507)	(20.41%)
	OTHER COSTS	2,365	2,376	876	(1,500)	(63.13%)
	EQUIPMENT (Non-Capital)	7,308	12,000	8,647	(3,353)	(27.94%)
	TOTAL DIRECT EXPENSES	***$ 1,637,766***	***$ 15,823,214***	***$ 2,053,589***	***$ (13,769,625)***	***(87.02%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ 32,736***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	***-***	***-***	***-***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 1,670,502**	**$ 15,823,214**	**$ 2,053,589**	**$ (13,769,625)**	**(87.02%)**
	INDIRECT ALLOCATION	***$ 294,010***	***$ 1,395,092***	***$ 375,941***	***$ (1,019,151)***	***(73.05%)***
	GENERAL FUND USE	***556,793***	***588,619***	***631,255***	***42,636***	***7.24%***
	TOTAL AGENCY NET	**$ (13,906)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		20.6%	2.8%	21.5%		
% of Total Expenses Funded by **Non-County General Funds**		7.7%	0.6%	4.5%		


Tri-County
Health Department
FY 2021 Adopted Emergency Preparedness, Response, and Communicable Disease Surveillance Division Funding Sources
Total $ 2,429,530
Revenue (Fees, Federal, State, Grants/Contracts)
$1,798,275
70.9%
County per Capita
$522,012
21.5%
Non-county General Funds
$109,243
4.5%

Public Health Emergency Preparedness (PHEP) Program

This federally funded program from the Centers for Disease Control and Prevention (CDC) promotes local preparedness for natural (i.e., wild fires, floods, disease outbreaks) and human-made (i.e., bioterrorism, radiological) disasters and emergencies through planning, training, and exercises with a wide variety of local partners and TCHD as a whole. These efforts also link to collaborative preparedness efforts between federal, state, and local agencies as well as local emergency management and health and medical partners throughout the North Central Region of Colorado. TCHD works to improve its capacity for early identification of disease outbreaks, rapid delivery of prophylaxis, and communication among first responders, health and medical partners, and public health agencies. This program integrates disease surveillance through the Colorado Electronic Disease Reporting System (CEDRS), 24/7 response capacity, and communication via the Health Alert Network (HAN). Emergency Preparedness and Response assessment includes risk analysis and sharing of expertise, situational awareness and information with both internal and external partners as well as the public before, during and after an incident. Efforts also include the development of plans (including the public health emergency operations plan, continuity of operations, crisis and emergency risk communication, and medical countermeasures and dispensing) and agreements in preparation for incident response. Finally, assurance of emergency preparedness and response is accomplished through training, education, public messaging, exercising, and capacity building events/activities. Each year, TCHD participates in numerous drills and exercises on topics such as medical countermeasures and dispensing, command/coordination/incident management, first responder drills, redundant communication, and other identified areas to improve training, planning and response capacity..

Funding Source(s): Restricted Federal Funds

Division: 5 **EMERGENCY PREPARENESS, RESPONSE, and COMMUNICABLE DISEASE SURVEILLANCE - PUBLIC HEALTH EMERGENCY PREPAREDNESS (PHEP) PROGRAM (520)**

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	8,784,357	-	(8,784,357)	(100.00%)
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	908,878	6,933,896	926,841	(6,007,055)	(86.63%)
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	40,000	-	(40,000)	(100.00%)
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 908,878**	**$ 15,758,253**	**$ 926,841**	**$ (14,831,412)**	**(94.12%)**
	FTE's	***6.14***	***6.29***	***6.12***	***-0.17***	***(2.70%)***
	Benefits as a Percentage of Wages	*36.93%*	*35.02%*	*34.58%*		
EXPENDITURES:						
	WAGES	$ 456,076	$ 6,747,111	$ 480,171	(6,266,940)	(92.88%)
	BENEFITS	168,416	2,362,531	166,067	(2,196,464)	(92.97%)
	Total Personnel	***$ 624,492***	***$ 9,109,642***	***$ 646,238***	***$ (8,463,404)***	***(92.91%)***
	CONTRACTS / SERVICES	12,540	4,999,062	9,000	(4,990,062)	(99.82%)
	TRAVEL	11,981	14,600	5,000	(9,600)	(65.75%)
	SUPPLIES	37,103	331,799	3,500	(328,299)	(98.95%)
	OPERATING	61,295	75,465	59,221	(16,244)	(21.53%)
	OTHER COSTS	1,025	376	376	-	0.00%
	EQUIPMENT (Non-Capital)	7,308	12,000	8,647	(3,353)	(27.94%)
	TOTAL DIRECT EXPENSES	***$ 755,744***	***$ 14,542,944***	***$ 731,982***	***$ (13,810,962)***	***(94.97%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 755,744**	**$ 14,542,944**	**$ 731,982**	**$ (13,810,962)**	**(94.97%)**
	INDIRECT ALLOCATION	***$ 204,962***	***$ 1,215,309***	***$ 194,859***	***$ (1,020,450)***	***(83.97%)***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ (51,827)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

National Syndromic Surveillance Program (NSSP)

The Syndromic Surveillance program is aligned with the Centers for Disease Control and Prevention (CDC) National Syndromic Surveillance Program that tracks health problems as they evolve and provides public health officials with data, information, and tools needed to better prepare for and coordinate responses to safeguard and improve the health of the American people. Mandated in the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, the CDC Syndromic Surveillance program was launched in 2003 to establish an integrated national public health surveillance system for early detection and rapid assessment of potential bioterrorism-related illness. Syndromic Surveillance serves to protect the health of the American people by providing timely insight into the health of communities, regions, and the nation by offering a variety of features to improve data collection, standardization, storage, analysis, and collaboration. The key components of the Syndromic Surveillance program include: building health monitoring infrastructure and workforce capacity where needed at the state, local, tribal, and territorial levels; facilitating the interchange of information that can be used to coordinate responses and monitor health-related outcomes routinely and during an event; expanding the utility of Syndromic Surveillance data to multi-use (and all-hazard) beyond early event detection and to contribute information for public health situational awareness, routine public health practice and improved health outcomes and public health; improving the ability to detect emergency health-related threats by supporting the enhancement of systems to signal alerts for potential problems; increasing local and state jurisdictions participation in Syndromic Surveillance; and advancing science and technology.

Funding Source(s): Restricted Federal Funds, Required General Funds

Division: 5	EMERGENCY PREPARENESS, RESPONSE, and COMMUNICABLE DISEASE SURVEILLANCE - NATIONAL SYNDROMIC SURVEILLANCE PROGRAM (NSSP) (550)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	110,562	175,004	175,004	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 110,562**	**$ 175,004**	**$ 175,004**	**$ -**	**0.00%**
	FTE's	***0.65***	***0.60***	***0.53***	***-0.07***	***(11.67%)***
	Benefits as a Percentage of Wages	*35.00%*	*34.25%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 46,524	$ 43,941	$ 42,077	(1,864)	(4.24%)
	BENEFITS	16,283	15,049	14,727	(322)	(2.14%)
	Total Personnel	***$ 62,807***	***$ 58,990***	***$ 56,804***	***$ (2,186)***	***(3.71%)***
	CONTRACTS / SERVICES	5,977	92,168	97,296	5,128	5.56%
	TRAVEL	930	3,052	930	(2,122)	(69.53%)
	SUPPLIES	24	-	-	-	0.00%
	OPERATING	30,377	576	576	-	0.00%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 100,114***	***$ 154,786***	***$ 155,606***	***$ 820***	***0.53%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	***-***	***-***	***-***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 100,114**	**$ 154,786**	**$ 155,606**	**$ 820**	**0.53%**
	INDIRECT ALLOCATION	***$ 10,891***	***$ 20,218***	***$ 19,398***	***$ (820)***	***(4.06%)***
	GENERAL FUND USE	***-***	***-***	***-***	***-***	***0.00%***
	TOTAL AGENCY NET	**$ (444)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Division: 5 **EMERGENCY PREPARENESS, RESPONSE, and COMMUNICABLE DISEASE SURVEILLANCE - SYNDROMIC SURVEILLANCE SUICIDE PREVENTION (551)**

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	201,520	201,520	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	17,486	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 17,486**	**$ 201,520**	**$ 201,520**	**$ -**	**0.00%**
	FTE's	***0.11***	***1.01***	***1.20***	***0.19***	***18.81%***
	Benefits as a Percentage of Wages	*35.00%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 9,052	$ 70,652	$ 76,068	5,416	7.67%
	BENEFITS	3,168	24,728	26,624	1,896	7.67%
	Total Personnel	***$ 12,220***	***$ 95,380***	***$ 102,692***	***$ 7,312***	***7.67%***
	CONTRACTS / SERVICES	-	34,500	34,134	(366)	(1.06%)
	TRAVEL	1,060	13,341	3,056	(10,285)	(77.09%)
	SUPPLIES	-	2,705	2,700	(5)	(0.18%)
	OPERATING	-	13,503	16,789	3,286	24.34%
	OTHER COSTS	236	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 13,516***	***$ 159,429***	***$ 159,371***	***$ (58)***	***(0.04%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	***-***	***-***	***-***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 13,516**	**$ 159,429**	**$ 159,371**	**$ (58)**	**(0.04%)**
	INDIRECT ALLOCATION	***$ 3,971***	***$ 42,091***	***$ 42,149***	***$ 58***	***0.14%***
	GENERAL FUND USE	***-***	***-***	***-***	***-***	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Division: 5 **EMERGENCY PREPARENESS, RESPONSE, and COMMUNICABLE DISEASE SURVEILLANCE - OVERDOSE DATA TO ACTION (552)**

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	5,178	150,000	150,000	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 5,178**	**$ 150,000**	**$ 150,000**	**$ -**	**0.00%**
	FTE's	***0.05***	***1.07***	***1.05***	***-0.02***	***(1.87%)***
	Benefits as a Percentage of Wages	*35.00%*	*34.99%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 2,729	$ 70,167	$ 68,233	(1,934)	(2.76%)
	BENEFITS	955	24,553	23,882	(671)	(2.73%)
	Total Personnel	***$ 3,684***	***$ 94,720***	***$ 92,115***	***$ (2,605)***	***(2.75%)***
	CONTRACTS / SERVICES	-	5,000	11,899	6,899	137.98%
	TRAVEL	-	5,758	2,550	(3,208)	(55.71%)
	SUPPLIES	-	2,405	2,423	18	0.75%
	OPERATING	189	7,481	7,480	(1)	(0.01%)
	OTHER COSTS	129	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 4,002***	***$ 115,364***	***$ 116,467***	***$ 1,103***	***0.96%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	***-***	***-***	***-***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 4,002**	**$ 115,364**	**$ 116,467**	**$ 1,103**	**0.96%**
	INDIRECT ALLOCATION	***$ 1,176***	***$ 34,636***	***$ 33,533***	***$ (1,103)***	***(3.18%)***
	GENERAL FUND USE	***-***	***-***	***-***	***-***	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Cities Readiness Initiative (CRI) Program

The CDC's Cities Readiness Initiative (CRI) is a federally funded program designed to enhance preparedness in the nation's largest cities and metropolitan statistical areas where more than 50% of the U.S. population resides related to medical countermeasures and dispensing. Using CRI funding, state and large metropolitan public health departments develop, test, and maintain plans to quickly receive and distribute life-saving medicine and medical supplies from the nation's Strategic National Stockpile (SNS) to local communities following a large-scale public health emergency. Initially, the CRI planning scenario was based on a response to a large-scale anthrax attack; however, through continued analysis and lessons learned, it became apparent that CRI jurisdictions must be prepared to respond to other public health emergencies. The Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 emphasized an all-hazards approach to public health preparedness planning, thereby expanding the scope of the CRI planning to include natural and man-made public health threats. The Emergency Preparedness and Response program has developed plans for receipt, storage, and distribution of large quantities of medicine and medical supplies to protect the public in the event of a public health emergency.

Funding Source(s): Restricted Federal Funds

Division: 5 **EMERGENCY PREPARENESS, RESPONSE, and COMMUNICABLE DISEASE SURVEILLANCE - CITIES READINESS INITITATIVE (CRI) (530)**

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	255,517	253,537	253,537	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 255,517**	**$ 253,537**	**$ 253,537**	**$ -**	**0.00%**
	FTE's	***2.18***	***2.10***	***2.10***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*35.00%*	*35.46%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 120,142	$ 118,947	$ 127,500	8,553	7.19%
	BENEFITS	42,050	42,183	44,625	2,442	5.79%
	Total Personnel	***$ 162,192***	***$ 161,130***	***$ 172,125***	***$ 10,995***	***6.82%***
	CONTRACTS / SERVICES	157	3,000	1,000	(2,000)	(66.67%)
	TRAVEL	5,027	5,590	3,090	(2,500)	(44.72%)
	SUPPLIES	1,323	7,650	7,143	(507)	(6.63%)
	OPERATING	3,188	16,073	9,945	(6,128)	(38.13%)
	OTHER COSTS	328	2,000	500	(1,500)	(75.00%)
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 172,215***	***$ 195,443***	***$ 193,803***	***$ (1,640)***	***(0.84%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ 32,736***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 204,951**	**$ 195,443**	**$ 193,803**	**$ (1,640)**	**(0.84%)**
	INDIRECT ALLOCATION	***$ 50,566***	***$ 58,094***	***$ 59,734***	***$ 1,640***	***2.82%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Communicable Disease

The Communicable Disease program work to protect the public by preventing the spread of infectious diseases. Communicable disease epidemiologists conduct ongoing epidemiologic surveillance to identify new and emerging infectious disease trends and outbreaks. They conduct day-to-day investigation of vaccine-preventable diseases such as pertussis and measles, enteric diseases such as E.coli and salmonella, and zoonotic diseases such as rabies and plague. They are trained in rapid response to disease outbreaks, working to identify the causative agent and putting control measures into place to prevent the spread of disease.

Funding Source(s): Restricted Federal Grant Funds, Restricted State Grant Funds, Required General Funds

Division: 5	**EMERGENCY PREPARENESS, RESPONSE, and COMMUNICABLE DISEASE SURVEILLANCE - COMMUNICABLE DISEASE (510)**				**Increase / (Decrease)**	
		FY2019 ACTUAL	**FY2020 REVISED**	**FY2021 ADOPTED**	**$**	**%**
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	96,191	91,373	91,373	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 96,191**	**$ 91,373**	**$ 91,373**	**$ -**	**0.00%**
	FTE's	***4.78***	***5.00***	***5.00***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*35.57%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 296,603	$ 329,732	$ 349,194	19,462	5.90%
	BENEFITS	105,516	115,415	122,219	6,804	5.90%
	Total Personnel	***$ 402,119***	***$ 445,147***	***$ 471,413***	***$ 26,266***	***5.90%***
	CONTRACTS / SERVICES	16,828	10,000	10,000	-	0.00%
	TRAVEL	4,866	6,430	580	(5,850)	(90.98%)
	SUPPLIES	1,610	-	-	-	0.00%
	OPERATING	4,847	5,450	5,450	-	0.00%
	OTHER COSTS	648	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 430,918***	***$ 467,027***	***$ 487,443***	***$ 20,416***	***4.37%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 430,918**	**$ 467,027**	**$ 487,443**	**$ 20,416**	**4.37%**
	INDIRECT ALLOCATION	***$ 22,444***	***$ 24,744***	***$ 26,268***	***$ 1,524***	***6.16%***
	GENERAL FUND USE	***361,631***	***400,398***	***422,338***	***21,940***	***5.48%***
	TOTAL AGENCY NET	**$ 4,460**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		58.0%	66.7%	68.0%		
% of Total Expenses Funded by **Non-County General Funds**		21.8%	14.7%	14.2%		

Administration

The general program provides support for the EPRCDS division and leadership. This program also includes the Safety and Security Program, which is dedicated to developing, coordinating, and consistently applying standard workplace safety and security efforts to improve both the culture of safety and staff capabilities related to safety throughout the TCHD organization to support both staff and the communities served by TCHD.

Funding Source(s): Required General Funds

Division: 5	EMERGENCY PREPARENESS, RESPONSE, and COMMUNICABLE DISEASE SURVEILLANCE - ADMINISTRATION (590)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		$ -	$ -	$ -	$ -	**0.00%**
	FTE's	***1.28***	***1.63***	***1.63***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*33.31%*	*40.06%*	*33.71%*		
EXPENDITURES:						
	WAGES	$ 108,796	$ 114,168	$ 142,636	28,468	24.94%
	BENEFITS	36,237	45,733	48,081	2,348	5.13%
	Total Personnel	***$ 145,033***	***$ 159,901***	***$ 190,717***	***$ 30,816***	***19.27%***
	CONTRACTS / SERVICES	1,175	-	-	-	0.00%
	TRAVEL	5,832	2,900	2,000	(900)	(31.03%)
	SUPPLIES	3,057	4,300	4,500	200	4.65%
	OPERATING	6,161	21,120	11,700	(9,420)	(44.60%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 161,257***	***$ 188,221***	***$ 208,917***	***$ 20,696***	***11.00%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		$ 161,257	$ 188,221	$ 208,917	$ 20,696	**11.00%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***195,162***	***188,221***	***208,917***	***20,696***	***11.00%***
	TOTAL AGENCY NET	**$ 33,905**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		88.0%	82.0%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		33.1%	18.0%	17.3%		

Environmental Health Division

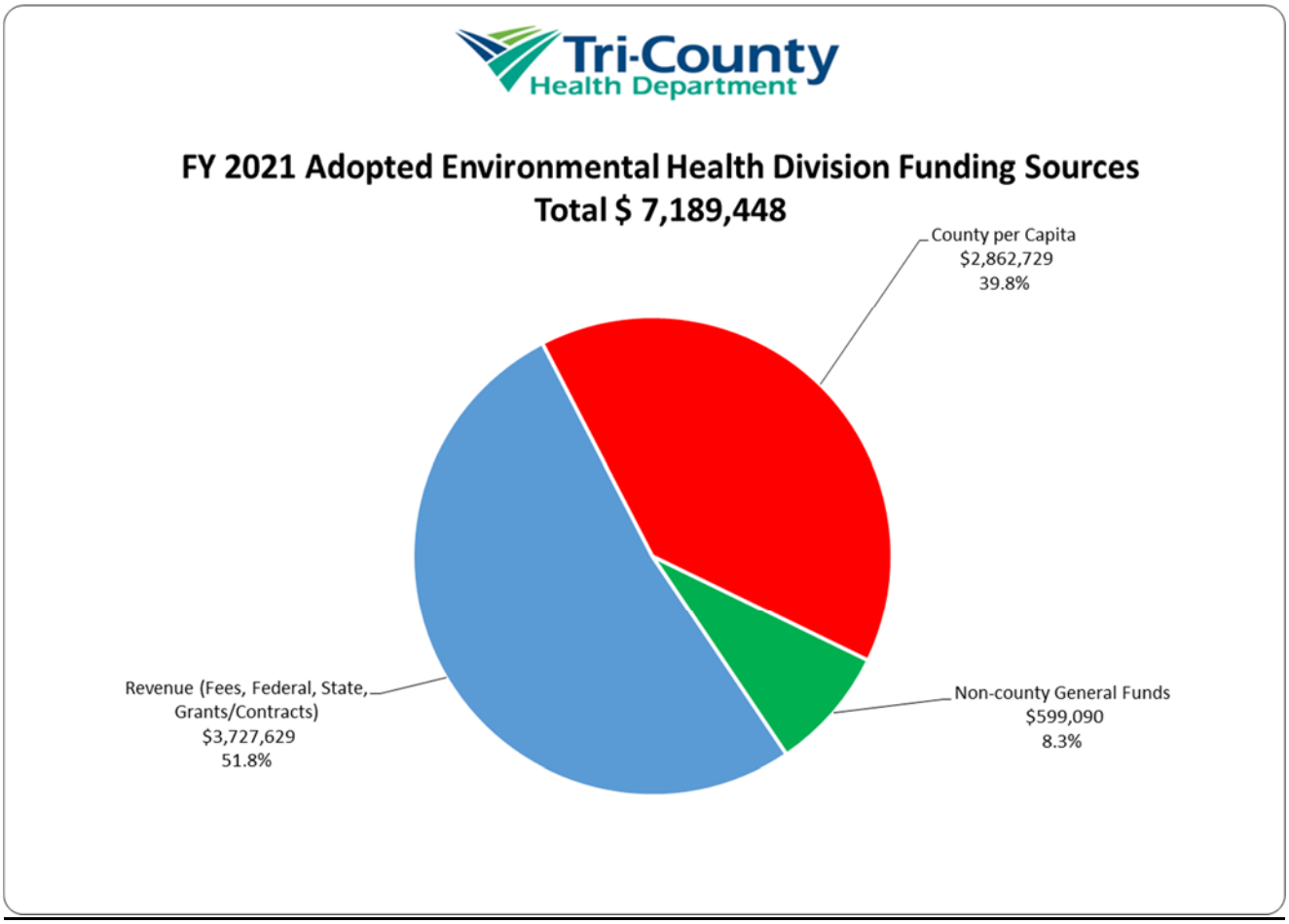


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ENVIRONMENTAL HEALTH DIVISION

Division: 6 ENVIRONMENTAL HEALTH

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	17,957	133,000	130,000	(3,000)	(2.26%)
	FEDERAL FUNDS	92,362	135,000	206,161	71,161	52.71%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	3,005,064	2,834,100	2,831,789	(2,311)	(0.08%)
	STATE CONTRACTS	16,217	259,597	259,305	(292)	(0.11%)
	FEDERAL PASS THRU FUNDS	29,961	50,937	31,937	(19,000)	(37.30%)
	OTHER GRANTS / CONTRACTS	270,430	277,160	268,437	(8,723)	(3.15%)
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 3,431,991**	**$ 3,689,794**	**$ 3,727,629**	**$ 37,835**	**1.03%**
	FTE's	***66.49***	***68.68***	***70.45***	***1.77***	***2.58%***
	Benefits as a Percentage of Wages	*34.75%*	*36.37%*	*34.54%*		
EXPENDITURES:						
	WAGES	$ 4,066,063	$ 4,141,981	$ 4,718,370	576,389	13.92%
	BENEFITS	1,412,799	1,506,550	1,629,538	122,988	8.16%
	Total Personnel	***$ 5,478,862***	***$ 5,648,531***	***$ 6,347,908***	***$ 699,377***	***12.38%***
	CONTRACTS / SERVICES	325,372	373,331	245,500	(127,831)	(34.24%)
	TRAVEL	148,508	140,319	106,925	(33,394)	(23.80%)
	SUPPLIES	51,927	76,507	46,435	(30,072)	(39.31%)
	OPERATING	178,075	243,124	156,934	(86,190)	(35.45%)
	OTHER COSTS	16,535	18,460	16,210	(2,250)	(12.19%)
	EQUIPMENT (Non-Capital)	-	14,232	(5,508)	(19,740)	(138.70%)
	TOTAL DIRECT EXPENSES	***$ 6,199,280***	***$ 6,514,504***	***$ 6,914,404***	***$ 399,900***	***6.14%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 6,199,280**	**$ 6,514,504**	**$ 6,914,404**	**$ 399,900**	**6.14%**
	INDIRECT ALLOCATION	***$ 108,530***	***$ 209,024***	***$ 275,044***	***$ 66,020***	***31.58%***
	GENERAL FUND USE	***2,711,607***	***3,033,734***	***3,461,819***	***428,085***	***14.11%***
	TOTAL AGENCY NET	**$ (164,212)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		31.2%	37.0%	39.8%		
% of Total Expenses Funded by **Non-County General Funds**		11.7%	8.1%	8.3%		


Tri-County
Health Department
FY 2021 Adopted Environmental Health Division Funding Sources
Total $ 7,189,448
County per Capita
$2,862,729
39.8%
Revenue (Fees, Federal, State, Grants/Contracts)
$3,727,629
51.8%
Non-county General Funds
$599,090
8.3%

Division Administration and Informatics

Budgeted activities include the core leadership team, which is responsible for planning, implementation, management, and evaluation of all environmental health activities and programs. This division's support program is also responsible for financial oversight, data collection and management, grant and contract management, Environmental Health Informatics activities, and some support staff services. Expenditures such as capital equipment, staff training, support staff services, and some local travel may be budgeted under this program to capture expected costs; however, during the course of the year, expenses are applied to the programs that actually incur the costs.
Funding Source(s): Required General Funds

Division: 6 ENVIRONMENTAL HEALTH - ADMINISTRATION (690, 695)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	175	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	4,108	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 4,283**	**$ -**	**$ -**	**$ -**	**0.00%**
	FTE's	***9.21***	***11.40***	***12.24***	***0.84***	***7.37%***
	Benefits as a Percentage of Wages	*34.52%*	*47.78%*	*34.66%*		
EXPENDITURES:						
	WAGES	$ 661,777	$ 597,155	$ 921,660	324,505	54.34%
	BENEFITS	228,450	285,345	319,477	34,132	11.96%
	Total Personnel	***$ 890,228***	***$ 882,500***	***$ 1,241,137***	***$ 358,637***	***40.64%***
	CONTRACTS / SERVICES	16,789	46,000	2,000	(44,000)	(95.65%)
	TRAVEL	17,392	16,320	-	(16,320)	(100.00%)
	SUPPLIES	24,538	28,798	25,393	(3,405)	(11.82%)
	OPERATING	100,339	141,047	88,041	(53,006)	(37.58%)
	OTHER COSTS	15,179	17,250	15,000	(2,250)	(13.04%)
	EQUIPMENT (Non-Capital)	-	5,000	-	(5,000)	(100.00%)
	TOTAL DIRECT EXPENSES	***$ 1,064,464***	***$ 1,136,915***	***$ 1,371,571***	***$ 234,656***	***20.64%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 1,064,464**	**$ 1,136,915**	**$ 1,371,571**	**$ 234,656**	**20.64%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***1,238,279***	***1,136,915***	***1,371,571***	***234,656***	***20.64%***
	TOTAL AGENCY NET	**$ 178,098**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		84.5%	82.0%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		31.8%	18.0%	17.3%		

Child Care Program

The goal of the Child Care program is to prevent the spread of infectious disease in childcare facilities and other public residential settings. Local health departments work with the Colorado Department of Human Services (CDHS) as well as the Colorado Department of Public Health and Environment (CDPHE) to assess and provide assistance to child care operators and staff as mandated by C.R.S. §25-1.5-101(1)h. The following services are conducted for CDHS licensed facilities: annual or biennial on-site inspections; investigation of complaints; review and approval of plans for newly constructed or remodeled childcare facilities; and education.

Funding Source(s): Fees, Required General Funds

Division: 6	ENVIRONMENTAL HEALTH - CHILD CARE (640)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	153,155	140,000	140,000	-	0.00%
	STATE CONTRACTS	-	11,250	11,250	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 153,155**	**$ 151,250**	**$ 151,250**	**$ -**	**0.00%**
	FTE's	***2.34***	***3.00***	***3.00***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*35.00%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 131,401	$ 187,266	$ 191,241	3,975	2.12%
	BENEFITS	45,991	65,545	66,936	1,391	2.12%
	Total Personnel	***$ 177,392***	***$ 252,811***	***$ 258,177***	***$ 5,366***	***2.12%***
	CONTRACTS / SERVICES	68	-	-	-	0.00%
	TRAVEL	7,297	7,300	7,300	-	0.00%
	SUPPLIES	1,232	2,300	600	(1,700)	(73.91%)
	OPERATING	1,242	1,050	1,000	(50)	(4.76%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 187,231***	***$ 263,461***	***$ 267,077***	***$ 3,616***	***1.37%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 187,231**	**$ 263,461**	**$ 267,077**	**$ 3,616**	**1.37%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***60,446***	***112,211***	***115,827***	***3,616***	***3.22%***
	TOTAL AGENCY NET	**$ 26,370**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		23.5%	34.9%	35.9%		
% of Total Expenses Funded by **Non-County General Funds**		8.8%	7.7%	7.5%		

Food Protection Program

The goal of the Food Protection program is to prevent the occurrence of foodborne illness from food prepared in licensed retail food establishments. This program is required by the Food Protection Act (C.R.S. §25-4-1601) and authority is granted to local health departments to administer the program and collect license fees. The following services are conducted for licensed facilities: risk-based inspections; investigation of complaints; review and approval of plans for new or remodeled facilities; opening inspections and approval of licenses; food safety education for restaurant operators; enforcement actions against facilities that continue to fail to meet safe food handling requirements; and assessment of damage to retail food establishments due to disasters, such as fire or flood, to ensure the maintenance of a safe food supply. All food service inspectors go through a formal "standardization" process every three years to ensure a uniform inspection approach. Continuing education is required to ensure a trained and competent workforce. This program is working to improve food safety through collaboration with state and local partners in food program data standardization efforts in support of Goal 8 of the TCHD Strategic Plan.

Funding Source(s): Fees (set in statute), Required General Funds

Division: 6 ENVIRONMENTAL HEALTH - FOOD PROTECTION PROGRAM (630)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	1,959,266	1,972,500	1,967,000	(5,500)	(0.28%)
	STATE CONTRACTS	-	33,750	33,750	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 1,959,266**	**$ 2,006,250**	**$ 2,000,750**	**$ (5,500)**	**(0.27%)**
	FTE's	***34.52***	***32.95***	***33.25***	***0.30***	***0.91%***
	Benefits as a Percentage of Wages	*35.52%*	*34.95%*	*34.94%*		
EXPENDITURES:						
	WAGES	$ 1,942,705	$ 1,872,995	$ 2,049,828	176,833	9.44%
	BENEFITS	690,070	654,621	716,183	61,562	9.40%
	Total Personnel	***$ 2,632,775***	***$ 2,527,616***	***$ 2,766,011***	***$ 238,395***	***9.43%***
	CONTRACTS / SERVICES	21,936	31,000	15,500	(15,500)	(50.00%)
	TRAVEL	64,007	56,446	55,546	(900)	(1.59%)
	SUPPLIES	8,638	3,500	3,500	-	0.00%
	OPERATING	22,318	26,052	21,554	(4,498)	(17.27%)
	OTHER COSTS	507	1,100	1,100	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 2,750,182***	***$ 2,645,714***	***$ 2,863,211***	***$ 217,497***	***8.22%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 2,750,182**	**$ 2,645,714**	**$ 2,863,211**	**$ 217,497**	**8.22%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***643,074***	***639,464***	***862,461***	***222,997***	***34.87%***
	TOTAL AGENCY NET	**$ (147,842)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		17.0%	19.8%	24.9%		
% of Total Expenses Funded by **Non-County General Funds**		6.4%	4.4%	5.2%		

General Environmental Health Services

The General Environmental Health Services category includes crosscutting Disease Prevention program activities and a combination of various division programs due to their relatively small budgets. Programs included are: Animal Control; Body Art; Air Pollution; and Marijuana Infused Product Manufacturer. The following services are conducted: education on the risk of contracting rabies from domestic and wildlife animals; investigation of disease outbreaks and food-borne illness complaints; annual inspections of marijuana infused product manufacturer; annual inspection of body art facilities; and work on regional air quality issues, including climate change. Additionally, TCHD's Institutions and Public Accommodations Program includes activities concerning mobile home parks, private housing, penal institutions, and public accommodations. These program components are addressed on a complaint basis only.

Funding Source(s): Fees, Contracts (restricted funds), Required General Funds

Division: 6	ENVIRONMENTAL HEALTH - GENERAL (610, 617, 620, 643, 692)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	103,000	-	(103,000)	(100.00%)
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	29,590	23,000	33,125	10,125	44.02%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	19,613	44,337	25,337	(19,000)	(42.85%)
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 49,203**	**$ 170,337**	**$ 58,462**	**$ (111,875)**	**(65.68%)**
	FTE's	***1.49***	***1.83***	***1.30***	***-0.53***	***(28.96%)***
	Benefits as a Percentage of Wages	*34.92%*	*35.02%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 93,444	$ 194,430	$ 93,889	(100,541)	(51.71%)
	BENEFITS	32,634	68,083	32,861	(35,222)	(51.73%)
	Total Personnel	***$ 126,078***	***$ 262,513***	***$ 126,750***	***$ (135,763)***	***(51.72%)***
	CONTRACTS / SERVICES	9,003	1,000	3,000	2,000	200.00%
	TRAVEL	3,753	5,783	3,824	(1,959)	(33.88%)
	SUPPLIES	513	19,002	50	(18,952)	(99.74%)
	OPERATING	8,828	6,886	3,000	(3,886)	(56.43%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	7,832	-	(7,832)	(100.00%)
	TOTAL DIRECT EXPENSES	***$ 148,175***	***$ 303,016***	***$ 136,624***	***$ (166,392)***	***(54.91%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 148,175**	**$ 303,016**	**$ 136,624**	**$ (166,392)**	**(54.91%)**
	INDIRECT ALLOCATION	***$ 5,013***	***$ 5,986***	***$ 99***	***$ (5,887)***	***(98.35%)***
	GENERAL FUND USE	***112,855***	***138,665***	***78,261***	***(60,404)***	***(43.56%)***
	TOTAL AGENCY NET	**$ 8,871**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		53.5%	36.8%	47.3%		
% of Total Expenses Funded by **Non-County General Funds**		20.1%	8.1%	9.9%		

Industrial Hygiene Program

The goal of the Industrial Hygiene program is to reduce indoor air pollution effects/events, workplace health and safety hazards, and workplace injuries and illnesses. Hazards in the workplace have been well documented, which led to the creation of the federal Occupational Safety and Health Act (OSHA) in 1970. According to the Environmental Protection Agency (EPA), indoor air pollution is one of the top five health hazards facing the general population.

Major sources of indoor air pollution include combustion sources (i.e., wood and tobacco products), lead, asbestos, outdoor sources (e.g., radon), mold, and various chemicals. The following services are conducted: investigation of complaints or inquiries; assistance in eliminating workplace health and safety hazards; follow up investigation for homes with children and high lead levels; and radon education and testing.

Funding Source(s): Fees, Grants, Required General Funds, Restricted Grant Funds

Division: 6	ENVIRONMENTAL HEALTH - INDUSTRIAL HYGENE (622, 627)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	9,142	5,600	5,600	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	6,240	6,600	6,600	-	0.00%
	OTHER GRANTS / CONTRACTS	6,530	5,000	5,000	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 21,912**	**$ 17,200**	**$ 17,200**	**$ -**	**0.00%**
	FTE's	***1.16***	***1.00***	***0.85***	***-0.15***	***(15.00%)***
	Benefits as a Percentage of Wages	*34.99%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 62,994	$ 56,269	$ 54,425	(1,844)	(3.28%)
	BENEFITS	22,044	19,696	19,048	(648)	(3.29%)
	Total Personnel	***$ 85,037***	***$ 75,965***	***$ 73,473***	***$ (2,492)***	***(3.28%)***
	CONTRACTS / SERVICES	10,460	-	4,000	4,000	0.00%
	TRAVEL	3,829	4,673	3,599	(1,074)	(22.98%)
	SUPPLIES	2,360	2,680	2,030	(650)	(24.25%)
	OPERATING	10,300	7,775	3,275	(4,500)	(57.88%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	1,400	-	(1,400)	(100.00%)
	TOTAL DIRECT EXPENSES	***$ 111,986***	***$ 92,493***	***$ 86,377***	***$ (6,116)***	***(6.61%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 111,986**	**$ 92,493**	**$ 86,377**	**$ (6,116)**	**(6.61%)**
	INDIRECT ALLOCATION	***$ 2,390***	***$ 3,835***	***$ 1,984***	***$ (1,851)***	***(48.27%)***
	GENERAL FUND USE	***77,323***	***79,128***	***71,161***	***(7,967)***	***(10.07%)***
	TOTAL AGENCY NET	**$ (15,141)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		49.1%	67.3%	66.6%		
% of Total Expenses Funded by **Non-County General Funds**		18.5%	14.8%	13.9%		

Land Use Program

The goal of the Land Use program is to incorporate sound environmental health principles in planning and development activities to create healthy living environments. Since chronic diseases and obesity are associated with inactivity (i.e., heart disease, stroke, and diabetes) and now rank among the nation's greatest public health risks, we promote "healthy eating, active living" policies and community designs. Land Use reviews address both regulatory requirements and recommendations. The following services are conducted: provide health-related comments on development applications; provide recommendations for incorporating environmental health policies into master planning efforts, codes and regulations; participate in key state programs and regional planning activities; collaborate with other entities; and provide education.

Funding Source(s): Fees, Grants, Required General Funds

Division: 6	ENVIRONMENTAL HEALTH - LAND USE (650)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	100,000	100,000	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	30,170	55,000	55,000	-	0.00%
	STATE CONTRACTS	-	191,160	191,160	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	202,990	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 233,160**	**$ 246,160**	**$ 346,160**	**$ 100,000**	**40.62%**
	FTE's	***4.37***	***4.60***	***6.10***	***1.50***	***32.61%***
	Benefits as a Percentage of Wages	*33.82%*	*34.97%*	*34.98%*		
EXPENDITURES:						
	WAGES	$ 311,288	$ 310,540	$ 436,961	126,421	40.71%
	BENEFITS	105,292	108,609	152,853	44,244	40.74%
	Total Personnel	***$ 416,580***	***$ 419,149***	***$ 589,814***	***$ 170,665***	***40.72%***
	CONTRACTS / SERVICES	37,059	50,000	50,000	-	0.00%
	TRAVEL	11,384	9,360	3,160	(6,200)	(66.24%)
	SUPPLIES	4,960	810	810	-	0.00%
	OPERATING	9,766	12,936	10,565	(2,371)	(18.33%)
	OTHER COSTS	270	25	25	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 480,019***	***$ 492,280***	***$ 654,374***	***$ 162,094***	***32.93%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 480,019**	**$ 492,280**	**$ 654,374**	**$ 162,094**	**32.93%**
	INDIRECT ALLOCATION	***$ 52,450***	***$ 138,903***	***$ 191,933***	***$ 53,030***	***38.18%***
	GENERAL FUND USE	***199,058***	***385,023***	***500,147***	***115,124***	***29.90%***
	TOTAL AGENCY NET	**$ (100,252)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		27.2%	50.0%	48.9%		
% of Total Expenses Funded by **Non-County General Funds**		10.2%	11.0%	10.2%		

Rocky Mountain Arsenal (RMA) Program

The goal of the RMA program is to protect the community from short and long-term environmental risks associated with the RMA's previous waste disposal activities and during ongoing operations and maintenance of the site. Off-post groundwater quality is monitored to verify there is no risk to the public through consumption of private well water and to verify that RMA cleanup efforts continue to be effective. On-post remediation oversight is provided consistent with the provisions of the Certificate of Designation issued by Adams County on September 29, 1997, and specific agreements TCHD has with Adams County and with the Department of the Army. The following services are conducted: sample and analyze water from selected private wells in the RMA off-post study area for contaminants; oversight of completed on-site waste disposal areas, caps and covers; act as liaison with affected communities in Adams County concerning RMA related issues and the responsible parties (U.S. Army and Shell Oil Co.); and provide oversight of RMA remediation and monitoring activities.
Funding Source(s): Contract (restricted funds)

Division: 6	ENVIRONMENTAL HEALTH - ROCKY MOUNTAIN ARSENAL (683)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	92,362	135,000	206,161	71,161	52.71%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 92,362**	**$ 135,000**	**$ 206,161**	**$ 71,161**	**52.71%**
	FTE's	***0.55***	***0.90***	***1.25***	***0.35***	***38.89%***
	Benefits as a Percentage of Wages	*15.47%*	*16.93%*	*29.91%*		
EXPENDITURES:						
	WAGES	$ 45,917	$ 73,547	$ 104,192	30,645	41.67%
	BENEFITS	7,103	12,454	31,163	18,709	150.22%
	Total Personnel	***$ 53,019***	***$ 86,001***	***$ 135,355***	***$ 49,354***	***57.39%***
	CONTRACTS / SERVICES	-	-	-	-	0.00%
	TRAVEL	960	1,872	1,872	-	0.00%
	SUPPLIES	2,336	3,805	8,336	4,531	119.08%
	OPERATING	6,665	11,872	11,896	24	0.20%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 62,980***	***$ 103,550***	***$ 157,459***	***$ 53,909***	***52.06%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 62,980**	**$ 103,550**	**$ 157,459**	**$ 53,909**	**52.06%**
	INDIRECT ALLOCATION	***$ 18,504***	***$ 31,450***	***$ 48,702***	***$ 17,252***	***54.86%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ 10,878**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Solid and Hazardous Waste Program

The goal of this program is to control the impacts of solid and hazardous wastes on human health and the environment. Local health departments are authorized by Colorado law to assist in compliance activities for solid waste sites. TCHD performs oversight of solid waste disposal sites to ensure that these facilities are properly constructed and operated to protect public health and the environment. The following services are conducted: investigate solid and hazardous waste complaints; monitor construction activities at hazardous waste disposal sites; monitor construction and operational activities at non-hazardous waste disposal sites; participate on the technical advisory committees for designated Superfund sites; serve as a community liaison to responsible parties and regulatory agencies for hazardous waste sites; respond to spills and emergencies involving hazardous materials to support local fire and law enforcement agencies 24/7; provide household chemical waste collection and education programs; inspection of waste tire generators; and perform methamphetamine lab cleanup oversight.

Funding Source(s): Fees, Contracts (restricted funds), Donations, Required General Funds

Division: 6	ENVIRONMENTAL HEALTH - SOLID & HAZARDOUS WASTE (668, 669, 677, 678, 679, 680, 686, 687)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	228,558	77,000	65,064	(11,936)	(15.50%)
	STATE CONTRACTS	9,617	16,237	15,945	(292)	(1.80%)
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	60,910	272,160	263,437	(8,723)	(3.21%)
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 299,085**	**$ 365,397**	**$ 344,446**	**$ (20,951)**	**(5.73%)**
	FTE's	***3.60***	***2.95***	***3.02***	***0.07***	***2.37%***
	Benefits as a Percentage of Wages	*33.68%*	*37.27%*	*34.13%*		
EXPENDITURES:						
	WAGES	$ 251,101	$ 195,559	$ 229,363	33,804	17.29%
	BENEFITS	84,564	72,881	78,282	5,401	7.41%
	Total Personnel	***$ 335,665***	***$ 268,440***	***$ 307,645***	***$ 39,205***	***14.60%***
	CONTRACTS / SERVICES	219,907	217,000	163,000	(54,000)	(24.88%)
	TRAVEL	7,882	10,199	7,776	(2,423)	(23.76%)
	SUPPLIES	3,064	6,262	2,516	(3,746)	(59.82%)
	OPERATING	9,344	18,686	9,053	(9,633)	(51.55%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	(5,508)	(5,508)	0.00%
	TOTAL DIRECT EXPENSES	***$ 575,862***	***$ 520,587***	***$ 484,482***	***$ (36,105)***	***(6.94%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 575,862**	**$ 520,587**	**$ 484,482**	**$ (36,105)**	**(6.94%)**
	INDIRECT ALLOCATION	***$ 28,607***	***$ 26,044***	***$ 30,492***	***$ 4,448***	***17.08%***
	GENERAL FUND USE	***125,622***	***181,234***	***170,528***	***(10,706)***	***(5.91%)***
	TOTAL AGENCY NET	**$ (179,761)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		15.1%	27.2%	27.4%		
% of Total Expenses Funded by **Non-County General Funds**		5.7%	6.0%	5.7%		

Vector Surveillance Program

The goal of the Vector Surveillance program is to reduce exposure and transmission of vector-borne diseases to the public. Vectorborne diseases have been recognized as potentially having fatal consequences. Diseases such as Arboviral Encephalitis (e.g., West Nile virus), plague, Hantavirus, and Colorado tick fever are endemic in the TCHD area. Because outbreaks of vector-borne diseases are not predictable, ongoing surveillance of mosquito breeding sites is conducted. Monitoring for the presence of Western Equine Encephalitis, St. Louis Encephalitis, and West Nile virus (WNV) is accomplished through horse, mosquito, and human surveillance and mosquito testing. Prairie dog mapping and die-off investigations are conducted to determine local black-tail prairie dog colony locations and the presence of plague. The following services are conducted: surveillance for arboviruses in the environment; participation in the Regional Encephalitis Monitoring program; routine mosquito light trapping and mosquito identification; collection and transport of animal specimens to the CDPHE laboratory for testing; education to the public; prairie dog colony complaint die-off investigation; hantavirus environmental investigations; and flea collection and submission to the Centers for Disease Control and Prevention (CDC).

Funding Source(s): Required General Funds

Division: 6 ENVIRONMENTAL HEALTH - VECTOR SURVEILLANCE PROGRAMS (613, 614)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	FTE's	***1.15***	***0.75***	***0.65***	***-0.10***	***(13.33%)***
	Benefits as a Percentage of Wages	*32.09%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 74,017	$ 53,608	$ 46,752	(6,856)	(12.79%)
	BENEFITS	23,751	18,764	16,364	(2,400)	(12.79%)
	Total Personnel	***$ 97,768***	***$ 72,372***	***$ 63,116***	***$ (9,256)***	***(12.79%)***
	CONTRACTS / SERVICES	-	-	-	-	0.00%
	TRAVEL	4,720	3,731	699	(3,032)	(81.27%)
	SUPPLIES	2,307	1,200	1,200	-	0.00%
	OPERATING	1,073	770	600	(170)	(22.08%)
	OTHER COSTS	-	85	85	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 105,868***	***$ 78,158***	***$ 65,700***	***$ (12,458)***	***(15.94%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 105,868**	**$ 78,158**	**$ 65,700**	**$ (12,458)**	**(15.94%)**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***62,383***	***78,158***	***65,700***	***(12,458)***	***(15.94%)***
	TOTAL AGENCY NET	**$ (43,485)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		42.8%	82.0%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		16.1%	18.0%	17.3%		

Water Program

The Water Program includes water quality, onsite wastewater treatment systems (OWTS), and recreational water (pools, spray pads, spas, and beaches). The goal of this program is to prevent disease transmission introduced into ground, surface, or recreational waters. The Water program addresses all aspects of water supplies including, but not limited to, drinking water, private well water, reclaimed water, gray water, and storm water.

The following services are conducted:

- Responding to citizen complaints or concerns
- Providing guidance/support to contamination incidents
- Participating in key watershed and stakeholder meetings
- Inspection of bio-solids land application sites.

The OWTS program assures that wastewater from homes and businesses not served by a public sewer is adequately treated to prevent contamination of surface and groundwater. The following services are conducted:

- Permit and inspect all new and repair OWTS
- Issue use permits after inspections are completed on existing systems by qualified wastewater professionals
- Investigate malfunctioning systems
- Consult with planning departments, homeowners, engineers, and installers
- Train and license OWTS contractors and cleaners

Recreational water features at aquatic venues and swim beaches have long been recognized as an efficient medium for the transmission of communicable diseases and are also subject to a variety of accidents/injuries. The following services are conducted:

- Bi-annual inspections of all public and semi-public swimming pools, spray pads, and spas
- Complaint investigations
- Plan reviews and opening inspections of newly constructed or remodeled pools, spray pads and spas

Funding Source(s): Fees, Contracts, Required General Funds (s): Restricted Grant Funds

Division: 6	ENVIRONMENTAL HEALTH - WATER PROGRAM (645, 653, 656, 657, 658)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	17,957	30,000	30,000	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	595,008	561,000	566,000	5,000	0.89%
	STATE CONTRACTS	6,600	7,200	7,200	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 619,565**	**$ 598,200**	**$ 603,200**	**$ 5,000**	**0.84%**
	FTE's	***8.09***	***9.30***	***8.79***	***-0.51***	***(5.48%)***
	Benefits as a Percentage of Wages	*35.18%*	*33.39%*	*33.28%*		
EXPENDITURES:						
	WAGES	$ 491,421	$ 600,612	$ 590,059	(10,553)	(1.76%)
	BENEFITS	172,899	200,552	196,371	(4,181)	(2.08%)
	Total Personnel	***$ 664,320***	***$ 801,164***	***$ 786,430***	***$ (14,734)***	***(1.84%)***
	CONTRACTS / SERVICES	10,152	28,331	8,000	(20,331)	(71.76%)
	TRAVEL	27,285	24,635	23,149	(1,486)	(6.03%)
	SUPPLIES	1,978	8,150	2,000	(6,150)	(75.46%)
	OPERATING	8,200	16,050	7,950	(8,100)	(50.47%)
	OTHER COSTS	579	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 712,512***	***$ 878,330***	***$ 827,529***	***$ (50,801)***	***(5.78%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 712,512**	**$ 878,330**	**$ 827,529**	**$ (50,801)**	**(5.78%)**
	INDIRECT ALLOCATION	***$ 1,567***	***$ 2,806***	***$ 1,834***	***$ (972)***	***(34.64%)***
	GENERAL FUND USE	***192,567***	***282,936***	***226,163***	***(56,773)***	***(20.07%)***
	TOTAL AGENCY NET	**$ 98,053**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		19.6%	26.3%	22.6%		
% of Total Expenses Funded by **Non-County General Funds**		7.4%	5.8%	4.7%		

Human Resources Division



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HUMAN RESOURCES DIVISION

Human Resources

Human Resources manages a variety of employee-centered programs with a commitment to refine services and processes to meet the ever-changing employee and Agency needs. Services provided by Human Resources include recruitment, on-boarding and orientation, benefits and retirement, compensation, compliance (Policy/Procedure/FMLA/ADA/Leaves of Absence), employee relations, employee performance management, employee recognition programs, worker's compensation.

Human Resources' staff take pride in providing a confidential, honest and objective approach in functions. The team strives to be proactive, responsive and a knowledgeable sounding board, providing a strong array of HR practices to TCHD employees.
Funding Source(s): General Funds

Division: 7	HUMAN RESOURCES	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		$ -	$ -	$ -	$ -	0.00%
	FTE's	*5.18*	*5.50*	*5.50*	*0.00*	*0.00%*
	Benefits as a Percentage of Wages	*-226.77%*	*-275.78%*	*324.11%*		
EXPENDITURES:						
	WAGES	$ 380,378	$ 395,838	$ (221,289)	(617,127)	(155.90%)
	BENEFITS	(862,582)	(1,091,625)	(717,225)	374,400	(34.30%)
	Total Personnel	*$ (482,204)*	*$ (695,787)*	*$ (938,514)*	*$ (242,727)*	*34.89%*
	CONTRACTS / SERVICES	82,760	79,500	75,500	(4,000)	(5.03%)
	TRAVEL	2,416	4,354	4,354	-	0.00%
	SUPPLIES	8,575	11,538	7,782	(3,756)	(32.55%)
	OPERATING	144,171	145,846	140,274	(5,572)	(3.82%)
	OTHER COSTS	693	10,650	4,373	(6,277)	(58.94%)
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	*$ (243,589)*	*$ (443,899)*	*$ (706,231)*	*$ (262,332)*	*59.10%*
	CAPITAL & LEASEHOLD IMPROVEMENTS	*$ -*	*$ -*	*$ -*	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		$ (243,589)	$ (443,899)	$ (706,231)	$ (262,332)	59.10%
	INDIRECT ALLOCATION	*$ -*	*$ -*	*$ -*	*$ -*	*0.00%*
	GENERAL FUND USE	*443,382*	*(443,899)*	*(706,231)*	*(262,332)*	*59.10%*
	TOTAL AGENCY NET	**$ 686,971**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		-132.3%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		-49.7%	0.0%	0.0%		

Employee Wellness

Employee Wellness initiatives have long been associated with improving health and morale of employees, increasing productivity, decreasing absenteeism, and helping to control employer healthcare costs. TCHD's employee program focuses on supporting employees to improve eating habits, adopt a more active lifestyle and maintain mental wellness. It is well documented that modifying behaviors in these areas can help lower one's risk for developing chronic conditions, including diabetes and heart disease. Family-friendly policies are also a focus of TCHD's internal program. These include flexible work schedules, infant-at-work, lactation-support, and healthy meeting policies.

Funding Sources: General Funds

Division: 7 HUMAN RESOURCES - EMPLOYEE WELLNESS (710)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	FTE's	***0.99***	***1.00***	***1.00***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*35.00%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 68,449	$ 72,257	$ 74,744	2,487	3.44%
	BENEFITS	23,957	25,290	26,160	870	3.44%
	Total Personnel	***$ 92,406***	***$ 97,547***	***$ 100,904***	***$ 3,357***	***3.44%***
	CONTRACTS / SERVICES	2,817	500	500	-	0.00%
	TRAVEL	991	1,615	1,615	-	0.00%
	SUPPLIES	2,982	4,800	3,700	(1,100)	(22.92%)
	OPERATING	1,627	5,500	4,000	(1,500)	(27.27%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 100,823***	***$ 109,962***	***$ 110,719***	***$ 757***	***0.69%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	***-***	***-***	***-***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 100,823**	**$ 109,962**	**$ 110,719**	**$ 757**	**0.69%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***83,369***	***109,962***	***110,719***	***757***	***0.69%***
	TOTAL AGENCY NET	**$ (17,454)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		60.1%	82.0%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		22.6%	18.0%	17.3%		

Division: 7 HUMAN RESOURCES - HUMAN RESOURCES (720,790)

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	FTE's	***4.19***	***4.50***	***4.50***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*-284.21%*	*-345.17%*	*251.12%*		
EXPENDITURES:						
	WAGES	$ 311,929	$ 323,581	$ (296,033)	(619,614)	(191.49%)
	BENEFITS	(886,539)	(1,116,915)	(743,385)	373,530	(33.44%)
	Total Personnel	***$ (574,610)***	***$ (793,334)***	***$ (1,039,418)***	***$ (246,084)***	***31.02%***
	CONTRACTS / SERVICES	79,943	79,000	75,000	(4,000)	(5.06%)
	TRAVEL	1,424	2,739	2,739	-	0.00%
	SUPPLIES	5,593	6,738	4,082	(2,656)	(39.42%)
	OPERATING	142,544	140,346	136,274	(4,072)	(2.90%)
	OTHER COSTS	693	10,650	4,373	(6,277)	(58.94%)
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ (344,413)***	***$ (553,861)***	***$ (816,950)***	***$ (263,089)***	***47.50%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ (344,413)**	**$ (553,861)**	**$ (816,950)**	**$ (263,089)**	**47.50%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***360,013***	***(553,861)***	***(816,950)***	***(263,089)***	***47.50%***
	TOTAL AGENCY NET	**$ 704,426**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		-76.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		-28.6%	0.0%	0.0%		

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Administration and Finance Division



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ADMINISTRATION AND FINANCE DIVISION

Division: 8 ADMINISTRATION and FINANCE					Increase / (Decrease)	
	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:					
COUNTY	$ 10,559,668	$ 10,956,330	$ 11,141,313	184,983	1.69%
COUNTY - PROJECT SPECIFIC	620	-	-	-	0.00%
FEDERAL FUNDS	-	-	-	-	0.00%
MEDICAID FUNDS	-	-	-	-	0.00%
FEES	1,277,416	1,463,678	1,350,000	(113,678)	(7.77%)
STATE CONTRACTS	1,914,773	1,882,445	1,882,445	-	0.00%
FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
OTHER GRANTS / CONTRACTS	7,500	-	11,000,000	11,000,000	0.00%
OTHER REVENUE	485,584	398,075	398,075	-	0.00%
FUND BALANCE USE	-	1,698,000	1,951,000	253,000	14.90%
IN-KIND REVENUE	428,162	428,162	428,162	-	0.00%
TOTAL DIVISION REVENUE	**$ 14,673,723**	**$ 16,826,690**	**$ 28,150,995**	**$ 11,324,305**	**67.30%**
FTE's	***29.21***	***30.65***	***29.25***	***-1.40***	***(4.57%)***
Benefits as a Percentage of Wages	*34.49%*	*36.32%*	*34.07%*		
EXPENDITURES:					
WAGES	$ 1,558,126	$ 1,610,884	$ 1,676,681	65,797	4.08%
BENEFITS	537,454	585,009	571,322	(13,687)	(2.34%)
Total Personnel	***$ 2,095,579***	***$ 2,195,893***	***$ 2,248,003***	***$ 52,110***	***2.37%***
CONTRACTS / SERVICES	322,241	477,255	7,273,394	6,796,139	1424.01%
TRAVEL	5,816	11,542	11,542	-	0.00%
SUPPLIES	122,088	108,451	2,107,952	1,999,501	1843.69%
OPERATING	1,959,484	2,955,567	3,589,649	634,082	21.45%
OTHER COSTS	18,430	26,000	14,200	(11,800)	(45.38%)
EQUIPMENT (Non-Capital)	2,597	-	1,000,000	1,000,000	0.00%
TOTAL DIRECT EXPENSES	***$ 4,526,235***	***$ 5,774,708***	***$ 16,244,740***	***$ 10,470,032***	***181.31%***
CAPITAL & LEASEHOLD IMPROVEMENTS	***$ 19,500***	***$ 1,698,000***	***$ 1,951,000***	$ 253,000	14.90%
IN-KIND EXPENSE	***428,162***	***428,162***	***428,162***	-	0.00%
TOTAL DIVISION EXPENDITURES	**$ 4,973,897**	**$ 7,900,870**	**$ 18,623,902**	**$ 10,723,032**	**135.72%**
INDIRECT ALLOCATION	***$ (4,920,854)***	***$ (4,440,557)***	***$ (4,556,734)***	***$ (116,177)***	***2.62%***
GENERAL FUND USE	***(14,530,317)***	***(13,366,377)***	***(14,083,827)***	***(717,450)***	***5.37%***
TOTAL AGENCY NET	**$ 90,363**	**$ -**	**$ 0**	**$ 0**	**0.00%**
(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**	0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**	0.0%	0.0%	0.0%		

Finance and Operations

The Administration and Finance Division is dedicated to the people and the purpose of Tri-County Health Department. We maintain effective management of Tri-County Health Department's (TCHD) financial activity and provide support services to all of the organization's divisions and programs. The role of Administration and Finance (A&F) is to oversee all financial aspects for the organization including coordinating financial activity to ensure that we conduct business in accordance with Board of Health and TCHD policy and procedures and within all guidelines of Generally Accepted Accounting Principles.

This division is responsible for the oversight and management of all financial activities including:

- Budget development, planning and management
- Financial Analysis, Forecasting and Reporting
- Annual Financial Statement preparation
- Annual External Audit
- Accounts payable
- Accounts receivable
- Contracts management
- Grants management
- Internal control policies and procedures
- Payroll processing and compliance
- Cash and Investment management
- Financial compliance with laws, regulations and policies

Funding Source(s): General Funds

Facilities Operations

Facilities, warehouse, distribution, and purchasing operations provide efficient and timely support to TCHD staff in the following areas:

- Purchasing (P-card, small purchases)
- Vaccine storage
- Warehouse operations and delivery service
- Remodel, repair, and maintenance services
- Motorized and non-motorized vehicle maintenance
- Strategic planning services related to office locations and space to optimize needs of the communities we serve

Funding Source(s): General Funds

Division: 8	ADMINISTRATION and FINANCE - FINANCE AND OPERATIONS (810, 820, 840, 860, 870, 890, 895, 899)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ 10,559,668	$ 10,956,330	$ 11,141,313	184,983	1.69%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	118	1,463,678	-	(1,463,678)	(100.00%)
	STATE CONTRACTS	1,914,773	1,882,445	1,882,445	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	7,500	-	-	-	0.00%
	OTHER REVENUE	485,584	398,075	398,075	-	0.00%
	FUND BALANCE USE	-	1,698,000	1,951,000	253,000	14.90%
	IN-KIND REVENUE	428,162	428,162	428,162	-	0.00%
TOTAL DIVISION REVENUE		**$ 13,395,805**	**$ 16,826,690**	**$ 15,800,995**	**$ (1,025,695)**	**(6.10%)**
	FTE's	***21.28***	***20.65***	***19.25***	***-1.40***	***(6.78%)***
	Benefits as a Percentage of Wages	*33.88%*	*36.32%*	*33.90%*		
EXPENDITURES:						
	WAGES	$ 1,239,475	$ 1,610,884	$ 1,250,523	(360,361)	(22.37%)
	BENEFITS	419,976	585,009	423,868	(161,141)	(27.55%)
	Total Personnel	***$ 1,659,451***	***$ 2,195,893***	***$ 1,674,391***	***$ (521,502)***	***(23.75%)***
	CONTRACTS / SERVICES	277,711	3,674,325	3,151,050	(523,275)	(14.24%)
	TRAVEL	4,383	11,542	11,542	-	0.00%
	SUPPLIES	93,779	108,451	67,052	(41,399)	(38.17%)
	OPERATING	1,632,122	2,955,567	2,671,077	(284,490)	(9.63%)
	OTHER COSTS	7,242	26,000	3,000	(23,000)	(88.46%)
	EQUIPMENT (Non-Capital)	2,597	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 3,677,286***	***$ 8,971,778***	***$ 7,578,112***	***$ (1,393,666)***	***(15.53%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ 19,500***	***$ 1,698,000***	***$ 1,951,000***	$ 253,000	14.90%
	IN-KIND EXPENSE	***428,162***	***428,162***	***428,162***	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 4,124,948**	**$ 11,097,940**	**$ 9,957,274**	**$ (1,140,666)**	**(10.28%)**
	INDIRECT ALLOCATION	***$ (5,161,645)***	***$ (5,433,624)***	***$ (8,162,135)***	***$ (2,728,511)***	***50.22%***
	GENERAL FUND USE	***(14,530,317)***	***(13,366,377)***	***(14,083,827)***	***(717,450)***	***5.37%***
	TOTAL AGENCY NET	**$ (97,815)**	**$ (2,204,003)**	**$ (77,971)**	**$ 2,126,032**	**(96.46%)**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Vital Records

TCHD is authorized by the State of Colorado to issue birth and death certificates through its Vital Records offices located in Greenwood Village, Commerce City and Castle Rock. Our award winning Vital Records Program is able to issue birth or death certificates for the State of Colorado regardless of the county of birth or death. Certificates can be issued through a wide variety of ordering methods such as in-person, online, by mail or electronically. Vital Records is a self-funded program through fees collected from services provided. Excess revenue from the Vital Records program is used to assist programs and services that are not fully funded.

Funding Source(s): Fees

Division: 8	ADMINISTRATION and FINANCE - VITAL RECORDS (880)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	620	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	1,277,298	1,463,678	1,350,000	(113,678)	(7.77%)
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 1,277,918**	**$ 1,463,678**	**$ 1,350,000**	**$ (113,678)**	**(7.77%)**
	FTE's	***7.93***	***10.00***	***10.00***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*36.87%*	*36.11%*	*34.60%*		
EXPENDITURES:						
	WAGES	$ 318,651	$ 409,274	$ 426,158	16,884	4.13%
	BENEFITS	117,478	147,797	147,454	(343)	(0.23%)
	Total Personnel	***$ 436,129***	***$ 557,071***	***$ 573,612***	***$ 16,541***	***2.97%***
	CONTRACTS / SERVICES	44,529	7,050	27,250	20,200	286.52%
	TRAVEL	1,433	-	-	-	0.00%
	SUPPLIES	28,309	26,900	40,900	14,000	52.04%
	OPERATING	327,361	317,758	318,572	814	0.26%
	OTHER COSTS	11,188	10,200	11,200	1,000	9.80%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 848,949***	***$ 918,979***	***$ 971,534***	***$ 52,555***	***5.72%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 848,949**	**$ 918,979**	**$ 971,534**	**$ 52,555**	**5.72%**
	INDIRECT ALLOCATION	***$ 240,791***	***$ 282,765***	***$ 300,495***	***$ 17,730***	***6.27%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ 188,178**	**$ 261,934**	**$ 77,971**	**$ (183,963)**	**(70.23%)**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

COVID-19

As part of the COVID-19 response, the CDC is providing $10.25 billion to states, territories, and local jurisdictions through CDC's existing Epidemiology and Laboratory Capacity (ELC) for Prevention and Control of Emerging Infectious Diseases cooperative agreement. Tri-County received its portion via a pass through grant from CDPHE. The project will strengthen and support local public health agencies responding to COVID-19 by funding personnel to perform critical containment activities, such as disease surveillance, case investigation, contact tracing, and testing, based on jurisdictional needs. The project also supports local responses to COVID-19 outbreaks, infection prevention efforts at health care and other settings, and promotes health equity aspects of the response. The project benefits all Coloradans by providing support to every local public health agency working on behalf of Colorado communities.

Funding Source(s): Restricted Federal Funds, Restricted State Funds

Division: 8	ADMINISTRATION and FINANCE - COVID-19 (819)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	11,000,000	11,000,000	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ -**	**$ -**	**$ 11,000,000**	**$ 11,000,000**	**0.00%**
	FTE's	***0.00***	***0.00***	***0.00***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*0.00%*	*0.00%*	*0.00%*		
EXPENDITURES:						
	WAGES	$ -	$ -	$ -	-	0.00%
	BENEFITS	-	-	-	-	0.00%
	Total Personnel	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	CONTRACTS / SERVICES	-	-	4,095,094	4,095,094	0.00%
	TRAVEL	-	-	-	-	0.00%
	SUPPLIES	-	-	2,000,000	2,000,000	0.00%
	OPERATING	-	-	600,000	600,000	0.00%
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	1,000,000	1,000,000	0.00%
	TOTAL DIRECT EXPENSES	***$ -***	***$ -***	***$ 7,695,094***	***$ 7,695,094***	***0.00%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ -**	**$ -**	**$ 7,695,094**	**$ 7,695,094**	**0.00%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ 3,304,906***	***$ 3,304,906***	***0.00%***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

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Planning and Information Management Division



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PLANNING AND INFORMATION MANAGEMENT DIVISION

Division: 9 PLANNING and INFORMATION MANAGEMENT

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	$ -	-	0.00%
	OTHER GRANTS / CONTRACTS	69,079	71,735	7,400	(64,335)	(89.68%)
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 69,079**	**$ 71,735**	**$ 7,400**	**$ (64,335)**	**(89.68%)**
	FTE's	***14.13***	***15.33***	***14.98***	***-0.35***	***(2.28%)***
	Benefits as a Percentage of Wages	*34.88%*	*36.45%*	*34.72%*		
EXPENDITURES:						
	WAGES	$ 1,220,107	$ 1,294,132	$ 1,351,018	56,886	4.40%
	BENEFITS	425,564	471,701	469,126	(2,575)	(0.55%)
	Total Personnel	***$ 1,645,671***	***$ 1,765,833***	***$ 1,820,144***	***$ 54,311***	***3.08%***
	CONTRACTS / SERVICES	75,596	75,950	58,350	(17,600)	(23.17%)
	TRAVEL	23,871	38,964	750	(38,214)	(98.08%)
	SUPPLIES	4,842	3,400	3,500	100	2.94%
	OPERATING	719,504	775,339	696,749	(78,590)	(10.14%)
	OTHER COSTS	2,406	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	76,015	113,515	110,000	(3,515)	(3.10%)
	TOTAL DIRECT EXPENSES	***$ 2,547,904***	***$ 2,773,001***	***$ 2,689,493***	***$ (83,508)***	***(3.01%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ 69,914***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 2,617,818**	**$ 2,773,001**	**$ 2,689,493**	**$ (83,508)**	**(3.01%)**
	INDIRECT ALLOCATION	***$ 5,789***	***$ 16,810***	***$ -***	***$ (16,810)***	***(100.00%)***
	GENERAL FUND USE	***2,500,328***	***2,718,076***	***2,682,093***	***(35,983)***	***(1.32%)***
	TOTAL AGENCY NET	**$ (54,200)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		69.3%	79.9%	82.5%		
% of Total Expenses Funded by **Non-County General Funds**		26.0%	17.6%	17.3%		

Data Analytics

This multi-disciplinary team continues to increase informatics and data analytic capacity at TCHD, including supporting work around the COVID-19 Response and Priority Area 2: Goal A (Enhance technology and information systems) in the 2019-2024 Strategic Plan. Staff within this program developed a data system, in house, for tracking COVID-19 cases and their contacts and developed a series of data dashboards for the public and our stakeholders to support decision-making. Staff apply epidemiological and statistical methods and advanced technology to understand the distribution and determinants of health and disease in the TCHD jurisdiction to help guide decision making and prioritization in TCHD's efforts to improve population health. The data analytic team has developed a large series of interactive data dashboards and story maps to help illustrate the occurrence of disease, injury, and risk and protective factors in our three county jurisdiction. Staff in this program also support the work of community health assessments, strategic planning, public health improvement planning, maintaining TCHD's public health accreditation, and measuring impact through a performance management system that include multiple quality improvement methods.

Funding Source(s): Required General Funds

Division: 9 PLANNING and INFORMATION MANAGEMENT - Data Analytics (930)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:					
COUNTY	$ -	$ -	$ -	-	0.00%
COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
FEDERAL FUNDS	-	-	-	-	0.00%
MEDICAID FUNDS	-	-	-	-	0.00%
FEES	-	-	-	-	0.00%
STATE CONTRACTS	-	-	-	-	0.00%
FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
OTHER GRANTS / CONTRACTS	38,588	-	7,400	7,400	0.00%
OTHER REVENUE	-	-	-	-	0.00%
FUND BALANCE USE	-	-	-	-	0.00%
IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE	**$ 38,588**	**$ -**	**$ 7,400**	**$ 7,400**	**0.00%**
FTE's	***3.93***	***4.00***	***4.00***	***0.00***	***0.00%***
Benefits as a Percentage of Wages	*35.00%*	*35.00%*	*35.00%*		
EXPENDITURES:					
WAGES	$ 334,623	$ 355,385	$ 311,981	(43,404)	(12.21%)
BENEFITS	117,117	124,387	109,193	(15,194)	(12.22%)
Total Personnel	***$ 451,740***	***$ 479,772***	***$ 421,174***	***$ (58,598)***	***(12.21%)***
CONTRACTS / SERVICES	1,013	250	250	-	0.00%
TRAVEL	10,340	17,155	-	(17,155)	(100.00%)
SUPPLIES	42	-	-	-	0.00%
OPERATING	25,541	19,414	20,399	985	5.07%
OTHER COSTS	-	-	-	-	0.00%
EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
TOTAL DIRECT EXPENSES	***$ 488,675***	***$ 516,591***	***$ 441,823***	***$ (74,768)***	***(14.47%)***
CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES	**$ 488,675**	**$ 516,591**	**$ 441,823**	**$ (74,768)**	**(14.47%)**
INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
GENERAL FUND USE	***437,476***	***516,591***	***434,423***	***(82,168)***	***(15.91%)***
TOTAL AGENCY NET	**$ (12,611)**	**$ -**	**$ -**	**$ -**	**0.00%**
(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**	65.1%	82.0%	81.3%		
% of Total Expenses Funded by **Non-County General Funds**	24.5%	18.0%	17.0%		

Division Administration

The leadership and support team is responsible for planning, implementation, management, and evaluation of all PIM activities and programs, including development, implementation, and monitoring of TCHD's Strategic Plan and Public Health Improvement Plan This also includes Performance Management and Quality Improvement, which are part of Priority Area 2: Goal C in the TCHD Strategic Plan as well as a key factor in maintaining Public Health Accreditation and monitoring agency-wide performance. This team has also become the technical experts around organizational change management, also called out in Priority Area 2: Goal C in the Strategic Plan. The Public Health Planning Initiatives Coordinator, Performance Management Coordinator, and Informatics Project Manager are included in this group. All staff in this program were activated in the COVID-19 response as well.
Funding Source(s): Required General Funds

Division: 9	PLANNING and INFORMATION MANAGEMENT - Division Administration (990)				Increase / (Decrease)	
		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	$	%
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	5,000	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 5,000**	**$ -**	**$ -**	**$ -**	**0.00%**
	FTE's	***3.49***	***4.00***	***4.00***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*34.37%*	*41.96%*	*34.50%*		
EXPENDITURES:						
	WAGES	$ 294,453	$ 283,998	$ 369,519	85,521	30.11%
	BENEFITS	101,217	119,176	127,491	8,315	6.98%
	Total Personnel	***$ 395,670***	***$ 403,174***	***$ 497,010***	***$ 93,836***	***23.27%***
	CONTRACTS / SERVICES	15,158	5,000	5,200	200	4.00%
	TRAVEL	2,969	11,530	-	(11,530)	(100.00%)
	SUPPLIES	83	2,000	1,000	(1,000)	(50.00%)
	OPERATING	16,168	11,150	11,000	(150)	(1.35%)
	OTHER COSTS	2,330	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 432,376***	***$ 432,854***	***$ 514,210***	***$ 81,356***	***18.80%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 432,376**	**$ 432,854**	**$ 514,210**	**$ 81,356**	**18.80%**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***427,352***	***432,854***	***514,210***	***81,356***	***18.80%***
	TOTAL AGENCY NET	**$ (24)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		71.8%	82.0%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		27.0%	18.0%	17.3%		

Human Papillomavirus (HPV)

This program ended in 2020, as TCHD was part of a Metro-Denver regional partnership to promote HPV education and awareness.

Funding Source(s): Restricted Grant Funds

Division: 9	PLANNING and INFORMATION MANAGEMENT - Human Papillomavirus (970)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	25,491	71,735	-	(71,735)	(100.00%)
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ 25,491**	**$ 71,735**	**$ -**	**$ (71,735)**	**(100.00%)**
	FTE's	***0.15***	***0.42***	***0.00***	***-0.42***	***(100.00%)***
	Benefits as a Percentage of Wages	*35.00%*	*37.27%*	*0.00%*		
EXPENDITURES:						
	WAGES	$ 14,513	$ 38,124	$ -	(38,124)	(100.00%)
	BENEFITS	5,080	14,207	-	(14,207)	(100.00%)
	Total Personnel	***$ 19,593***	***$ 52,331***	***$ -***	***$ (52,331)***	***(100.00%)***
	CONTRACTS / SERVICES	-	-	-	-	0.00%
	TRAVEL	110	579	-	(579)	(100.00%)
	SUPPLIES	-	-	-	-	0.00%
	OPERATING	-	2,015	-	(2,015)	(100.00%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 19,702***	***$ 54,925***	***$ -***	***$ (54,925)***	***(100.00%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	-	-	-	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 19,702**	**$ 54,925**	**$ -**	**$ (54,925)**	**(100.00%)**
	INDIRECT ALLOCATION	***$ 5,789***	***$ 16,810***	***$ -***	***$ (16,810)***	***(100.00%)***
	GENERAL FUND USE	-	-	-	-	***0.00%***
	TOTAL AGENCY NET	**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		0.0%	0.0%	0.0%		
% of Total Expenses Funded by **Non-County General Funds**		0.0%	0.0%	0.0%		

Information Technology Program

The Information Technology (IT) program has worked through the strategies of Priority Area 2: Goal A aligning with the new TCHD Strategic Plan. IT is designed to provide a self-supporting, reliable, and secure computer operating architecture and environment at TCHD. The IT program supports both full and part-time TCHD employees by administering account information, assisting with application software issues, and solving technical problems using an efficient Help Desk system. IT configures, implements, maintains, monitors, and administers a wide variety of network and communication services such as: voice over IP (VoIP) systems, server equipment, personal computers, and associated peripheral hardware. Additionally, IT maintains computer equipment inventories, administers cellular phones, and ensures software license compliance. The IT team also provides and operates a reliable, robust, and secure infrastructure to support mission-critical applications software for electronic health records system, accounting system (financial, payroll, procurement, and reporting services), E-mail services, environmental health system, and Women, Infants and Children (WIC) support. Finally, they monitor, maintain, and administer IT security, Internet connectivity, and the Wide Area Network infrastructure that connects all TCHD locations to our central computing resources, including a disaster recovery site/plan. IT was instrumental in implementing innovations around the COVID-19 response that allowed TCHD staff to work remotely, to support various technical aspects of the response, and in ensuring the provision of core public health services in these challenging times.

Funding Source(s): Required General Funds

Division: 9 **PLANNING and INFORMATION MANAGEMENT - Information Technology (950)**

		FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		**$ -**	**$ -**	**$ -**	**$ -**	**0.00%**
	FTE's	***5.65***	***6.00***	***6.00***	***0.00***	***0.00%***
	Benefits as a Percentage of Wages	*35.08%*	*34.60%*	*34.62%*		
EXPENDITURES:						
	WAGES	$ 434,750	$ 467,889	$ 502,831	34,942	7.47%
	BENEFITS	152,531	161,873	174,102	12,229	7.55%
	Total Personnel	***$ 587,282***	***$ 629,762***	***$ 676,933***	***$ 47,171***	***7.49%***
	CONTRACTS / SERVICES	59,313	70,700	52,900	(17,800)	(25.18%)
	TRAVEL	5,603	3,600	-	(3,600)	(100.00%)
	SUPPLIES	4,635	1,100	2,200	1,100	100.00%
	OPERATING	675,212	739,325	662,925	(76,400)	(10.33%)
	OTHER COSTS	76	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	76,015	113,515	110,000	(3,515)	(3.10%)
	TOTAL DIRECT EXPENSES	***$ 1,408,135***	***$ 1,558,002***	***$ 1,504,958***	***$ (53,044)***	***(3.40%)***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ 69,914***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		**$ 1,478,049**	**$ 1,558,002**	**$ 1,504,958**	**$ (53,044)**	**(3.40%)**
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***1,450,804***	***1,558,002***	***1,504,958***	***(53,044)***	***(3.40%)***
	TOTAL AGENCY NET	**$ (27,245)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		71.3%	82.0%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		26.8%	18.0%	17.3%		

Medical Epidemiology

Our Medical Epidemiologist consults with programs throughout TCHD seeking expertise in epidemiologic analyses, knowledge on the clinical aspects of disease, or medical interpretation of data. Additionally, this position also oversees development and implementation of epidemiology-based studies for the department on a wide variety of public health topics. Our Medical Epidemiologist has been a critical resource to staff throughout the COVID-19 response by providing specific infectious disease medical expertise across a multitude of topics.

Funding Source(s): Required General Funds

Division: 9	PLANNING and INFORMATION MANAGEMENT - Medical Epidemiology (910)	FY2019 ACTUAL	FY2020 REVISED	FY2021 ADOPTED	Increase / (Decrease) $	Increase / (Decrease) %
REVENUE:						
	COUNTY	$ -	$ -	$ -	-	0.00%
	COUNTY - PROJECT SPECIFIC	-	-	-	-	0.00%
	FEDERAL FUNDS	-	-	-	-	0.00%
	MEDICAID FUNDS	-	-	-	-	0.00%
	FEES	-	-	-	-	0.00%
	STATE CONTRACTS	-	-	-	-	0.00%
	FEDERAL PASS THRU FUNDS	-	-	-	-	0.00%
	OTHER GRANTS / CONTRACTS	-	-	-	-	0.00%
	OTHER REVENUE	-	-	-	-	0.00%
	FUND BALANCE USE	-	-	-	-	0.00%
	IN-KIND REVENUE	-	-	-	-	0.00%
TOTAL DIVISION REVENUE		$ -	$ -	$ -	$ -	0.00%
	FTE's	***0.91***	***0.91***	***0.98***	***0.07***	***7.69%***
	Benefits as a Percentage of Wages	*35.00%*	*35.00%*	*35.00%*		
EXPENDITURES:						
	WAGES	$ 141,768	$ 148,736	$ 166,687	17,951	12.07%
	BENEFITS	49,619	52,058	58,340	6,282	12.07%
	Total Personnel	***$ 191,387***	***$ 200,794***	***$ 225,027***	***$ 24,233***	***12.07%***
	CONTRACTS / SERVICES	113	-	-	-	0.00%
	TRAVEL	4,849	6,100	750	(5,350)	(87.70%)
	SUPPLIES	83	300	300	-	0.00%
	OPERATING	2,584	3,435	2,425	(1,010)	(29.40%)
	OTHER COSTS	-	-	-	-	0.00%
	EQUIPMENT (Non-Capital)	-	-	-	-	0.00%
	TOTAL DIRECT EXPENSES	***$ 199,016***	***$ 210,629***	***$ 228,502***	***$ 17,873***	***8.49%***
	CAPITAL & LEASEHOLD IMPROVEMENTS	***$ -***	***$ -***	***$ -***	$ -	0.00%
	IN-KIND EXPENSE	*-*	*-*	*-*	-	0.00%
TOTAL DIVISION EXPENDITURES		$ 199,016	$ 210,629	$ 228,502	$ 17,873	8.49%
	INDIRECT ALLOCATION	***$ -***	***$ -***	***$ -***	***$ -***	***0.00%***
	GENERAL FUND USE	***184,696***	***210,629***	***228,502***	***17,873***	***8.49%***
	TOTAL AGENCY NET	**$ (14,320)**	**$ -**	**$ -**	**$ -**	**0.00%**
	(Revenue minus Expenses & Allocations)					
% of Total Expenses Funded by **County General Funds**		67.4%	82.0%	82.7%		
% of Total Expenses Funded by **Non-County General Funds**		25.4%	18.0%	17.3%		

Glossary



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GLOSSARY

ACDHS	Arapahoe County Department of Human Services – provides public assistance to the citizens of Arapahoe County.
ACHSD	Adams County Department of Human Services – provides public assistance to the citizens of Adams County.
ADA	Americans with Disabilities Act – a 1990 federal civil rights law that prohibits discrimination and guarantees that people with disabilities have the same opportunities as everyone else to enjoy employment opportunities, to purchase goods and services, and to participate in State and local government programs and services.
AHC	Accountable Health Communities – this model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.
BOCC	Board of County Commissioners – the decision-making board for a county.
BOH	Board of Health – the policy-making body for Tri-County Health Department that is comprised of nine members: three each from Adams, Arapahoe and Douglas Counties.
CARES	Coronavirus Aid, Relief, and Economic Security Act – committed over $2 trillion in economic relief to protect the American people from the public health and economic impacts of COVID-19. Tri-County has received CARES funding from our three counties and CDPHE.
CCPD	Cancer, Cardiovascular and Chronic Pulmonary Disease Grants Program – was created in 2005 to fund competitive grants to provide a cohesive approach to cancer, cardiovascular disease, and chronic pulmonary disease prevention, early detection, and treatment in Colorado.
CDC	Center for Disease Control and Prevention - the leading national public health institute of the United States under the Department of Health and Human Services.
CDHS	Colorado Department of Human Services - the principal department of the Colorado state government that operates Colorado's social services.
CDPHE	Colorado Department of Public Health and Environment - the principal department of the Colorado state government responsible for public health and environmental regulation.
CEDRS	Colorado Electronic Disease Reporting System – a CDPHE system for laboratories, health care providers, or public health staff who need to report a case of illness.
CFR	Code of Federal Regulations – collection of administrative laws governing federal regulatory agency practice and procedures.
CHA	Community Health Assessment – a systematic examination of the health status indicators for a given population that is used to identify key problems and

	assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues.
CMMI	Center for Medicare and Medicaid Innovation – develops new payment and service delivery models in accordance with the requirements of section 1115A of the Social Security Act.
CRS	Colorado Revised Statute – the laws passed by the Colorado Legislature, which are collected, edited and printed each year by the Office of Legislative Legal Services.
DCDHS	Douglas County Department of Human Services – provides public assistance to the citizens of Arapahoe County.
DRCOG	Denver Regional Council of Governments – representatives of the Denver metro area counties, cities and towns working together to ensure the region remains a great place to live, work and play.
DSME	Diabetes Self-Management Education – the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards.
EHR	Electronic Health Records – computer system that collects patient information, schedules appointments, and facilitates billing.
ELC	Epidemiology and Laboratory Capacity – a CDC agreement that awards annual funding to state, local, and territorial health departments to: improve laboratory capacity to support vector-borne disease surveillance; improve completeness and timeliness of vector-borne disease surveillance reporting; increase availability of timely and accurate information on vector-borne disease risk and prevention; and identify faster and more completely vector-borne disease outbreaks.
EPA	Environmental Protection Agency – established in 1970 to consolidate in one agency a variety of federal research, monitoring, standard-setting and enforcement activities to ensure environmental protection.
Expenditure	The payment of cash for the purpose of acquiring an asset or service.
FY	Fiscal Year- a period that a company or government uses for accounting purposes and preparing financial statements. For TCHD, this is also the calendar year, although the fiscal year doesn't have to follow the calendar year. The State of Colorado's fiscal year runs from July 1 to June 30.
FMLA	Family Medical Leave Act - a 1993 federal labor law that provides certain employees up to 12 weeks of unpaid, job-protected leave per year.
Fund Balance	The excess of the assets and deferred outflows of resources of a fund over its liabilities and deferred inflows of resources.
GASB	Governmental Accounting Standards Board – the source of generally accepted accounting principles used by state and local governments in the United States.
HRSN	Health-Related Social Needs, such as food insecurity, housing instability, and lack of transportation, are associated with worse health outcomes, and are increasingly the focus of health-related social needs interventions within healthcare.

MCPN	Metro Community Provider Network – works with the community to provide excellent, culturally-sensitive health services to meet the needs of each individual.
NACCHO	National Association of County and City Health Officials – works to improve the public's health while adhering to a set of core values: equity, excellence, participation, respect, integrity, leadership, science & innovation.
NDPP	National Diabetes Prevention Program – a partnership of public and private organizations working to prevent or delay type 2 diabetes. Partners make it easier for people at risk for type 2 diabetes to participate in evidence-based lifestyle change programs to reduce their risk of type 2 diabetes.
NENS	Non-English, Non-Spanish – assists patients through the use of linguistically and culturally responsive multilingual care navigation, by ensuring NENS children and adults screened and referred for specialty care and services are able to access that care, and connecting NENS child and adult patients without a medical home.
OMB	Office of Management and Budget – oversees the performance of federal agencies, and administers the federal budget.
OSHA	Occupational Safety and Health Act – a 1970 federal law enacted to reduce workplace hazards and implement safety and health programs for both employers and their employees.
OWTS	Onsite Wastewater Treatment Systems – a broad term referring to any system for the collection, storage, treatment, neutralization, or stabilization of sewage that occurs on the property
P-Card	Procurement Card – a type of Commercial Card, similar to a consumer credit card, that allows businesses to make electronic payments for a variety of business expenses (e.g., goods and services).
PHAB	Public Health Accreditation Board – a nonprofit organization dedicated to improving and protecting the health of the public by advancing and transforming the quality and performance of state, local, tribal, and territorial public health departments.
PHIP	Public Health Improvement Plan – a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process.
QI	Quality Improvement – a systematic, formal approach to the analysis of practice performance and efforts to improve performance.
Revenue	Sources of income financing governmental operations.
RFP	Request for Proposal – a formal process to obtain pricing and details for services.
RFQ	Request for Quote – a formal process to obtain pricing for specific products or supplies.
SAMSHA	Substance Abuse and Mental Health Services Administration - the agency within the U.S. Department of Health and Human Services leading public health efforts to advance behavioral health and reduce the impact of substance abuse and mental illness on America's communities.

SDOH	Social Determinants of Health – conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
SNS	Strategic National Stockpile – the national repository of antibiotics, vaccines, chemical antidotes, antitoxins, and other critical medical equipment and supplies.
STI	Sexually Transmitted Illnesses – an infection transmitted through sexual contact, caused by bacteria, viruses, or parasites.
Strategic Plan	The document used to communicate organizational goals, the actions needed to achieve those goals and all of the other critical elements developed during development of the plan.
TCHD	Tri-County Health Department.
TCOPP	Tri-County Overdose Prevention Partnership – a community-based partnership of public and private partners serving the Counties of Adams, Arapahoe, and Douglas, Colorado, with two main priorities: 1. Prevent opioid overdose deaths in our counties. 2. Increase awareness and education about factors leading to and preventing opioid overdose deaths.



Tri-County Health Department

2021 Department Overview

Adams | Arapahoe | Douglas Colorado

ADAMS COUNTY COLORADO

ARAPAHOE COUNTY COLORADO'S FIRST

DOUGLAS COUNTY COLORADO

Table of Contents

Tri-County Health Department | 2021 Department Overview

Introduction
- History of Tri-County Health Department
- Health Department Formation and Governance
- Core and Foundational Public Health Services
- Mission, Vision, Values, and Guiding Principles

Board of Health
- Board of Health

Office of the Executive Director
- Policy and Intergovernmental Affairs
- Strategic Communications

Administration and Finance
- Revenues
- Budget Process
- Basis of Budget and Accounting
- Finance and Operations
- Facilities
- Vital Records

Human Resources
- Employee Recruitment
- Employee Compensation
- Employee Benefits
- Employee Relations
- Workforce Development
- Workers' Compensation
- Employee Wellness

Planning and Information Management
- Strategic Planning
- Community Health Improvement Planning: Public Health Improvement Plan
- Program Planning and Evaluation
- Public Health Accreditation
- Information Technology and IT Project Management
- Health Data and GIS Program
- Medical Epidemiology
- HIPAA Compliance

Community Health Promotion
- Community Health Promotion Division Administration
- Tobacco Education and Prevention
- Substance Use Prevention
- Mental and Behavioral Health Promotion and Suicide Prevention
- Maternal and Child Block Grant
  - Child and Adolescent Health
  - Medical Home for Children and Youth with Special Health Needs
  - Perinatal Health
  - Advancing Breastfeeding in Colorado
- Community Nutrition – Policy and Systems Change Through Advocacy and Education
- Healthy Beverage Partnership Initiative
- Early Childhood Health Promotion
- School Liaison
- Worksite Wellness
- Diabetes Education Program
- Health Equity

Emergency Preparedness, Response, and Communicable Disease Surveillance
- Emergency Preparedness and Response Program
- Cities Readiness Initiative Program
- Communicable Disease Surveillance Program
- Workplace Safety and Security Program
- Syndromic Surveillance Program
- COVID-19 Pandemic Response

Environmental Health
- Environmental Health Division Administration and Informatics
- Food Protection Program
- Child Care Program
- General Environmental Health Services
- Water Program
- Land Use Program
- Solid and Hazardous Waste Program
- Household Chemical Roundup
- Industrial Hygiene
- Rocky Mountain Arsenal Program
- Vector Surveillance

Table of Contents

Nursing

- Division Operations
- Immunizations Program
- Call Center
- Disease Prevention and Clinical Services – Sexual Health
- Senior Dental (Arapahoe County)
- Home Visitation Programs
  - Nurse Family Partnership
  - Adams County Nurse Support Contract Program
  - Arapahoe County Nurse Support Contract Program
  - Douglas County Nurse Support Contract Program
- Child Fatality Review
- HCP - A Program for Children and Youth with Special Healthcare Needs
- Public Health Nursing Clinical Education
- Regional Health Connectors
- Healthy Communities and Health Enrollment Team
- Disease Prevention and Clinical Services – Harm Reduction and HIV Prevention Program

Nutrition

- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Food Security
- Breastfeeding Peer Counselors
- Baby and Me Tobacco Free
- Dietetic Internship

Appendices

- Appendix A: Resolutions Forming TCHD
- Appendix B: TCHD Core and Foundational Services Table
- Appendix C: Code of Colorado Regulations State Board of Health Core Public Health Services
- Appendix D: List of Partnerships and Coalitions by County



Executive Summary

The Tri-County Health Department (TCHD) serves diverse communities of approximately 1.6 million people in Adams, Arapahoe and Douglas Counties. Since 1966, TCHD's commitment to the constituents and stakeholders in each county has been guided by an awareness of both common and unique health and environmental issues among these communities. TCHD delivers a broad array of public health services and functions to the residents of Adams, Arapahoe, and Douglas County communities, including environmental health, communicable disease control, immunization, community nutrition, sexual health, tobacco and substance abuse prevention, and maternal and child health. TCHD works both locally and regionally to routinely monitor community health statuses, investigate and address ongoing and emerging health hazards, lead and mobilize partners to address health priorities, develop and execute community health improvement plans, inform, educate, and empower communities to address its most salient health and environmental issues, and increasingly engage with community partners across a multitude of sectors to increase the impact of public health interventions and to improve the social determinants of health.

The purpose of this report is to provide an overview of the breadth and reach of programs and services provided to Adams, Arapahoe, and Douglas Counties by TCHD. Each section of this report provides a narrative description of the Division and program, a summary of the Division-specific and/or program-specific budget, a summary of the FTE by Division and program, and relevant performance management indicators for each program, demonstrating recent trends in numbers of clients served, client visits, encounters, or interactions, etc. The indicators reported here are internal performance indicators that describe how much, to what extent, and to whom services are provided. To the extent possible county-level and multi-year data is provided. A separate, county-specific 2021 Community Health Update will be provided that summarizes relevant population health outcomes for select indicators for Adams, Arapahoe, and Douglas Counties, particularly in areas of our Public Health Improvement Plan. This report is organized by listing, initially describing activities of administrative and foundational Divisions and then reviewing the public-facing and client-facing Divisions and programs.

TCHD's size, extensive programs, and diverse staff and resources allow the agency to provide high quality public health services in an efficient and effective manner that takes advantage of economies of scale in areas such as staffing, capacity, and critical infrastructure. These strengths give TCHD the resources to nimbly and flexibly respond to common issues across our three counties, address more community-specific challenges, and collaborate with other partners to find solutions to address complex regional challenges such as mental and behavioral health, substance abuse, suicide, food insecurity, emerging groundwater contaminants, and air quality among others. TCHD's staff are accessible to and collaborate effectively with federal, state, county, and municipal-level organizations and community partners in ways that benefit communities within the TCHD jurisdiction. Overall, TCHD and its staff are experienced, skilled, and poised to address emerging public health challenges, as the agency seeks to achieve its vision of "optimal health across the lifespan for the populations we serve".



Introduction

Tri-County Health Department (TCHD) serves over 1.6 million people in diverse communities within Adams, Arapahoe and Douglas Counties, and offers over 60 programs/services ranging from birth certificates, immunizations and health care referrals, restaurant inspections, and infectious disease investigations. TCHD operates out of 11 offices in this 3,000 square mile area and includes in its jurisdiction 26 municipalities, 15 school districts with more than 360 public schools, and 12acute care hospitals.

TCHD began operations on January 1, 1948 and initially served the 160,000 residents of Adams, Arapahoe and Jefferson Counties. Jefferson County separated from TCHD in 1958 to form its own local health department and Douglas County officially joined TCHD on January 1, 1966, creating the current jurisdictional structure.

Health Department Formation and Governance

The structure of public health has evolved over time, as have the laws that govern local public health agencies in Colorado. The Sabin Health Laws, passed in 1947, governed public health up until the 2008 Public Health Act was adopted. The Public Health Act of 2008 established a uniform public health system in Colorado and defined core services that were required of every local public health agency. Most public health services and functions are included in Section 25—Health of the Colorado Revised Statutes. For example, C.R.S. 25-1-506 specifically mandates that each county in Colorado must establish a public health agency by resolution of its Board of County Commissioners. In 2009, following the passage of the Colorado Public Health Reauthorization Act (Public Health Act), the Boards of Commissioners in Adams, Arapahoe, and Douglas counties each adopted resolutions designating Tri-County Health Department as its district public health department. The full history of resolutions that formed TCHD, including the most recent adopted in 2009, can be found in Appendix A.

Core Public Health Services

The Public Health Act provided a much-needed update and reorganization for Colorado's public health system. It provided the foundation for the adoption of the Minimum Qualifications for Public Health Director and Minimum Qualification for Medical Officer (6 CCR 1014-6) in 2009 (revised 2015), the requirement to regularly conduct Community Health Assessments and to develop Public Health Improvement Plans, and outlined the set of Core Public Health Services identified in rule initially adopted in 2011. Since its passage, TCHD has used the Core Public Health Services structure to guide and align our programs, and outlines of this alignment have been provided to our counties during budget review process over the past several years. Appendix B includes the most recent version of this outline for FY2019. In 2018-2019, extensive work was undertaken by the Colorado Department of Public Health and Environment (CDPHE) and the Colorado Association of Local Public Health Officials (of which TCHD is a member) to assess the current public health system structure and financial constraints and to develop a new framework to update and transform public health in Colorado. This effort led to a modification of the structure of core public health services in 2019, which was adopted by Colorado's State Board of Health (6 CCR 1014-7) in April 2019 and went into effect January 2020 (Appendix C). Due to diversion of effort to respond to the COVID-19 pandemic, TCHD has not fully operationalized all of the changes in the 2020 revision to the Core Public Health Services and aligned our programs with them; therefore the agency's structure and budget still reflect the previous framework.

An additional and important rule is the Colorado Minimum Quality Standards for Public Health Services (6 CCR 1014-9) adopted in 2013. This rule addresses how governmental public health agencies should operate and seek to continuously improve services. The rule specifies that through the adoption of measurable standards for public health services, Colorado's public health system, including local and district health departments, will continuously improve the quality of its services and programs, will demonstrate accountability, and will raise public health capacity. The rule was created using national standards as developed by the Public Health Accreditation Board as a basis to direct local public health agencies across Colorado and uses a slightly different approach to defining core public health services. Because the national public health accreditation process requirement requires use of these standards, TCHD organizes its accreditation efforts (initial accreditation in 2017, re-accreditation anticipated in 2022) around this structure.

TCHD bases our approach to the provision of public health services in Adams, Arapahoe, and Douglas Counties on this statutory and regulatory foundation. The report that follows provides a description of TCHD's programs and services based on current organizational and budgetary structure.

Introduction cont.

Mission, Vision, Values, and Guiding Principles

Vision
Optimal health across the lifespan for the populations we serve.

Mission
Promote, protect and improve the lifelong health of individuals and communities in Adams, Arapahoe and Douglas Counties through the effective use of data, evidence-based prevention strategies, leadership, advocacy, partnerships, and the promotion of health equity.

Values and Guiding Principles
Values for the agency are demonstrated in the behavior and decisions of all our employees and in how we conduct our efforts in the communities we serve. TCHD, its Board and its employees have adopted these eight core values that guide behavior, organizational policy, and decision-making. These values not only apply to how we interact with each other internally, but how we treat our partners and clients externally.

Respect – We treat others with the same dignity as we wish to be treated. We honor the whole person and recognize the importance of work-life balance and diverse perspectives. We recognize the power of teamwork and appreciate the unique contributions that each member of a team can make.

Integrity – We maintain consistency in what we say and what we do. We uphold high ethical standards and maintain accountability to each other and the communities that we serve.

Courage – We stand up for what is right in the face of adversity. We communicate openly and welcome honest feedback. We advocate for those who cannot do it for themselves.

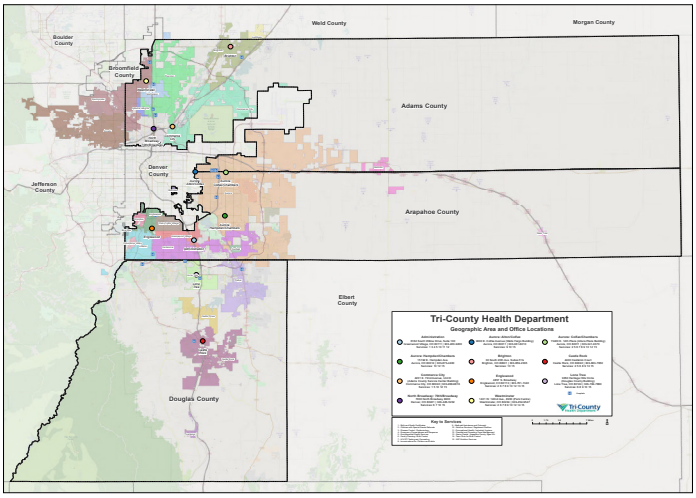
Excellence – We strive for the highest quality in everything that we do. We pursue opportunities and seek creative and innovative solutions to the challenges that face us.

Leadership – We believe that everyone can be a leader. We empower others to act; we encourage everyone to reach their fullest potential; and we model our core values.

Collaboration – We seek to sustain and enhance the reach and impact of our efforts through the respectful engagement with community partners (local, regional and state).

Stewardship – We maintain stewardship of public monies and facilities through active management and always striving to provide targeted, high quality, and cost-effective services for the community.

Innovation – We seek and encourage innovative approaches to address public health issues, reach diverse communities and improve agency operation



Board of Health

The Board of Health is the statutoriliy-mandated entity that oversees TCHD and is comprised of nine members: three each from Adams, Arapahoe and Douglas Counties. Board members are appointed by their respective County Commissioners and serve five-year terms. The Board of Health is responsible for hiring and evaluating the Public Health Director, providing financial oversight, policy making, acting in an advisory capacity to the Public Health Director, and adopting and revising rules and regulations related to the administration of public health laws within the District. In today's public health system, the leadership role of boards of health makes them an essential link between public health services and a healthy community. The TCHD Board of Health has played an essential role in the development of TCHD's Strategic Plan, TCHD's Public Health Improvement Plan, and Public Health Accreditation. Most notably, over the past year, TCHD's Board of Health has been heavily involved in COVID-19 pandemic response efforts including approving district-wide public health orders.

Board of Health
Funding/Revenue Source(s): General Funds

FY21 Division FTE: 0
FY21 Division Budget: $15,000

BOARD OF HEALTH MEMBERS

Adams County

Julie Mullica, MPH,
Vice President
Term expires: January 2022

Rosanna Reyes, RN
Term expires: January 2025

Julie Schilz, BSN, MA
Term expires: January 2026

Arapahoe County

Jan Brainard, RN
Term expires: February 2023

Thomas Fawell, MD
Term expires: February 2022

Kaia Gallagher, PhD,
President
Term expires: February 2026

Douglas County

Marsha Jaroch, NP
Term expires: January 2025

Zachary Nannestad, MPH,
Secretary
Term expires: January 2024

Linda Fielding, MD
Term expires: January 2023

Office of Executive Director

Executive Director

The Executive and Deputy Director are responsible for providing strategic leadership by working with the Board of Health and the Executive Management Team to establish agency goals, strategies, plans, and policies. Programs included in the Office of Executive Director include Strategic Communications and the Policy and Public Affairs Officer. They also oversee eight functional divisions: Nutrition; Community Health Promotion; Nursing; Emergency Preparedness, Response and Communicable Disease Surveillance; Environmental Health; Human Resources; Administration and Finance; and Planning and Information Management.

Office of Executive Director Division
Funding/Revenue Source(s): General Funds

FY21 Division FTE: 8.09
FY21 Division Budget: $1,497,009

**Division budget includes budget for Board of Health*

Office of Executive Director Division
Funding/Revenue Source(s): General Funds

FY21 Program FTE: 5.09
FY21 Program Budget: $1,112,272

**Includes Executive Director, Deputy Director, Policy and Intergovernmental Affairs, and Metro Denver Partnership for Health Grant.*

Policy and Intergovernmental Affairs

The Policy and Public Affairs Officer position was created as a stand-alone program in the Office of the Executive Director, reporting to the Executive Director and providing support across agency divisions and programs. The Policy and Public Affairs Officer leads agency-wide efforts addressing community-based policy development and implementation; serves as the TCHD liaison with federal, state and local elected officials; works with agency leadership, staff and the board of health to develop and implement policy; and acts as an agency spokesperson in settings related to policy and relationship building. This work is done in collaboration with subject matter expert staff and with the goal of promoting, protecting and improving the lifelong health of individuals and communities in Adams, Arapahoe and Douglas Counties. Through a wide variety of internal and external engagement with a broad range of stakeholders, the Policy and Public Affairs Officer supports efforts to inform and educate about public health issues and functions, develop public health policies, enforce public health laws, and promote strategies to improve access to care. To support the agency in these areas, the Policy and Public Affairs Officer:

POLICY AND INTERGOVERNMENTAL AFFAIRS AGENCY SUPPORT AREAS

- Regularly researches legislative and government affairs issues and prepares information for the Executive Director, Executive Management Team, and Board of Health.
- Provides coaching and training to agency staff working with local governments and in policy adoption and implementation.
- Develops staff resources around the policy-change process, communication with elected officials, messaging and framing, and community engagement around public health policy.
- Works with staff across the agency to coordinate efforts and make connections.
- Develops a process for agency-wide, annual, policy agenda setting.
- Seeking opportunities to promote health equity in communities through collaboration with TCHD leadership, staff, and partners.

Policy and Intergovernmental Affairs cont.

POLICY AND INTERGOVERNMENTAL AFFAIRS AGENCY SUPPORT AREAS CONT.

- Enhances relationships and builds trust with elected officials, partners, communities and institutions across the TCHD jurisdiction.
- Hosts an annual elected officials event for all elected officials in TCHD's jurisdiction and includes speakers from the General Assembly, the Governor's Office, the Colorado Department of Public Health and Environment (CDPHE), the Denver Regional Council of Governments (DRCOG), and the Colorado Association of Local Public Health Officials (CALPHO).
- Creates and regularly disseminates Elected Officials Newsletter.

During the COVID-19 pandemic, the Policy and Public Affairs Officer provided and continues to provide very similar support within the emergency response framework related to COVID-19 policy, providing a direct connection between the state's COVID-19 policy makers and TCHD's leadership, staff, elected officials, partners, and stakeholders. New relationships have been made or enhanced through this work including work with businesses, schools, places of worship, parks and recreation departments, libraries, human services and other institutions.

Strategic Communications

The Office of Communications works to promote healthy behavior and reduce public health risks as well as educate the public through proven and diverse communication and marketing strategies. It also provides media and marketing training to staff. The activities of the Communications staff include; strategic communication planning; media relations; public information; adherence to brand standards; social media; measurement and evaluation of marketing and communication campaigns; media monitoring; oversight of the TCHD website and Intranet; marketing for TCHD programs and services; graphic design and production of brochures, fact sheets, collateral materials, and reports. Communications staff also work closely with regional partners such as cities and counties, schools, community partners and state and federal government to align and share public health messages.

Strategic Communications Program
Funding/Revenue Source(s): General Funds

FY21 Program FTE: 3.00
FY21 Program Budget: $374,668

Strategic Communications Metrics, 2019-2020

	2019	2020
Total media campaign impressions	100,664,586	59,314,808
Total website hits (sessions)	329,533	3,073,951
Total number of social media impressions (Facebook, Twitter, and Instagram)	1,224,302	3,176,038

Administration and Finance

The Administration and Finance Division provides support to the 11 TCHD offices in Adams, Arapahoe, and Douglas Counties. The Division develops the organization's annual budget and provides budgetary oversight along with the Executive Director, Deputy Director, and TCHD Division Directors.

TCHD has received an unqualified audit opinion for 2019 and for the past nine years in a row. The auditors found that the financial statements were in accordance with accounting principles generally accepted in the United States.

Administration and Finance Division
Funding/Revenue Source(s): General Funds

FY21 Division FTE: 30.25
FY21 Division Budget: $28,150,995

Revenues

Forecasted revenues for FY 2021 are estimated to be $55.5 million. This is a decrease of 7.18% as compared to the revenue projection of $59.8 million in the FY 2020 revised budget. This change in revenue is primarily due to CARES Act funding, in fee revenue and State contracts.

TCHD receives revenue to fund operations from a variety of sources, which are listed below.

County Appropriations – These are the funds provided by Adams, Arapahoe, and Douglas counties for core public health services through a per capita formula (currently $7.10).

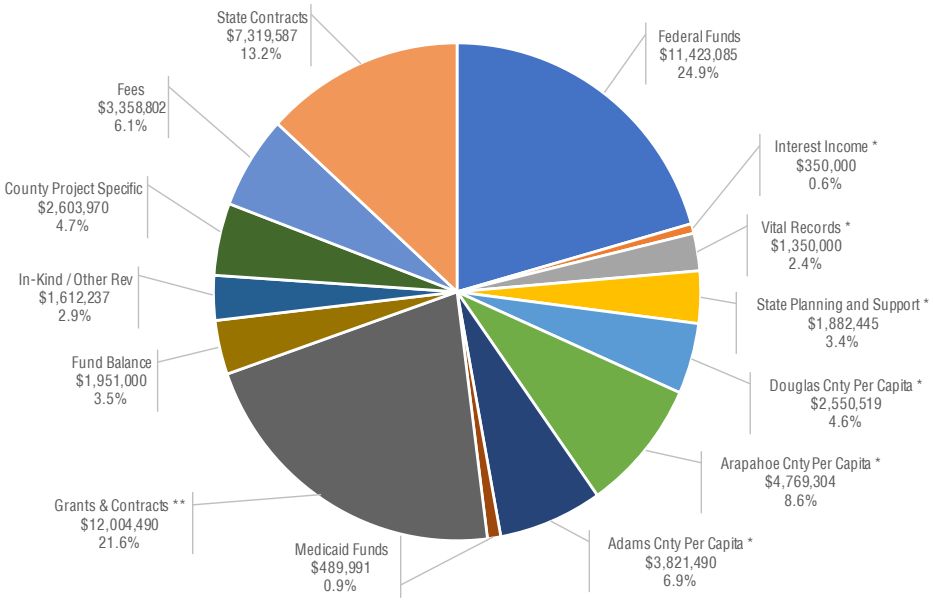
County Program Specific Funds – Funds provided by individual counties for specific programs.
Funds are restricted to these programs.

Grants/Contracts – Funding from foundations and other organizations for specific programs.
Funds are generally restricted to these programs.

Fees/Donations – Fees and donations collected while performing specific public health services (e.g., restaurant inspections) for the public or private businesses.

State Funds and Federal Pass through Funds – Funds received from the Colorado Department of Public Health and Environment (CDPHE) and other state agencies. This includes State Planning and Support for general public health services as well as program specific funding for programs in various TCHD divisions.

FYI 2021 Adopted Sources of Revenues, Total $55,486,920



Medicaid Funds – Nursing funding provided through joint federal and state government cooperation. These funds are received from providing direct services to qualified patients.

Use of Fund Balance – Operational funding provided from the TCHD Fund Balance for capital improvement purposes (i.e., facility renovations, information technology updates, other capital replacements).

In-Kind Revenue – Non-cash income that takes the form of provided supplies or free rent. In-kind revenue is offset in the budget by an equal amount of in-kind expense.

Budget Process

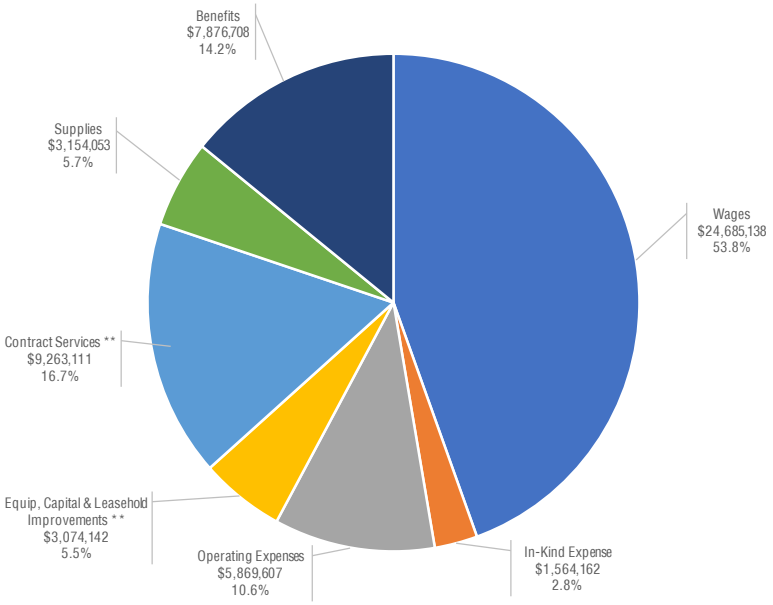
Tri-County Health Department is required to adopt an annual budget per Colorado Revised Statute (CRS) Title 29, Article 1, Section 103. The budget must include: adopted expenditures and revenues for the budget year; estimated beginning and ending fund balances; and, corresponding actual figures for the prior fiscal year and estimated figures for the current fiscal year. CRS Title 29, Article 1, Section 108 requires the TCHD Board of Health to hold a public hearing on the matter of adopting the adopted budget and subsequently adopt the budget after an affirmative vote of the majority of the board.

TCHD budgets annually on a calendar basis, January 1 to December 31. Budget revenues are identified by source. Expenditures are identified by agency, division, and program groups. For each of these groups, revenue and expenditures show the most recent completed and audited fiscal year, the current budget year, and the adopted budget. The budget must be balanced with expenditures not exceeding total anticipated revenue or general fund allocation (**FY21 TCHD Budget Book**).

Basis of Budgeting and Accounting

Tri-County Health Department uses the modified accrual basis of accounting for both budgeting and financial statements. Revenues are recognized in the accounting period when it is earned while expenses are recognized in the period when the liability is incurred. The budget is used as a legal instrument authorizing the expenditure of public funds, as an accounting framework for allocating fiscal stewardship, and as a management tool for planning the direction for utilizing revenues.

FYI 2021 Adopted Expenditures by Type, Total $55,486,920



Finance and Operations Program

The Finance and Operations Program within the Administration and Finance Division is dedicated to the people and the purpose of TCHD. The Finance and Operations Program maintains effective management of TCHD's financial activity and provides support services to all of the organization's divisions and programs. The role of this program is to oversee all financial aspects for the organization including coordinating financial activity to ensure that TCHD conducts business in accordance with Board of Health and TCHD policy and procedures and within all guidelines of Generally Accepted Accounting Principles. TCHD experienced increases in CORA requests and legal fees in 2020 due to COVID-19 pandemic response.

This Division is responsible for the oversight and management of all financial activities including:

Finance and Operations Program
Funding/Revenue Source(s): General Funds

FY21 Program FTE: 17.25
FY21 Program Budget: $15,350,149

FINANCIAL ACTIVITIES

Budget development, planning and management	Financial analysis, forecasting and reporting	Financial compliance with laws, regulations and policies
Annual external audit	Contracts management	Internal control policies and procedures
Accounts payable	Grants management	Payroll processing and compliance
Accounts receivable	Annual financial statement preparation	Cash and Investment management

TCHD Financial Operations Metrics, 2016-2020

	2016	2017	2018	2019	2020
Number of grants managed	83	89	88	91	90
Number of purchase orders fulfilled	2536	1932	1963	2129	1654
Number of purchasing cards managed	57	59	51	41	33
Number of annual purchasing card transactions	2,489	3,613	3,369	3,040	2,655
Number of contracts managed annually	224	219	249	218	268
Expense Contracts	105	82	120	92	109
Revenue Contracts	81	84	72	78	110
Other Contracts*	48	53	57	48	49
Cost of legal review of contracts	$40,489	$40,118	$23,445	$18,943	$10,327
Annual cost of litigation	$74,706	$71,697	$84,799	$69,920	$44,202
Number of Colorado Open Records Access (CORA) requests	11	31	116	74	122
Attorney-Initiated Requests	-	-	6	13	12
Media-Initiated Requests	-	-	10	9	19
Public-Initiated Requests	-	-	88	49	91
Outbreak-Associated Requests**	-	-	12	3	0
Annual cost of CORA requests	-	$4,433	$5,713	$9,119	$19,513
Total amount of legal fees paid	$138,928	$123,917	$117,646	$107,657	$199,651

**Other include intragovernmental agreements, memoranda of understanding, and non-denomination.*

***Outbreak Requests include 2019 Red Robin Outbreak, 2019 ICE Detention Center Outbreak, 2019 La California Outbreak, 2018 La California Outbreak*

Facilities

There are currently 11 offices located throughout the Tri-County region. Each county provides at least one office for use by TCHD at no cost, but there are many expenses that are paid for by the Department to meet the needs of programs and projects located in these offices. TCHD leases the other offices, which requires the Department to negotiate the leases and pay rent out of available funding. The budget for Facilities is included in Finance and Operations Program Budget above.

Facilities Program

Funding/Revenue Source(s): General Funds

FY21 Program FTE: 3.00
FY21 Program Budget: $450,846
FY21 In-Kind Revenue, Use of County-Owned Facilities (Rent): $428,162

Facilities, warehouse, distribution, and purchasing operations provide efficient and timely support to TCHD staff in the following areas:

FACILITY SUPPORT OPERATIONS

Vaccine storage	Motorized and non-motorized vehicle maintenance
Warehouse operations and delivery service	Strategic planning services related to office locations and space to optimize needs of the communities we serve
Remodel, repair, and maintenance services	

Facilities cont.

Facilities Metrics, 2016-2020

	2016	2017	2018	2019	2020
Number of reactive maintenance items	320	462	423	380	414
Number of scheduled maintenance items	28	45	26	39	37
Number of facilities tickets addressed and closed	348	520	440	650	408

FACILITY LOCATIONS

Administration (Leased)
6162 S. Willow Drive, Suite 100
Greenwood Village, CO 80111 303/220-9200

Aurora East: Colfax/Chambers
(Provided by Arapahoe County)
15400 E. 14th Place, Suite 115
Aurora, CO 80011 303/341-9370

Aurora South: Hampden/Chambers (Leased)
15192 E Hampden Avenue
Aurora, CO 80014 303/873-4400

Aurora West: Alton/Colfax WIC Services Only (Leased)
9000 E. Colfax Avenue, Suite 105
Aurora, CO 80010 303/361-6010

Brighton WIC Services Only (Leased)
30 S. 20th Avenue
Brighton, CO 80601 303/659-2335

Castle Rock (Provided by Douglas County)
410 South Wilcox
Castle Rock, CO 80109 303/663-7650

Commerce City (Provided by Adams County)
4201 E. 72nd Avenue, Suite D
Commerce City, CO 800221 303/288-6816

Englewood (Provided by Arapahoe County)
4857 S. Broadway
Englewood, CO 80113 303/761-1340

Lone Tree (Provided by Douglas County)
9350 Heritage Hills Circle
Littleton, CO 80124 303/784-7866

North Broadway Office (Leased)
7000 North Broadway #400
Denver, CO 80221 303/426-5232

Westminster (Leased)
1401 W 122nd Ave #200
Westminster, CO 80234 303/452-9547

Vital Records

TCHD is authorized by the State of Colorado to issue birth and death certificates through its Vital Records offices located in Greenwood Village, Commerce City, and Castle Rock. Our 5-Star Performance Award winning Vital Records Program is able to issue birth or death certificates for the State of Colorado regardless of the county of birth or death. Certificates can be issued through a wide variety of ordering methods such as in-person, online, by mail or electronically. Vital Records is a self-funded program through fees collected from services provided. Excess revenue from the Vital Records program is used to assist programs and services that are not fully funded. The Vital Records Office in Castle Rock opened in January 2018. TCHD had a decrease in birth and death certificates provided and subsequent revenue in 2020 due to the COVID-19 pandemic.

Vital Records Program
Funding/Revenue Source(s): Fees

FY21 Program FTE: 10.00
FY21 Program Budget: $1,350,000

Vital Records Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total revenue	$1,247,244.50	$1,377,853.50	$1,292,717.50	$1,290,175.00	$1,488,908.00
Commerce City	$448,092.50	$522,731.75	$371,255.50	$410,965.00	$541,635.00
Greenwood Village	$799,152.00	$855,121.75	$822,208.00	$760,044.00	$866,731.00
Castle Rock	-	-	$99,254.00	$119,166.00	$80,542.00
Total certificates issued	86,251	95,666	87,230	84,677	99,623
Commerce City	30,123	35,745	24,550	27,165	37,048
Greenwood Village	56,128	59,921	56,362	50,265	57,605
Castle Rock	-	-	6,318	7,247	4,970
Death certificate revenue	$871,328.00	$1,029,028.00	$889,022.00	$851,150.00	$1,093,435.00
Commerce City	$256,011.00	$397,831.00	$246,368.00	$308,715.00	$474,702.00
Greenwood Village	$615,317.00	$631,197.00	$605,551.00	$499,793.00	$587,786.00
Castle Rock	-	-	$37,103.00	$42,642.00	$30,947.00
Total death certificates issued	61,870	72,968	62,971	60,180	77,497
Commerce City	17,941	27,853	17,140	21,608	33,400
Greenwood Village	43,929	45,115	43,251	35,686	41,941
Castle Rock	-	-	2,580	2,886	2,156
Birth certificate revenue	$375,916.50	$348,825.50	$403,695.50	$439,025.00	$395,473.00
Commerce City	$192,081.50	$124,900.75	$124,887.50	$102,250.00	$66,933.00
Greenwood Village	$183,835.00	$223,924.75	$216,657.00	$260,251.00	$278,945.00
Castle Rock	-	-	$62,151.00	$76,524.00	$49,595.00
Total birth certificates issued	24,381	22,698	24,259	24,497	22,126
Commerce City	12,182	7,892	7,410	5,557	3,648
Greenwood Village	12,199	14,806	13,111	14,579	15,664
Castle Rock	-	-	3,738	4,361	2,814

Human Resources Division

Human Resources manages various employee-centered programs with a commitment to support the ever-changing employee and Agency needs. Human Resources services include recruitment, onboarding and orientation, benefits and retirement, compensation, compliance (Policy/Procedure/FMLA/ADA/Leaves of Absence), employee relations, employee health and wellness, employee performance management and development, employee recognition programs, and worker's compensation. The Human Resource team takes pride in providing a personal, honest, and objective approach. The team strives to be proactive, responsive, and a knowledgeable sounding board for employee needs while providing a robust array of human resource best practices.

Human Resources Division
Funding/Revenue Source(s): General Funds

FY21 Division FTE: 5.50
FY21 Division Budget: $706,231

Employee Recruitment

In 2019, the recruitment function moved from a manual system to an applicant tracking system resulting in a significant improvement to time to fill. TCHD recruits, screens, hires, and orients an average of 60 employees a year. In 2020 and 2021, recruitment contracted with over 350 temporary employees and volunteers to support the COVID-19 response.

Employee Benefits

Eighty-five percent of TCHD employees take the health and welfare benefits offered. For the last three years, TCHD has gone out to bid on various products to ensure our benefit costs are as competitive as possible while providing a high quality of products. TCHD has saved over $250,000 in premium costs in the last three years due to vendor improvements.

Employee Compensation

In 2019-2020, HR took the first step in a TCHD strategic plan initiative to update the competitive compensation and benefits and provide a higher level of transparency and understanding of TCHD pay practices. HR refreshed and standardized a market-based job classification framework, the TCHD Pay Plan, and developed an Employee Compensation Resource Guide. The result was an 18% jump in employee satisfaction in this area in 2020. A full market compensation review is completed every two years on every position and yearly on highly competitive jobs.

Employee Relations

TCHD has been successful in achieving a low rate of employee relations issues. There have been zero EEOC claims on TCHD in the last five years. HR provides ongoing employee relations support and counsel for leadership, and provides Management 101 training to ensure all new supervisors and managers start with essential tools to succeed in their new duties.

Workforce Development

Although the pandemic had a significant impact on staff capacity and agency goals, professional development and training remain essential at TCHD. Most in-person training has been adapted to virtual formats and ongoing content development to address evolving needs. TCHD identified professional development and training as a priority in 2019 within the agency Strategic Plan. This priority brought forward workforce development plans to promote and enhance staff learning and development opportunities. In January 2020, the agency formally introduced a Learning Management System (LMS) with a robust content library to over 400 agency staff. Today, 100% of all staff have logged into the LMS, and employees have completed 388 courses in just the last 30 days.

As Health Equity and Racial Justice became a critically important theme for the public health sector this past year, the agency prioritized training and educational strategies that specifically target these areas. All TCHD staff will complete a foundational Equity Training, Introduction to Health Equity and Racial Justice by November 2021. Through this training experience, staff will have increased familiarity with racial justice, understand how concepts apply to all aspects of agency work, gain specific historical and contemporary public policy examples to reference, and focus on relationship building with colleagues. The training is designed to be a catalyst for future initiatives for agency employees related to racial equity.

Workers' Compensation

In 2019, a new incident response reporting process was launched for workers' compensation claims, a new preventative approach to claims such as targeted ergonomic adjustments, staff education on the highest types of claims, ergonomic support to employees working remotely, and a collaborative approach to alert employees of safety issues such as ice in parking lots. These efforts, along with remote working, have had a significant impact with decreased claims in 2020. In the last two years claim costs have reduced approximately $80,000, leading to lower premiums in workers' compensation insurance for TCHD.

Employee Wellness

Employee Wellness Program
Funding/Revenue Source(s): General Funds

FY21 Program FTE: 1.00
FY21 Program Budget: $110,719

Wellness initiatives have long been associated with improving employees' health and morale, increasing productivity, decreasing absenteeism, and helping to control employer healthcare costs. TCHD's employee Wellness Program focuses on supporting employees to improve eating habits, adopt a more active lifestyle and maintain mental wellness. Modifying behaviors in these areas can lower one's risk for developing chronic conditions, including diabetes and heart disease. Family-friendly policies are also a focus of TCHD's internal program. These include flexible work schedules, infant-at-work, lactation-support, stress management training, mindfulness and meditation offerings, gym discounts, EAP support, and healthy meeting policies.

In 2020, Employee Wellness increased the emphasis on safe work practices and employee mental health wellbeing as many TCHD employees have deployed to work in COVID-19 emergency response positions. The Employee Wellness and the COVID-19 Safety Response Team have provided ongoing symptom screening process, COVID-19 return to work guidelines, mindfulness, meditation, stress management, and de-escalation training and support. Employee Wellness and the incident response Safety Team has initiated 19 critical incident therapy sessions with 271 participants to support employees dealing with the COVID-19 response concerns.

Human Resources Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total number of FTEs	249	300	288	291	334
Total number of individuals employed	408	417	411	385	388
Percent of employees retained	84%	87%	86%	87%	87%
Average tenure of employees in years	-	-	7	7	8
Total number of open positions filled	55	76	63	72	43
Total number of positions posted	-	-	-	95	91

Planning and Information Management Division

The Planning and Information Management Division enables TCHD employees and stakeholders to access and use information and data to inform decision-making through planning and evaluation by providing timely, responsive, and effective technical assistance and customer service across the agency and by creating value through interdisciplinary collaboration, process improvement, and effective communication. Services include: data collection, analysis, data visualization to monitor health status, to prioritize health issues, and to facilitate evidence-based decision making; identify technological solutions to meet agency needs and provide IT support and IT project management; manage performance management system development and maturation; facilitate continuous quality improvement; and provide agency-wide strategic planning and population-focused planning initiatives.

Planning and Information Management Division

Funding/Revenue Source(s): General Funds

FY21 Division FTE: 14.98
FY21 Division Budget: $2,689,493

Planning and Information Management Division Administration

This core leadership team is responsible for oversight, planning, implementation, and evaluation of programs within the Division. The Planning and Information Management Division administrative team consists of the Division Director, the Performance Management Coordinator, the Planning Initiatives Coordinator, the Program Planning and Evaluation Coordinator, and the Informatics Project Manager. The team is responsible for development and oversight of the agency's Strategic Plan and the Public Health Improvement Plan; the administration and oversight of the agency's performance management and quality improvement systems; program-focused planning and evaluation technical assistance; and assurance and oversight of the agency's large-scale technical projects through Informatics Project Management. Each function is described briefly below.

Division Administration

Funding/Revenue Source(s): General Funds

FY21 Program FTE: 4.00
FY21 Program Budget: $514,210

**Includes Division Director, Strategic Planning, Community Health Planning, Performance Management and Quality Improvement, Program Planning and Evaluation, and Informatics Project Management.*

Strategic Planning

In 2019, TCHD adopted a six-year agency-wide Strategic Plan. While much progress was made in 2020, some of TCHD's strategic efforts were paused due to the COVID-19 response. Activities will continue, or resume, in 2021 dependent on the agency's capacity to shift resources from the COVID-19 response.

The Priority Areas include Employee Retention and Development, Excellence in Business Practices, Strengthen Organizational Culture, and Partner for Healthy Communities. The Priority Areas help support, either directly or indirectly, both our core services as well as the implementation of the Public Health Improvement Plan. The plan provides the agency with a roadmap that allows the agency to navigate changes in the complex environment of public health at the local level and further allows TCHD to take action on critical issues and to advance our mission, vision and values. **TCHD Strategic Plan**.

Community Health Planning: Public Health Improvement Plan

Our 2019-2024 Public Health Improvement Plan includes three primary Priority Areas and one developmental Priority Area. These include: Access to Mental and Physical Health Care Services, Mental Health, Health and Food, and the developmental priority area, Health and Housing. Activities in each priority area shifted in 2020 to focus on the impact due to COVID-19. Housing, food, access to care, and mental health have become more critical than ever during the response to COVID-19. These key drivers of health have been central to the COVID-19 human needs response as the impacts of this virus have tested our economic and social structures in deep ways. These efforts will continue through 2021. The vision for each Priority Area is listed below. **TCHD Public Health Improvement Plan**

Community Health Planning: Public Health Improvement Plan cont.

TRI-COUNTY PUBLIC HEALTH IMPROVEMENT PLAN PRIORITY AREAS

Access to Mental and Physical Health Care Services

Vision: *In a healthy community, all people across the life course, regardless of their income or other circumstances, can access high quality physical health, mental health, and substance use services.*

Mental Health

Vison: *In a healthy community, positive mental health and social connections allow people to have the mental and physical energy, vitality, and resilience to live joyfully and cope with the stresses of life, work productively, and make meaningful contributions to their communities.*

Health and Food

Vison: *In a healthy community, all residents can access safe, nutritious, affordable, and culturally relevant food and are able to practice healthy eating habits.*

Health and Housing

Vison: *In a healthy community, quality, attainable housing is available and people have the tools and resources to stay in their communities and feel connected to their neighborhood.*

Program Planning and Evaluation

The Planning and Information Management Division provides program planning and evaluation services to internal programs and to external partners. Staff ensure appropriate understanding and use of data for public health assessment, planning, and evaluation. This work includes writing evaluation sections of grants; creating logic models for program planning or re-assessment; correcting, analyzing, and reporting data from evaluation plans; assisting staff in designing and conducting research projects; developing and updating targets for population health measures for Public Health Improvement Plan, Strategic Plan, and program dashboards; and working with staff to include evidence-based strategies in their program planning, assessment, and evaluation.

Highlights of planning and evaluation projects in the past several years include:

INTERNAL WORK

- 2018 Community Health Assessment
- 2019-2024 Public Health Improvement Plan
- 2019-2024 TCHD Strategic Plan
- Grant Writing Assistance for STI Program, Title X program, Tobacco Grant Programs, Arapahoe County Senior Dental Clinic
- NEAR@Home Home Visitation Model Evaluation
- Nurse Support Program Annual Evaluation and Data Analysis
- Nurse Support Program One Key Question Analysis
- Partnership Tracking Tool Evaluation
- Title V Maternal and Child Health Program Strategic Planning
- Tobacco Program Logic Models

PARTNER WORK

- Community Pharmacist Pilot Evaluation
- Douglas County School District Restorative Justice Evaluation Mapping, consultation
- Douglas County School District Sources of Strength Qualitative Data Analysis
- Early Childhood Partnership of Adams County Teen Parent Data & Resources Storymap
- Evaluation and Assessment for the Douglas
- County Youth Substance Abuse Coalition
- Evaluation Consultation with the Crisis Center
- Food Survey of Refugee Families in partnership with the Colorado African Organization
- Let's Talk Stigma Reduction Campaign Evaluation
- Metro Denver Healthy Beverage Partnership Strategic Planning Facilitation
- South Metro Health Alliance Storymap

Performance Management and Quality Improvement

The purpose of the Performance Management and Quality Improvement (PMQI) program at TCHD is to support and promote operational excellence for all people, processes, and programs throughout the agency. The PMQI program does this by providing training, coaching, and data management as well as providing its two main deliverables: the Performance Management System and Lean Process Improvement. Some of the major accomplishments of the PMQI program include the following.

PERFORMANCE MANAGEMENT AND QUALITY IMPROVEMENT: RECENT ACCOMPLISHMENTS

- The creation of quality improvement (Lean) training complete with standard tools that aid the agency in planning, executing, and documenting innovation.
- The creation of performance dashboards for all major programs throughout the agency that include process, outcome, and population measures. These dashboards were heavily utilized for the creation of this report.
- The creation of performance forums where programs present their progress, challenges, and innovations to their colleagues throughout the agency as a form of positive accountability and peer learning.
- The creation of the PMQI Council that includes individuals from all divisions who receive specialized training so they can serve as coaches and champions who promote a culture of quality throughout the agency.
- The completion and sustained usage of the QI Self-Assessment Tool 2.0, originally developed by the National Association of County and City Health Officials (NACCHO), so that our performance management system itself is able to be assessed and improved over time.

The PMQI program also functions as a source of consultation and project management for the agency on an ongoing basis. This often includes the facilitation of meetings and events specifically tailored to the needs of a given project (i.e. brainstorming, process mapping, root-cause analysis, etc.). Additionally, the PMQI program has provided assistance as part of TCHD's response to the COVID-19 pandemic. When establishing processes for case investigation and contact tracing, the PMQI program facilitated process mapping and documenting of standards. The PMQI program also helped lead efforts throughout the response that resulted in increased documentation and tracking.

Public Health Accreditation

The Public Health Accreditation Board (PHAB) nationally recognized Tri-County Health Department in November 2017 for demonstrating excellence in the field of public health. Earning National Accreditation for five years means that TCHD meets or exceeds the rigorous standards established by the non-profit, non-governmental PHAB. TCHD was noted for its strong quality improvement culture, for using evidence-based practices in TCHD programs and strategies as well as for TCHD's strong relationships with TCHD's community partners and the Board of Health. The achievement of National Accreditation and TCHD's annual reporting to maintain accreditation continues to help guide the agency's work to better protect, promote, and preserve the health of the people in the community. In 2022, TCHD will be applying for PHAB re-accreditation, and will be preparing required documentation for this application process in 2021-2022.



Informatics Project Management

The Informatics Project Manager's role is to identify, implement, and evaluate innovative applications of technology and information systems that address agency and public health priorities by analyzing how information is organized and used, and to provide oversight over project planning and implementation of informatics and information technology (IT) solutions. The Informatics Project Manager catalogues current information systems, identifies vulnerabilities and gaps, and recommends corrective actions. The Project Manager models business processes and workflows within projects or programs, with input from program staff and vendors, and works with program staff and stakeholders to design or procure information systems that meet user needs. For prioritized projects, the Project Manager delineates system and user requirements for cost, timeliness of access, and breadth and depth of information. This individual manages user support for certain projects.

Information Technology Program

Information Technology Program
Funding/Revenue Source(s): General Funds

FY21 Program FTE: 6.00
FY21 Program Budget: $1,504,958

The Information Technology (IT) program is designed to provide a self-supporting, reliable, and secure computer operating architecture and environment at TCHD. The IT program supports both full and part-time TCHD employees by administering account information, assisting with application software issues, and solving technical problems using an efficient Help Desk system. IT configures, implements, maintains, monitors, and administers a wide variety of network and communication services such as: voice over IP (VoIP) systems, server equipment, personal computers, and associated peripheral hardware. Additionally, IT maintains computer equipment inventories, administers cellular phones, and ensures software license compliance. The IT team also provides and operates a reliable, robust, and secure infrastructure to support mission-critical applications software for electronic health records system, accounting system (financial, payroll, procurement, and reporting services), E-mail services, environmental health system, and Women, Infants and Children (WIC) support. Finally, they monitor, maintain, and administer IT security, Internet connectivity, and the Wide Area Network infrastructure that connects all TCHD locations to the agency's central computing resources, including a disaster recovery site/plan. IT was instrumental in implementing innovations around the COVID-19 response that allowed TCHD staff to work remotely, to support various technical aspects of the response, and in ensuring the provision of core public health services in these challenging times.

TCHD's IT Program continues to improve, optimize, and streamline IT operations. In 2019, the IT Program examined its internet service provider to ensure that services were meeting the needs of the agency's demands for bandwidth, especially as the agency increases utilization of cloud-based applications; a new internet service provider was chosen, which resulted in a 1500% increase in available bandwidth and an 82% decrease in agency internet costs, saving TCHD over $23,000 per year. In 2020, TCHD evaluated the standard laptop issued to TCHD staff and aligned TCHD staff work requirements with laptop specifications, which resulted in a costs savings of over $22,000 per year.

Cybersecurity and innovation are also critical goals of the TCHD IT Program. Cybersecurity remains a critical focus to combat emerging threats to the TCHD data and computing environments. TCHD conducted a third-party cybersecurity audit in 2019 and plans to conduct these audits biannually. In 2019, the TCHD IT Program implemented a cybersecurity Layered Network Security (LNS) model, ensuring no single device or system was responsible for cybersecurity alone. This model included implementing geographical protection from attackers, internal firewalls separating TCHD staff machines from critical TCHD servers, and zero-day threat emulation with endpoint protection. The LNS model won a Promising Practice Award from NACCHO. The model continues to evolve, protecting TCHD from an ever-increasing amount of cybersecurity threats each day.

Lastly, when the COVID-19 pandemic struck Colorado, the need for remote-operated call centers, remote work needs, and a shift of technological focus was required. To meet these unprecedented challenges, the TCHD IT Program implemented a new communications platform, migrating the on-premise system to a secure, HIPAA-compliant phone service. This implementation allowed for social distancing, while still meeting the needs of the populations TCHD serves. In addition, an entirely new firewall cluster was implemented, with enhanced remote work and threat prevention capabilities. This allowed for all TCHD staff to perform their work remotely, and continue to serve the public at a high level during a time when the most help was needed.

Information Technology Program cont.

Information Technology Metrics, 2016-2020

	2016	2017	2018	2019	2020
Percent uptime	99.11%	98.93%	98.77%	99.87%	99.67%
Uncontrolled downtime, in hours	19.5	23.5	27	11	28.5
Controlled downtime, in hours	42	44	42	49.5	38
Number of controlled outages	13	14	12	8	13
Number of IT helpdesk tickets resolved	3,413	3,623	3,650	3,434	4,324

Health Data and Geographic Information System (GIS)

The Health Data and GIS Program specializes in analyzing public health data in the context of how communities, cultures, and the physical environment can influence population level health. This is accomplished through the collection, management, and analysis of health, demographic, and community data—bringing them together in a way that can communicate the complex factors around health. This involves analyzing those relationships through GIS, statistical modeling, community engagement, and by creating useful data dissemination products through thoughtful graphic design and presentation. Through these processes, the Health Data and GIS Program is committed to a forward-thinking approach to health data, analysis, and data tools used across the agency and provides data and information to TCHD programs, elected officials, county and city staff, the public, and partners with the goal of improving communities through better opportunities for health.

Health Data and GIS Program
Funding/Revenue Source(s): General Funds

FY21 Program FTE: 4.00
FY21 Program Budget: $441,823

The Health Data and GIS Program is responsible for the collection, understanding, monitoring of all health and environment datasets used in the work of a public health department. These include but are not limited to:

HEALTH AND ENVIRONMENTAL DATASETS

- Vital Records (birth & death certificate data)
- All routine health surveillance datasets
  - Behavioral Risk Factor Surveillance System (BRFSS)
  - Healthy Kids Colorado Survey
  - Pregnancy Risk Assessment Monitoring System (PRAMS)
  - National Violent Death Reporting System
- Colorado Hospital Association Data
- US Census and American Community Survey Datasets
- Colorado Health Observation Regional Data Service
- Colorado Immunization Information System
- TCHD Facility Inspection (Restaurant) data
- TCHD Onsite Waste Water Treatment System Inspection/Permitting
- Colorado Division of Water Resources
- Colorado Oil & Gas Conservation Commission

Health Data and GIS cont.

Development of data and analytic services across the agency as needed by program staff. This includes but is not limited to:

DATA AND ANALYTIC SERVICES

• Digital data collection tools	• GIS mapping
• Analytics within the following platforms	• Data storage and management solutions
• SAS, GIS, SQL	• Web mapping tools
• Statistical modeling of health outcomes	• Dashboards (Tableau, ESRI)
• Website development for data delivery	• Creating of factsheets, infographics, page layout (Adobe Creative Suite)
	• Data automation

INFRASTRUCTURE ADMINISTRATION AND MAINTENANCE

- ArcGIS Enterprise (On Premise) / ArcGIS Online
- SQL Server
- FME Server
- Tableau Server (On Premise), Tableau Public
- Windows IIS webhosting (https://data.tchd.org)

CORE TECHNICAL SKILLSET OF TEAM

- Advanced statistics
- GIS
- Graphic/Website design
- Coding languages:
  SAS, HTML, Python, SQL, R, Arcade,
- Data automation

The Health Data and GIS Program has taken an approach of delivering health information based on topic where the goal was to not just turn around data that may be available from the state health department or elsewhere, but to compile all the data around a topic—including non-health datasets that may influence a health outcome—and begin to tell an understandable story about what and where issues are occurring with the community. The following are a few examples of these products:

WEB-BASED DATA DELIVERY

Opioid Misuse - *https://opioid-tchdgis.opendata.arcgis.com/*
Substance Abuse - *https://substanceabuse-tchdgis.opendata.arcgis.com/*
Mental Health - *https://mentalhealth-tchdgis.opendata.arcgis.com/*
Youth Tobacco Use - *https://tobacco-tchdgis.opendata.arcgis.com/*
African American Infant Mortality - *https://infantmortality-tchdgis.hub.arcgis.com/*
Household Chemical Round-Up- *https://storymaps.arcgis.com/stories/325445a7d14045c095d3b161e12166c0*
Oil and Gas Operations - *https://tchdgis.maps.arcgis.com/apps/webappviewer/index.html?id=00008781f6834cec92386ddffa22c52e*

Health Data and GIS cont.

Health Data and GIS: Awards

PROGRAM RECOGNITION

- 2017 ESRI Special Achievement in GIS Award
- 2018 NACCHO Model Practice Award
- 2020 ESRI webinar on TCHD's COVID1-19 case investigation/contact tracing system
- 2020 FME webinar on TCHD's COVID-19 data automation
- 2020 Center for Digital Government – County Government Experience Award for TCHD's COVID1-19 case investigation/contact tracing system
- 2020 NACCHO webinar on TCHD's COVID1-19 case investigation/contact tracing system
- 2020 Colorado Public Health Association Technical Innovation Award for TCHD's COVID-19 case investigation/contact tracing system
- 2021 ESRI Map Book showcase of TCHD's COVID-19 data work

Medical Epidemiology

TCHD's Medical Epidemiologist consults with programs throughout the agency TCHD seeking expertise in epidemiologic analyses, knowledge on the clinical aspects of disease, or medical interpretation of data. Additionally, this position also oversees development and implementation of epidemiology-based studies for the agency on a wide variety of public health topics. TCHD's Medical Epidemiologist has been a critical resource to staff throughout the COVID-19 response by providing specific infectious disease medical expertise across a multitude of topics.

Medical Epidemiology

Program Funding/Revenue Source(s):
General Funds

FY21 Program FTE: 1.00
FY21 Program Budget: $228,502

In 2018, a team of TCHD epidemiologists focused on a teen pregnancy prevention project. The team completed demographic analysis of teen births in the TCHD region, which identified specific areas in Adams and Arapahoe counties with a disproportionate burden of births impacting Hispanic teens. This work was followed by a qualitative study of beliefs and attitudes around teen pregnancy among Hispanic youth, parents, and sexual health service providers in Aurora, Thornton, and Commerce City. TCHD's Teen Pregnancy Prevention report provided valuable insight into the risk and protective factors for teen pregnancy through the voices of teens and parents. Key themes included the need for better communication around pregnancy prevention and access to quality education on sexual health for both teens and parents.

HIPAA Compliance

TCHD is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and must maintain strict compliance with this Act, as the agency provides clinical services and obtains, stores, and transmits protected health information (PHI) routinely. Currently, TCHD's Director of Planning and Information Management serves as TCHD's HIPAA Privacy Officer and the IT Operations Manager serves as TCHD's HIPAA Security Officer. Collectively, they are responsible for assuring TCHD's policies, procedures, and practices are in compliance with HIPAA, are responsible for investigation potential breaches of HIPAA, and provide recurrent HIPAA training to all staff. HIPAA Compliance is provided in-kind by Planning and Information Management Division Administration.

Community Health Promotion

The Community Health Promotion (CHP) Division advances population health by promoting changes in policies, systems, and environments that support community nutrition, breastfeeding, healthy school environments, maternal and child health, mental and behavioral health, workplace wellness while preventing substance abuse, injury, diabetes, and tobacco use and exposure.

Community Health Promotion Division

Funding/Revenue Source(s): General Funds, County Restricted Funds, State Restricted Funds, Federal Restricted Funds, Other Restricted Funds, and In-Kind Revenue

FY21 Division FTE: 28.40
FY21 Division Budget: $3,654,920

Community Health Promotion Division Administration

The CHP leadership and administrative team provides oversight and support for planning, implementation, performance management and quality improvement of Community Health Promotion activities and programs. Additional responsibilities include financial oversight, grants and contracts management, ensuring adherence to agency policies and processes, administrative support, and advancing prioritized efforts to support the TCHD Strategic Plan and Public Health Improvement Plan.

Community Health Promotion Division Administration

Funding/Revenue Source(s): General Funds

FY21 Program FTE: 2.40
FY21 Program Budget: $310,027

Tobacco Education and Prevention

The Tobacco Education and Prevention Program focuses on evidence-based policy, systems, and environmental change strategies as well as community engagement and education for decreasing youth and adult tobacco and nicotine use. Efforts focus on policy changes to prevent youth access to and initiation of nicotine products and the elimination of secondhand smoke and nicotine aerosol exposure. Staff work through strategic partnerships to promote smoking cessation among target populations and support school districts, public housing authorities, detention facilities, youth-serving organizations, healthcare providers, and municipal governments and other community agencies. Tobacco Education and Prevention also partners closely, including through shared staff, with the Substance Use Prevention Program staff on interventions addressing shared risk and protective factors – factors in the community that make young people more or less likely to engage in risky behaviors including use of tobacco and other substances. This program also works towards achieving goals in the Mental Health and Housing priorities of the TCHD Public Health Improvement Plan.

Tobacco Education and Prevention Program

Funding/Revenue Source(s): Restricted State Funds

FY21 Program FTE: 7.00
FY21 Program Budget: $1,318,077

TCHD regularly invests grant funding directly with community partners who chose to engage in tobacco prevention work. Through a sub-grants, TCHD has funded 13 school districts, four housing authorities, four youth-serving organizations, and two institutions of higher learning since 2013. This approach supports reinvestment of tax dollars directly into the community, builds capacity among community partners, and has helped catalyze dozens of policies and practice changes protecting hundreds of thousands of students, residents, workers, and visitors to TCHD counties. In the last two years alone, the Tobacco Education and Prevention team has advocated for strong tobacco control policy in municipalities in all three counties and supported the passage of four smoke-free and retail licensing ordinances in all three counties. In addition, a total of 120 participants were enrolled in tobacco cessation classes and counseling in the prior year.

Tobacco Education and Prevention cont.

Tobacco Control Policy Work by County, 2016-2020

	2016	2017	2018	2019	2020
Number of local governments actively engaged with TCHD in tobacco control policy work	3	4	3	9	9
Adams	1	1	1	2	4
Arapahoe	1	2	1	3	2
Douglas	-	-	-	2	2
Adams/Arapahoe	1	1	1	2	1
Number of new or expanded municipal policies (smoke free or youth access)	2	-	-	4	3
Adams	-	-	-	1	1
Arapahoe	2	-	-	1	-
Douglas	-	-	-	1	-
Adams/Arapahoe	-	-	-	1	2
Number of partners funded to advance tobacco prevention, cessation, and control	16	16	16	4	5
Adams	7	7	7	2	2
Arapahoe	6	6	6	1	1
Douglas	1	1	1	1	1
Adams/Arapahoe	2	2	2	1	1
Number of youth-created media campaign impressions	15,695,948	22,606,193	15,804,186	7,707,589	29,206,909

Substance Abuse Prevention

At the request of the County Commissioners, TCHD facilitates the Tri-County Overdose Prevention Partnership (TCOPP), comprised of partners across the three counties coming together to address opiate use, prevent initial use, reduce and prevent deaths, and provide for a supportive community. TCOPP implements a seven-strategy framework focused across the continuum from primary prevention through treatment and recovery. TCHD also supports a community coalition facilitated by Douglas County School District (through a formal partnership agreement) and one in Aurora, both of which utilize SAMHSA's Strategic Prevention Framework to assess community needs, plan evidence-based interventions, and evaluate success. TCHD implements the Communities That Care prevention model along the 1-70 corridor and Western Arapahoe County

Substance Abuse Prevention Program

Funding/Revenue Source(s): General Funds, Restricted State Funds, Restricted Federal Funds

FY21 Program FTE: 3.94
FY21 Program Budget: $632,592

**Includes SAMSHA grant*

Substance Abuse Prevention cont.

to prevent youth crime and violence, as well as substance use initiation. This model helps local communities identify and assess locally-relevant risk and protective factors and then select from a menu of effective, evidence-based programs and strategies to address the specific needs of local youth. TCHD's Substance Abuse Prevention programs partners closely, including through shared staff, with the Tobacco Education and Prevention program and the Maternal and Child Health Program on interventions addressing shared risk and protective factors – factors in the community that make young people more or less likely to engage in risky behaviors including use of tobacco and other substances as well as more or less likely to experience poor mental health and attempt suicide. Many of these programs work towards achieving goals in the Mental Health and Access to Care priorities of the TCHD's Public Health Improvement Plan.

The focus for all programs is collaboration – all substance use prevention work is done through partnerships and coalitions. Staff are especially proud of the continuous growth of these TCHD-supported partnerships through new members and increased participation by new and long-time members. TCHD has been awarded three highly-competitive grant awards in the last two years for coalition development for youth substance use prevention, an acknowledgment of TCHD's strong partnerships and engaged communities. Highlights of coalition achievements include a pilot of a restorative discipline practices in one school district, youth-led community beautification projects in two communities, parent education events and webinars, and a youth-created media campaign.

Substance Abuse Prevention Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Number of Assessments Completed	1	2	3	-	4
Adams	-	-	-	-	1
Arapahoe	-	1	1	-	-
Douglas	1	-	-	-	-
Adams/Arapahoe	-	1	1	-	2
Adams/Arapahoe/Douglas	-	-	1	-	1
Number of Community Coalitions for Substance Abuse Prevention	4	6	6	6	5
Adams	1	1	1	1	-
Arapahoe	-	1	1	1	1
Douglas	1	1	1	1	1
Adams/Arapahoe	1	2	2	2	2
Adams/Arapahoe/Douglas	1	1	1	1	1
Number of partners supported with technical guidance and funding to advance youth substance abuse prevention	-	2	2	3	3
Adams	-	-	-	-	-
Arapahoe	-	1	1	1	1
Douglas	-	-	-	1	1
Adams/Arapahoe	-	1	1	1	1

Mental and Behavioral Health Promotion and Suicide Prevention Program

Mental and Behavioral Health Promotion and Suicide Prevention Program

Funding/Revenue Source(s): General Funds

FY21 Program FTE: 1.10
FY21 Program Budget: $131,067

**Includes NENS Referral Grant*

TCHD serves as a convener and backbone to collective work and where appropriate, is uniting efforts across sectors to implement the recently developed TCHD-area Mental Health Promotion Framework and the TCHD-area Suicide Prevention Framework. Staff assess and communicate community needs, gaps, and solutions; analyze and share data, trends, and evidence-based practices; and lead identification of barriers and implementation of effective strategies. A priority is placed on reducing mental health stigma; increasing access to and utilization of services; reducing environmental, social, and economic factors that contribute to stress (e.g., increase access to affordable housing and reducing food insecurity); and building capacity within other sectors, including school districts. Throughout future implementation, community members will influence the work and strategies will aim to reduce inequities. The TCHD-initiated regional mental health campaign, Let's Talk Colorado, which has grown to a widespread collaboration among local public health agencies and healthcare systems, was recognized as a promising practice in 2020 by the National Association of City and County Health Officials.

A related effort, the Non-English, Non-Spanish (NENS) Referral Grant Project, is funded through the Denver Health and Hospitals Foundation to improve navigation within the Early Intervention System, which among other interventions helps ensure early intervention for social-emotional and behavioral health needs. Historically, the existing system is built in a manner that best serves English speakers, and is not easy to navigate if a family speaks another language. In response, NENS project assists patients 0-5 years through the use of linguistically and culturally responsive multilingual care navigation by ensuring NENS children and adults screened and referred for specialty care and services are able to access that care, and connecting NENS child and adult patients without a medical home. Through this project, TCHD works to create a streamlined referral-to-evaluation process for NENS children who are referred from the Denver Health Lowry clinic.

Additional mental health promotion efforts are described throughout this report in sections including but not limited to those focused on perinatal health, child and adolescent health, substance abuse prevention, worksite wellness, and medical home for children and youth with special healthcare needs.

Let's Talk Colorado Mental Health Campaign Metrics, 2017-2020

Year	Number of Media Impressions
2017	45,617,882
2018	55,729,056
2019	48,303,603
2020	48,161,411

Maternal and Child Health (MCH) Block Grant

Maternal and Child Health Program

Funding/Revenue Source(s): Restricted Federal Funds, Restricted State Funds

FY21 Program FTE: 4.31
FY21 Program Budget: $671,790

Maternal and Child Health (MCH) Block Grant cont.

Child and Adolescent Health

TCHD leverages funding from the Maternal and Child Health Block Grant to support a variety of efforts focused on improving child and adolescent health. Work in this area includes a focus on early childhood developmental screening and referral and reducing bullying and suicide among youth. TCHD staff work with partners across the early childhood and youth systems in all three counties to identify gaps, and improve and align support and services, for children, youth and families. Bullying and youth suicide prevention within the Community Health Promotion division has worked to examine community-level factors affecting multiple kinds of violence and injury prevention, including issues related to substance abuse prevention and physical and mental health outcomes. Strategies utilized are aimed at addressing the underlying factors that influence multiple health outcomes. Staff work across school districts to share information and community resource linkages related to preventing bullying and youth suicide using a framework of shared risk and protective factors. Additionally, through the legislatively mandated, TCHD-led Child Fatality Review Teams (CFRT), staff utilize data and partnerships to inform and improve youth suicide prevention work within communities.

The majority of the program is supported financially by the Federal Maternal Child Health Block Grant (Title V). This program helps achieve objectives within the Mental Health priority in the TCHD Public Health Improvement Plan.

Child and Adolescent Health Program Metrics, 2019-2020

	2019	2020
Number of children who have been impacted by developmental screening/referral	523	676
Number of staff who have been trained on ASQ and/or ASQ:SE and referral processes	99	144

Medical Home for Children and Youth with Special Healthcare Needs

TCHD leverages funding from the Maternal and Child Health Block Grant to support efforts aimed at improving access to and coordination across medical care and community resources for children and youth with special healthcare needs. TCHD staff work with partners across the system of care for children and youth to remove barriers to quality care. The majority of the program is supported financially by the Federal Maternal Child Health Block grant (Title V).

Perinatal Health

TCHD leverages funding from the Maternal and Child Health Block Grant to support initiatives to improve the health of women of reproductive age. Current priorities include increasing identification, screening and referrals for women experiencing maternal mood disorders, increasing support and services for women who misuse substances in the perinatal period and decreasing the disparities in infant mortality. The majority of the program is supported financially by the Federal Maternal Child Health Block grant (Title V), administered by CDPHE. This program work supports the Mental Health priority in the TCHD Public Health Improvement plan. TCHD's perinatal health initiative, including collaborative leadership with Denver Public Health, was recognized as a cutting edge practice in 2020 by the National Association of Maternal and Child Health Programs.

Perinatal Mental Health Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Number of referrals to Community Mental Health Center (community outreach, Adams County only)	21	70	111	114	58
Number of community partners utilizing pregnancy-related depression (PRD) awareness messaging in daily operations (all counties)	-	24	19	15	9
Number of pediatric and OB/GYN practices completing PRD screening and referral improvements	5	4	4	-	-

Maternal and Child Health (MCH) Block Grant cont.

Perinatal Health cont.

Perinatal Substance Use Prevention Program Metrics, 2019-2020

	2019	2020
Number of community partners and healthcare providers trained on perinatal substance use prevention	20	13
Adams	16	8
Arapahoe	4	4
Douglas	-	1
Number of TCHD staff trained on perinatal substance use prevention	54	51
Adams	21	-
Arapahoe	29	51
Douglas	4	-

Advancing Breastfeeding in Colorado

The goal of this project is to transform communities to support health by reducing barriers to breastfeeding and promoting breastfeeding-friendly environments. This initiative is part of a regional collaborative funded through CDPHE's Cancer Cardiovascular and Pulmonary Disease (CCPD) Grant Program. Partners working together to leverage resources and maximize capacity include Denver, Jefferson County, Boulder County, and Tri-County health departments. The program's target settings are childcare providers and medical offices that serve low-income families. Team members collaborate closely with staff working under TCHD's CCPD-funded Worksite Wellness Initiative. Existing coalitions, developed under the Worksite Wellness Initiative, are leveraged to support and facilitate the objectives of the breastfeeding initiative. The Colorado Health Institute serves as regional fiscal manager.

Advancing Breastfeeding in Colorado Program

Funding/Revenue Source(s): Restricted State Funds

FY21 Program FTE: 1.00
FY21 Program Budget: $137,839

Advancing Breastfeeding in Colorado - CCPD Grant Funded: This 3-year project involves working one-on-one with childcare centers to guide them through the process of achieving the Colorado Breastfeeding Friendly Certification. The process of becoming certified can take a year or more because it requires childcare centers to implement significant policy and environmental changes. The first year of the project (2018) was focused on recruiting childcare settings and providing technical assistance on the process of certification. During year two (2019) the centers adopted policies and created lactation spaces, with some achieving certification. Year three (2020) numbers reflect the impact of the pandemic which virtually halted progress for a six-month period.

Number of New (Unique) Childcare Settings Provided with Technical Assistance (TA), 2018-2020

	2018	2019	2020
Adams	5	13	0
Arapahoe	14	8	1
Douglas	0	11	0

Number of Lactation Spaces Created in Childcare Settings, 2018-2020

	2018	2019	2020
Adams	1	5	0
Arapahoe	1	3	2
Douglas	0	3	1

Number of Childcare Settings to Earn the Breastfeeding Friendly (BFF) Certification, 2018-2020

	2018	2019	2020
Adams	0	3	2
Arapahoe	0	4	0
Douglas	0	3	0

Community Nutrition

Community Nutrition Program
Funding/Revenue Source(s): General Funds

FY21 Program FTE: 3.50
FY21 Program Budget: $415,951

Staff collaborate with early childhood entities, school districts, workplace partners and community organizations to promote sustainable, evidence-based healthy eating and active living policies and practices. Technical assistance is provided to assist organizations with assessing current practices, adopting and implementing long-term changes, and connecting with additional resources to meet identified needs, which leverages and extends grant-funded efforts. TCHD registered dietitians bring a public health lens to community organization boards and committees, actively collaborate on healthy eating and active living messaging campaigns, and provide data and subject matter expertise to inform public policy and proposed regulations. TCHD works with school districts, serving on district wellness committees and engaging school leaders to advance district priorities, communicate guidelines, and promote adoption of best practices. Other examples include serving on early childhood councils, chamber of commerce committees, parks and recreation collaboratives, and other community coalitions. Staff convene external partners and internal cross-program workgroups to enhance planning and coordination of TCHD's advocacy and education with childcare and school sectors. Additionally, this team coordinates a centralized system for responding to the high volume of ad hoc requests received by TCHD's main line for participation in health-influencing community events. TCHD's centralized event system ensures rapid response, resource-saving efficiencies and high partner satisfaction among a wide variety of requesting governmental agencies, community based organizations, hospitals and more. TCHD participated in 133 health-supporting community events requested via this pipeline in 2019, reaching over 5,965 community members. Although the number of events TCHD participated in during 2020 was limited to 41 due to COVID-19 restrictions, 2,372 community members were reached with in-person events during the first quarter and then virtual presentations, drive-through food pantries, drive through resource fairs, and participation in farmer's markets for the remainder of the year.

Early Childhood Health Promotion Metrics, 2016-2020

	2016	2017	2018	2019	2020
Early Childhood Education providers trained*	175	199	141	180	89
Adams	-	7	19	13	13
Arapahoe	-	62	91	96	59
Douglas	-	130	31	71	17
Healthy Eating Active Living (HEAL) Best Practice Self-Assessments Collected from providers	13	12**	19**	33**	5
Adams	4	3	5	-	-
Arapahoe	8	5	7	30	5
Douglas	1	3	4	2	-

**Numbers by county are estimated and are counted by the county where the training occurred, not necessarily where the provider practices. Trainings are conducted by the Early Childhood Nutrition Specialist.*
***Includes one or more assessments outside of jurisdiction.*

Following training sessions, those who have opted in to receiving information through email are sent updates about HEAL topics. More than 400 individuals are on the contact list. For those filling out the self-assessment, the follow-up ranges from a one-on-one conversation or an email interaction about strengths and growth areas, to resource connection in order to achieve identified goals.

School Liaison

TCHD is a planning member for the Colorado Healthy Schools Collaborative; in 2020, assisted with two statewide convenings with school related partners such as CDE and RMC Health along with many school wellness and school nurse/health professionals. In 2020, TCHD's activities and relationships with schools expanded beyond our 15 school districts to include support for some private and charter schools as well.

Community Nutrition cont.

School Liaison cont.

School Liaison Metrics, 2019-2020

	2019	2020
# School wellness-related policies/procedures updated or adopted	2	0*
# District or school wellness teams with TCHD participation	14	4* (Sheridan, Englewood, Douglas County, Adams 12)
# School staff/leadership receiving school communication products from TCHD	190	340
# School leaders registered for bi-weekly webinars	-	464 (Includes both school and childcare staff, ~150-200 per webinar)
# Newsletters/other written communications provided for districts/schools	5	21
# Webinars provided for school leaders	-	10

**TCHD School Coordinator staffing change mid-2019; position was redesigned and filled in 2020 just prior to start of pandemic.*

Healthy Beverage Partnership Initiative

Healthy Beverage Partnership Initiative
Funding/Revenue Source(s): General Funds

FY21 Program FTE: 0.50
FY21 Program Budget: $53,395

The Healthy Beverage Partnership (HBP) conducts efforts with funding through CDPHE's CCCPD Grants Program since 2015. TCHD is one of four metro area public health agencies collaborating regionally as the HBP to increase access to healthy food and beverages and to decrease consumption of unhealthy food and beverages. Sugary drinks are the largest source of added sugar in the U.S. diet and the single largest contributor to daily caloric intake, contributing to type 2 diabetes, obesity, heart disease, and tooth decay. Health implications of sugary drinks include disproportionate impact of low-income communities and people of color. HBP is increasing community knowledge and capacity around municipal policy change supporting healthy beverages offered with bundled (price includes beverage) restaurant children's meals, and TCHD's efforts are currently focused in Aurora. Staff are working to increase community and coalition engagement on this issue in conjunction with key partners including Children's Hospital Colorado and American Heart Association, along with other community-based organizations. This program advances goals of the Food and Health priority of the TCHD Public Health Improvement Plan. In 2018, this program was awarded a NACCHO Model Practice Award for its collective impact informed approach and collaborative model that included stakeholders from six public health agencies representing approximately 60% of Colorado's population.

Healthy Beverage Program Metrics, 2019-2020

	2019	2020
Municipal-Level Healthy Beverage Kids Meal Policies Adopted	0	0
Number of Municipal-Level Implementation Plans Executed	2	1
Number of Decision-Maker Consultations	7	17
Number of Signed Commitment Forms/Partnership Agreements	15	7
Number of trainings/presentations Conducted for Community Groups	9	8

Worksite Wellness

TCHD enhances worksite policies and practices through outreach to local and regional employers with funding provided by CDPHE's Cancer Cardiovascular and Pulmonary Disease Grant Program. Through active facilitation of five coalitions and a regional advisory council, TCHD provides training, technical advising and financial opportunities to support employers in the process of implementing breastfeeding and healthy food and beverage-friendly policies and programs. Employer priorities of mental health, stress reduction, and reducing tobacco and substance use are also addressed, and a health equity frame is woven through the entire initiative. Project partners include local chambers of commerce, the American Heart Association, Kaiser Permanente, Aetna, Health Links, and many other local and regional stakeholders. Coalitions include public and private employers from the greater Metro area. This initiative was recognized as a NACCHO Model Practice in 2020.

Worksite Wellness Program

Funding/Revenue Source(s):Restricted State Funds

FY21 Program FTE: 1.70

FY21 Program Budget: $300,300

Worksite Wellness Program Metrics by County, 2016-2020

	2016	2017	2018	2019	2020
Number of unique worksites that completed a Healthy Business Certification					
Adams	5	4	7	5	2
Arapahoe	15	3	2	5	2
Douglas	15	2	2	3	1
Number of new unique employees reached each year with Workplace Wellness best practices (through the new worksites joining the Initiative each year)					
Adams	9,622	620	3,887	5,329	37
Arapahoe	11,278	1,707	427	2,678	81
Douglas	13,771	233	285	209	6
Number of new Worksite Wellness policies adopted					
Adams	2	5	28	10	5
Arapahoe	5	4	10	13	6
Douglas	6	2	8	4	4
Number of worksite lactation rooms created					
Adams	-	-	1	5	6
Arapahoe	-	-	2	9	6
Douglas	-	-	1	11	22

Diabetes Education Program

Diabetes Education Program
Funding/Revenue Source(s):Restricted State Funds

FY21 Program FTE: 2.95
FY21 Program Budget: $335,000

The Diabetes Education Program (DEP) has implemented programming with funding through CDPHE's Cancer, Cardiovascular, and Chronic Pulmonary Disease Grants Program since 2015. TCHD maintains relationships with 24 partners including primary care practices, community based organizations, recreational centers, businesses, and churches in order to outreach/market, recruit for, and offer the following two programs: Diabetes Self-Management Education and Support (DSMES) and the Centers for Disease Control and Prevention's (CDC) evidenced-based National Diabetes Prevention Program (NDPP), marketed by TCHD as Journey to Wellness. TCHD is a recognized DSME site with the American Diabetes Association and has full CDC recognition for TCHD's NDPP program, indicating attainment of all program benchmarks and provision of evidenced based education to the community. DSMES provides eight hours of curriculum over the course of one or two months, and NDPP provides 24 hours of curriculum over the course of a year.

The DEP goals are to increase awareness of and access to participation in the programs to achieve the following outcomes: increased healthy lifestyle habits; reduced rates of prediabetes, diabetes, and diabetes-related complications; and reduced healthcare costs associated with such conditions. The program's target population includes under- or uninsured individuals without other means of accessing these services and those at high risk of health inequities, diabetes, and other chronic diseases. The DEP's priority geographic areas of southwest Adams County and Arapahoe County along the Colfax corridor were determined from a scan identifying marginalized and vulnerable areas with the highest concentration of the above conditions, but participants from other communities also participate. Participants are screened for food and housing insecurity and offered resources and assistance with navigating the healthcare system. Average weight loss for NDPP clients in 2020 was 5.1% and average decrease in Hgb A1c for DSMES clients was 3%, exceeding targets.

TCHD provides these services in English and Spanish, and offers in-person and virtual options. Program staff participate in state-level workgroups that influence and ensure implementation of the Colorado Diabetes Action Plan. This program work supports the Food and Health priority in the TCHD Public Health Improvement Plan.

Diabetes Prevention Program Participation by County, 2016-2020

	2016	2017	2018	2019	2020
Number of new* clients enrolled in NDPP classes**					
Adams	23	66	50	80	53
Arapahoe	9	77	31	37	49
Douglas	13	50	0	2	14
Participants from other counties or participants who do not formally meet NDPP eligibility requirements	-	5	7	18	45
Number of new clients enrolled in DSMES services**					
Adams	42	72	87	34	19
Arapahoe	10	36	40	12	10
Douglas	11	11	3	1	0
Participants from other counties or "ineligible" participants (partners/support)	14	11	11	11	4

**As the NDPP is a year-long program, there is overlap of cohorts from one year to the next.*

***In addition to the 24 hours of curriculum for each NDPP participant and 8 hours of curriculum offered to each participant in DSMES, staff provide 1:1 support and follow up throughout the time period of enrollment via email, phone, and in-person appointments.*

Health Equity

Equity is achieved when everyone, regardless of who they are or where they come from has the opportunity to thrive. The advancement of health equity is necessary to successfully promote, protect and improve the lifelong health of individuals in Adams, Arapahoe and Douglas Counties. Health equity has been part of TCHD's mission since 2014, and the agency continues to integrate health equity into the delivery of programs agency-wide. Through input gathered during TCHD's 2018 Community Health Assessment community members, partners, and staff told us that health in their communities is most highly influenced by social connection, opportunity, health and wellness services, neighborhood conditions, and safety. Centering equity at the heart of the Department's work requires us to see health outcomes and behaviors in the context of the social, economic, and environmental factors in TCHD's counties and communities which are the foundations for establishing a healthy life. Although health equity work is done across the agency, a formal Health Equity Coordinator position has been created under the Community Health Promotion Division to coordinate and provide focus on health equity, as this work is central to TCHD's work within communities served.

Health equity work at TCHD focuses on opportunities for integrating equity best practices into the work TCHD does. As called out in the Department's Health Equity and Environmental Justice Policy this includes expanding TCHD's understanding of what creates health in communities, strengthening the capacity of communities to create their own health futures, and implementing a health in all policies approach with health equity as the goal. Since 2015, a Health Equity Workgroup has met to share learnings and champion efforts to integrate equity best practices. A snapshot of TCHD's health equity work includes:

HEALTH EQUITY ACTIVITIES INCLUDE:

- Prioritize Health Equity and Meaningful Community Engagement is a goal in the Department's Strategic Plan. The Strategic Plan was informed by input from TCHD staff and Board of Health members and highlights the importance of promotion of health equity in the Department's work.

- Creating a foundational Equity and Racial Justice Training that all staff will complete in 2021. The objectives and concepts for this training were developed by a volunteer workgroup with 15 staff across the agency in summer 2020.

- The Earned Income Tax Credit (EITC) is cited as one of the nation's most successful antipoverty tools, promoting employment while providing valuable tax refunds to lower-to-moderate wage earners, and is an important approach to addressing health equity. The Maternal and Child Health team leads a department wide effort to spread the word among employees and clients, with client-facing divisions being provided co-branded campaign materials from The Piton Foundation, talking points, and other awareness materials on EITC benefits. In 2020, resources were shared with over 130 community partners who provide direct services to clients in the TCHD jurisdiction. In addition, the team worked with Bright by Text, a statewide platform that provides parents with trusted resources, to send text messages on EITC in English and Spanish to 14,454 recipients in January, March and April 2020.

- The COVID-19 pandemic has highlighted in harsh detail the impact of structural inequities on health outcomes and has provided a particularly important opportunity for focused health equity work. Members of our communities of color in all three counties have been disproportionately represented among our 127,000+ cases, 7000+ hospitalizations, and 1500+ deaths. As outlined in our COVID Response Statistics below, we have created an entire branch to respond to a range of housing, transportation, and financial support needs for persons impacted by isolation and quarantine, and more recently, have launched a Vaccine Equity strategy to help ensure equitable access to new vaccine across our counties.

Health equity work is also happening within divisions and programs, building staff capacity and implementing quality improvements to address the factors that influence health. This explicit focus on health equity across the agency is foundational to support community members in leading their healthiest lives. The majority of health equity-related work within TCHD is provided in-kind by staff and programs described above.

Emergency Preparedness, Response, and Communicable Disease Surveillance

The Emergency Preparedness, Response, and Communicable Disease Surveillance Division (EPRCDS) leads agency efforts to promote coordination, collaboration, and communication among all divisions within TCHD and with external partners to ensure that public health is an effective partner in safety, preparedness, response, and recovery efforts. EPRCDS also supports Elbert County Health and Human Services to ensure depth of service during incident response including communicable disease efforts.

Emergency Preparedness, Response, and Communicable Disease Surveillance Division

Funding/Revenue Source(s): Restricted Federal Funds, General Funds

FY21 Division FTE: 17.63
FY21 Division Budget: $2,053,589

Emergency Preparedness and Response Program

The Emergency Preparedness and Response (EPR) Program provides an important core public health service and is committed to strengthening the jurisdictions health security by protecting against, responding to, and recovering from public health threats, natural, or human-made, and being part of a system for community resiliency. On a day-to-day basis, EPR is responsible for maintaining the Public Health Emergency Operations Plan (PHEOP) and all associated systems and documentation related to how TCHD, as an agency, responds to any incident impacting Adams, Arapahoe, and Douglas Counties. TCHD EPR also supports Elbert County Health and Human Services to ensure depth of service during incident response. This program is also responsible for maintaining the agency Continuity of Operations Plan, detailing how the agency will continue to protect the public's health while it is impacted by an incident. Held to a high standard, TCHD EPR undergoes rigorous federal and state assessments, tests response capabilities through exercises, and responds to real world incidents with a focus on continual improvement.

Public Health Emergency Preparedness Program

Funding/Revenue Source(s): Restricted Federal

FY21 Program FTE: 6.12
FY21 Program Budget: $731,982

TCHD may serve in one of three roles during an incident impacting the health and medical system within the counties it serves. First, for public health incidents, TCHD serves as incident command and the lead in coordinating response efforts, working with partners at the county, state, and federal level to ensure all stakeholders are integrated into the response and information is shared to maintain situational awareness. Second, during an incident with a strong public health component, TCHD serves as the subject matter expert and works in tandem with other response partners to develop and operationalize appropriate tactics. Finally, for an incident impacting the health and medical system, TCHD may be activated as the Emergency Support Function #8 (Health and Medical) Lead to coordinate information, resource requests or other needs of the response related to public health, hospitals, behavioral health, fatalities management, or other health and medical partners.

TCHD EPR actively coordinates with cross-jurisdictional and cross-discipline partners throughout the state on emergency preparedness and response planning activities. Subject matter experts work together through the North Central Region Board of Directors and a network of committees and working groups established to identify threats, recognize capability gaps, and create a consistent response framework across the ten counties in the Denver Metropolitan Area. EPR staff also participate in and lead similar efforts across the state and at the national level through leadership on the Colorado Healthcare Coalition Council, the National Association of County and City Health Officials (NACCHO) Surge Workgroup, and the Centers for Disease Control and Prevention (CDC) Office of Public Health Preparedness and Response (OPHPR) Board of Scientific Counselors.

In January 2017, Tri-County Health Department officially received Project Public Health Ready (PPHR) re-recognition from the National Association of County and City Health Officials (NACCHO). Local health departments seeking recognition by PPHR undergo a thorough evaluation process by peer review. PPHR required Tri-County Health Department to meet capabilities in three key areas: all-hazards preparedness planning, workforce capacity development and demonstration of readiness through exercises or real events. The TCHD EPR program holds three Model Practices as recognized by the National Association of City and County Health Officials (NACCHO). In 2014, the agency was recognized for the development of the Public Health Incident Management Team, and in 2015, the program was again recognized for their work in coordinating planning efforts regarding alternate care facilities in support of large-scale medical surge operations which served as the basis for local planning efforts during the 2020-2021 response hospital surge during the COVID-19 pandemic. Additionally, in 2019, the agency received recognition for planning efforts around response to a radiological/nuclear incident impacting the TCHD jurisdiction.

Public Health Incident Management Team (PHIMT)

Using the basic tenants of the Incident Command System (ICS), TCHD EPR leads the Public Health Incident Management Team (PHIMT), providing incident management during complex or long-term incident response operations at TCHD. This cross-divisional team is made up of approximately 45 TCHD staff members trained in command and general staff responsibilities to fill vital incident response positions tasked with setting the framework, crafting the tactics, and supporting response efforts. The EPR Program manages a quarterly training cycle for the PHIMT and includes full team and position specific trainings as well as an exercise during each cycle.

Training and Exercises

Training and exercise events help the agency and TCHD's partners better prepare for and respond to incidents impacting the jurisdiction. Because emergencies rarely impact a single jurisdiction, the integrated nature of the trainings and exercises also prepares TCHD staff and partner organizations to support each other when we have reached capacity to effectively respond without support.

Health Alert Network (HAN)

The Health Alert Network Provides a method of actively sharing information of public health incidents with local partners. These messages can be relayed as:

HEALTH ALERT NETWORK

- **HAN Alert** – conveys the highest level of importance and warrants immediate action
- **HAN Advisory** – Provides important information for a specific incident
- **HAN Update** – provides updated information regarding an incident or situation
- **HAN Public Health Brief** – for your information and does not require action

Health Alert Network Metrics, 2016-2020

	2016	2017	2018	2019	2020
Number of alerts	9	4	1	4	1
Number of advisories	19	16	21	24	22
Number of updates	9	5	8	9	25
Number of public health briefs	2	4	4	3	1
Number of providers in the database	5,115	5,176	5,167	5,170	5,171

Incidents with TCHD PHIMT Activation 2016-2020

PHIMT ACTIVATION 2016-2020

- Hepatitis A Response 2016
- Rabies Incident 2016
- Mumps Response 2017
- Officer-Involved Shooting 2017
- Water World Incident 2018
- Recycling Facility Fire 2018
- Apartment Complex Fire 2018
- Arapahoe County Fair Salmonella Outbreak and Investigation 2018
- Hepatitis A Response 2018-2020
- Spring Blizzard (Bomb Cyclone) 2019
- STEM School Shooting Highlands Ranch 2019
- Measles Response 2019
- COVID-19 Pandemic 2020-current

Cities Readiness Initiative (CRI) Program

Cities Readiness Initiative Program

Funding/Revenue Source(s): Restricted Federal Funds

FY21 Program FTE: 2.10

FY21 Program Budget: $193,803

The CDC's Cities Readiness Initiative (CRI) is a federally funded program designed to enhance preparedness in the nation's largest cities and metropolitan statistical areas where more than 50% of the U.S. population resides related to medical countermeasures and dispensing. Using CRI funding, state and large metropolitan public health departments develop, test, and maintain plans to quickly receive and distribute life-saving medicine and medical supplies from the nation's Strategic National Stockpile (SNS) to local communities following a large-scale public health emergency. Initially, the CRI planning scenario was based on a response to a large-scale anthrax attack; however, through continued analysis and lessons learned, it became apparent that CRI jurisdictions must be prepared to respond to other public health emergencies. The Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 emphasized an all-hazards approach to public health preparedness planning, thereby expanding the scope of the CRI planning to include natural and man-made public health threats. The Emergency Preparedness and Response program has developed plans for receipt, storage, and distribution of large quantities of medicine and medical supplies to protect the public in the event of a public health emergency.

Communicable Disease Surveillance Program

Communicable Disease Surveillance Program

Funding/Revenue Source(s): Restricted Federal Funds

FY21 Program FTE: 5.00

FY21 Program Budget: $487,443

The Communicable Disease Surveillance program works to protect the public by preventing the spread of infectious diseases. Communicable disease epidemiologists conduct ongoing epidemiologic surveillance to identify new and emerging infectious disease trends and outbreaks. The epidemiologists work to identify causes of disease, identify people who are at risk, determine how to control or stop the spread, and/or prevent it from happening again. They conduct day-to-day investigation of vaccine-preventable diseases such as pertussis and measles, enteric diseases such as E.coli and salmonella, and zoonotic diseases such as rabies and plague. They are trained in rapid response to disease outbreaks, working to identify the causative agent and putting control measures into place to prevent the spread of disease. The Communicable Disease Surveillance Program also provides education and technical expertise on disease control to both our partners and the public.

Disease Control Surveillance Program Metrics, 2016-2020

	2016	2017	2018	2019	2020 *
Number of notifiable disease case investigations reported	2,134	1,088	1,088	1,070	127
Adams	421	334	357	379	42
Arapahoe	549	515	517	500	57
Douglas	264	239	214	191	28
Number of notifiable disease case investigations interviewed (%)	1,043	994	947	974	118
	85%	91%	87%	91%	93%
Adams	360	316	312	347	37
	86%	95%	87%	92%	88%
Arapahoe	459	460	449	448	53
	84%	89%	87%	90%	93%
Douglas	224	218	186	179	28
	85%	91%	87%	94%	100%

Communicable Disease Surveillance Program cont.

Disease Control Surveillance Program Metrics, 2016-2020 cont.

	2016	2017	2018	2019	2020 *
Total number of disease outbreaks (all types)	80	113	85	75	19
Adams	32	35	25	31	6
Arapahoe	38	59	42	31	9
Douglas	10	19	18	13	4
Total number of child care center outbreaks	18	15	15	20	1
Adams	11	4	4	6	0
Arapahoe	5	8	9	12	1
Douglas	2	3	2	2	0
Total number of long term care facility outbreaks	42	78	55	38	18
Adams	15	25	18	14	6
Arapahoe	23	41	23	14	8
Douglas	6	12	13	10	4
Total number of retail food outbreaks	9	16	9	8	0
Adams	2	5	1	4	0
Arapahoe	6	8	5	2	0
Douglas	1	4	2	2	0

**Due to the COVID-19 pandemic, the Colorado Department of Public Health and Environment took over certain types of disease investigations so that TCHD could focus on COVID-19 case investigation and contact tracing.*

Workplace Safety and Security Program

The Workplace Safety and Security Program is dedicated to developing, coordinating, and consistently applying standard workplace safety and security efforts to improve both the culture of safety and staff capabilities related to safety throughout TCHD to support both staff and the communities served by TCHD. This program also works in close coordination with designated staff that support safety and security efforts in Adams, Arapahoe and Douglas Counties to assure alignment of initiatives.

Workplace Safety and Security Metrics

	2019
Percentage of Staff Trained for an Active Shooter Event	93%
Percentage of Staff Trained in De-escalation	13.2%
Percentage of staff with confidence in general safety	83%
Staff confidence in how to respond to an active shooter	65%
Staff confidence in how to de-escalate verbal incidents	63%
Number of workplace safety office inspections	11
Number of fire drills	8
Number of tornado drills	11

***Due to COVID-19 pandemic response, workplace safety trainings were halted in 2020 and the workplace safety survey was not disseminated to staff. These efforts began in 2019.*

Syndromic Surveillance Program

TCHD and Denver Public Health jointly began participating in the National Syndromic Surveillance Program (NSSP) in 2013 collecting timely syndromic surveillance data for situational awareness and enhanced response to hazardous events and disease outbreaks. Currently, the TCHD Syndromic Surveillance Program serves as the site administrator for the local syndromic surveillance system for the entire State of Colorado. Counties participating in the local syndromic surveillance system include Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Larimer, La Plata, Mesa, Montezuma, Jefferson, and Pueblo counties. TCHD collaborates with hospitals and the Health Informatics Exchange (HIE) vendors to build, maintain, and expand data connectivity for syndromic surveillance.

Syndromic Surveillance Program

Funding/Revenue Source(s): Restricted Federal Funds

FY21 Program FTE: 2.78

FY21 Program Budget: $431,444

**Includes NSSP, OD2A, and SVP*

The TCHD Syndromic Surveillance Program monitors public health hazards in Adams, Arapahoe, and Douglas counties including communicable disease trends (e.g. COVID-19, influenza), mental health-related hospital visits (e.g. suicidal ideation, suicide attempts, and sexual violence), substance overdose (e.g. opioid, heroin, and alcohol), and many other public health hazards (e.g. firearm injury and carbon monoxide poisoning). The TCHD Syndromic Surveillance Program shares timely information with both internal and external partners within the TCHD jurisdiction, including county and city emergency managers, suicide prevention teams, substance overdose prevention team, communicable disease partners, CDPHE, and hospital/hospital system partners (e.g. infection preventionists, emergency department physicians, and emergency management staff). As an example, throughout the COVID-19 pandemic, TCHD generates daily information for TCHD COVID-19 Case Updates and CDPHE COVID-19 Case Data along with weekly COVID-19 notification reports and shares this information broadly with partners. In addition to all of the above, TCHD also shares confidential notification reports with partners when time sensitive information related to outbreaks, incidents, and/or pandemics impact the TCHD jurisdiction.

The funding from the CDC to support TCHD's original syndromic surveillance efforts sunsetted at the end of August 2019. Currently, TCHD is receiving funding through the CDC Epidemiology and Laboratory Capacity (ELC) grant as well as through the CDC Overdose Data to Action (OD2A) and Syndromic Surveillance Suicide and Violence Prevention (SVP) grants to enhance the surveillance efforts related to substance overdose, suicide and violence such as developing definitions for timely monitoring, enhancing timely information sharing, and monitoring trends related to infectious diseases, substance overdose, suicidal ideation, suicide attempts, intimate partner violence, sexual violence, and gun violence. TCHD continues to onboard additional facilities and counties across the state to expand the footprint for Colorado's syndromic surveillance network, leveraging syndromic surveillance partnerships, and looking at ongoing opportunities to use data to support prevention efforts and enhancing the community of practice. The ongoing funding and enhanced partnerships allow for real-time data to be utilized to support prevention efforts in Adams, Arapahoe, and Douglas Counties. The Syndromic Surveillance Program provided additional reporting in 2020 due to the COVID-19 pandemic.

Syndromic Surveillance Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Number of Syndromic Surveillance Specific Cases Submitted to the Communicable Disease Surveillance Team	20	22	29	6	167
Number of Syndromic Surveillance Notification Reports Disseminated	-	3	4	4	54
Number of participating providers in the Colorado Syndromic Surveillance System	28	35	36	55	77

COVID-19 Pandemic Response

On March 5, 2020, the first confirmed case of SARS-CoV-2 (COVID-19) was reported to TCHD. As of March 11, 2021, Tri-County Health Department has activated over 500 staff, contractors, and volunteers to work on the pandemic response. Below, are highlights from March 2020-March 2021 to illustrate the impact and the preventative measures TCHD and partners took to reduce transmission and support Adams, Arapahoe, and Douglas counties:

TCHD COVID-19

- 120,000+ Cases
- 1,500+ Deaths
- 7,000+ Hospitalizations
- 165,400+ COVID-19 Cases and Contacts Reported
- 1,500,000+ COVID-19 Tests Completed
- 26,700+ Call Center Calls Answered
- 120+ Community Outreach Webinars and Town Halls
- 530+ Communication Materials Created
- 7,500+ Responses Made to Public Health Order Compliance Concerns
- 5,200+ mentions in the media

COVID-19 Pandemic Response

Funding/Revenue Source(s): Restricted State Funds

FY21 Program FTE: 0.00

FY21 Program Budget: $11,000,000

COVID-19 Funding

As part of the COVID-19 response, the CDC is providing $10.25 billion to states, territories, and local jurisdictions through CDC's existing Epidemiology and Laboratory Capacity (ELC) for Prevention and Control of Emerging Infectious Diseases cooperative agreement. TCHD received its portion via a federal pass through grant from CDPHE. The funding project will help strengthen and support local public health agencies responding to COVID-19 by funding personnel to perform critical containment activities, such as disease surveillance, case investigation, contact tracing, and testing, vaccination, case management, and equity based on jurisdictional needs. The project grant also supports local responses to COVID-19 outbreaks, infection prevention efforts at health care and other settings, and promotes health equity aspects of the response. The project additional funding benefits all Coloradans by providing support to every local public health agency working on behalf of Colorado communities.

CASE INVESTIGATION CONTACT TRACING INVESTIGATION STATISTICS AND (AS OF MARCH 14, 2021) BY COUNTY	
Total COVID-19 Cases Reported	
Adams	50,575
Arapahoe	50,912
Douglas	22,896
Number of completed case investigations	86,820
Adams	37,391
Arapahoe	32,377
Douglas	17,052
Number of COVID-19 contacts identified	37,108
Adams	16,520
Arapahoe	14,146
Douglas	6,442
Number of contact investigations completed	29,040
Adams	13,829
Arapahoe	10,955
Douglas	4,256
Median number of days from case report to investigation completion	1.4 days

COVID-19 Pandemic Response cont.

GENERAL COVID-19 RESPONSE STATISTICS	
Number of TCHD response staff activated	282
Number of TCHD temporary COVID-19 response-related positions filled	294
Number of COVID-19 related calls taken by TCHD Call Center	27,747
Number of COVID-19 related complaints received by TCHD	7,659
Retail Food Establishment Complaints	3,010
Recreational Facility Complaints (i.e., Gyms, Pools)	754
Retail Business Complaints (i.e., retail stores, malls, Big Box)	715
Office Type Business Complaints (i.e., office buildings, other work places)	503
Other Complaints	2,677
Number of COVID-19 related complaints received by TCHD by County	7,278
Adams	1,989
Arapahoe	3,105
Douglas	2,184
Number of inquiries made to TCHD's Business Reopening Task Force	3,948
Adams	793
Arapahoe	1,354
Douglas	539
Number of Business-Focused Webinars Hosted by TCHD	95
Weekly Webinars for All Businesses	35
Special Topic Webinars	25
Webinars in Spanish	35
Number of referrals received by the TCHD Community Services Branch by County (8/1/2020-2/28/2021)	3,530
Adams	1,687
Arapahoe	1,529
Douglas	314
Referrals received by TCHD Community Services Branch by type of referral need (8/1/2020-1/19/2021)	3,975
Job Security	596
Financial Hardship	1,270
Essential Item Affordabilty	517
Essential Item Delivery	898
Shelter	28
Health Care Access	251
In Home Care	35
Other	380
Number of individuals referred further to community partners and social services due to COVID-19-related needs by county of residence (08/01/2020-2/28/2021)	632
Adams	225
Arapahoe	290
Douglas	117

COVID-19 Pandemic Response cont.

TCHD COVID-19 SCHOOL AND CHILD CARE TASK FORCE

- 14 School and Child Care-focused town halls/webinars with 450+ registrants
- Supported 15 school districts, 415 schools, 103 private schools and 48 charter schools
- Provided 30 school-focused newsletters and updates
- Supported Community Outbreak Task Force on over 700 COVID-19 cases in child care settings
- Provided COVID-19 information to 1,183 licensed child care providers with 9,894 child care workers that serve 69,255 children
- Provided 197 space/site evaluation and assessments in child care settings as part of COVID-19 response

Health Data and GIS: COVID-19 Informatics

Throughout the COVID-19 response, the data environment and expectations of data delivery shifted rapidly. Data was expected to be delivered daily through multiple mechanisms including dashboards, map layers, spreadsheets, and reports. The alignment and integration with state systems and local systems added additional layers of complexity to navigating this new landscape. However, because of the infrastructure, systems, and staffing in place within the Health Data and GIS Program, TCHD was able to successfully navigate this unprecedented challenge highlighted in the work below:

COVID-19 DATA PROCESSES

- **Automated data processes that run 24hrs a day, 7 days a week**, managing and processing case, testing, vaccine, and outbreak data.
- **49 Public facing dashboards**, which are updated daily (County, School District, Neighborhood, Census Tract).
- **26 Internal facing dashboards**.
- **15 custom live data feeds** to partners across the jurisdiction delivered via map services, Application Programming Interface (API), and spreadsheets.
- Developed **in-house case investigation/contact tracing system** used by 300+ staff , which is now adopted and used by multiple health departments across the country.
- Responded to **hundreds of COVID-19 data requests** from a multitude of stakeholders including TCHD staff, city/county staff, BOCC, school districts, water districts, healthcare providers, researchers, CDPHE, general public

COVID-19 and Health Equity

An Equity Officer position was created in the COVID-19 PHIMT structure and this position is responsible for prioritizing and integrating the principles of equity throughout the agency's pandemic response. Highlights of the equity work across the response include:

COVID-19 HEALTH EQUITY HIGHLIGHTS

- The TCHD Call Center increased staffing in 2021 to both answer vaccine questions and help individuals sign up for appointments. Since January 1, 2021 the call center has received 9,360 calls, approximately 7,500 of those calls were related to the COVID-19 vaccine and staff have signed up 656 individuals for vaccine appointments.
- The Community Services Branch (CSB) started in May 2020 to provide support and resources to COVID-19 positive cases and contacts so individuals can safely isolate or quarantine.
- Creation of a Vaccine Equity Plan to proactively develop partnerships and approaches to assure equitable access to COVID-19 vaccines across our communities.

Environmental Health

The Environmental Health (EH) Division focuses on preventing communicable disease and environmental conditions that could be harmful to health through education and consultation, response and investigation and enforcement of regulations.

Environmental Health Division

Funding/Revenue Source(s): County General Funds, State General Funds, County Restricted Funds, Federal Restricted Funds, Fees

FY21 Division FTE: 70.45
FY21 Division Budget: $6,914,404

Environmental Health Division Administration and Informatics

Budgeted activities include the core leadership team, which is responsible for planning, implementation, management, and evaluation of all environmental health activities and programs. This division's support program is also responsible for financial oversight, data collection and management, grant and contract management, Environmental Health Informatics activities, and some support staff services. Expenditures such as capital equipment, staff training, support staff services, and some local travel may be budgeted under this program to capture expected costs; however, during the course of the year, expenses are applied to the programs that actually incur the costs.

Environmental Health Division Administration and Informatics

Funding/Revenue Source(s): General Funds

FY21 Program FTE: 12.24
FY21 Program Budget: $1,371,571

Food Protection Program

The goal of the Food Protection program is to prevent the occurrence of foodborne-illness from food prepared in licensed retail food establishments. This program is required by the Food Protection Act (C.R.S. §25-4-1601) and authority is granted to local health departments to administer the program and collect license fees. The following services are conducted for licensed facilities: risk-based inspections; investigation of complaints; review and approval of plans for new or remodeled facilities; opening inspections and approval of licenses; food safety education for restaurant operators; enforcement actions against facilities that continue to fail to meet safe food handling requirements; and assessment of damage to retail food establishments due to disasters, such as fire or flood, to ensure the maintenance of a safe food supply. All food service inspectors go through a formal "standardization" process every three years to ensure a uniform inspection approach. Continuing education is required to ensure a trained and competent workforce. This program is working to improve food safety through collaboration with state and local partners in food program data standardization efforts.

Food Protection Program

Funding/Revenue Source(s): Fees, General Funds

FY21 Program FTE: 33.25
FY21 Program Budget: $2,863,211

Food Protection Program cont.

Food Protection Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total Retail Food Establishments					
Adams	1,556	1,621	1,658	1,588	1,742
Arapahoe	2,271	2,359	2,472	2,359	2,472
Douglas	943	955	955	967	1,002
Total Retail Food Inspections					
Adams	3,469	3,940	3,772	4,063	1,602
Arapahoe	5,631	5,305	5,730	4,892	1,613
Douglas	2,060	2,549	2,275	2,350	740
Total number of Follow-up Inspections					
Adams	667	841	685	776	89
Arapahoe	1,152	1,123	1,071	846	68
Douglas	436	571	457	466	15
Total number of Temporary Events					
Adams	26	16	12	13	0
Arapahoe	23	32	22	34	0
Douglas	26	26	26	29	2
Total number of complaints					
Adams	176	278	134	118	102
Arapahoe	304	296	186	194	145
Douglas	122	103	103	111	67
Total Number of Voluntary Closures*					
Adams	10	10	8	15	1
Arapahoe	14	6	10	7	7
Douglas	1	0	1	1	0
Total Number of License Revocations					
Adams	0	0	1	2	0
Arapahoe	2	0	0	0	0
Douglas	3	0	1	0	0
Total Retail Food Plan Reviews					
Adams	87	97	133	159	120
Arapahoe	166	269	251	226	178
Douglas	55	70	112	74	75

**Temporary voluntary closure due to non-compliance, typically resolved in 1-2 business days.*

Child Care Program

The goal of the Child Care program is to prevent the spread of infectious disease in childcare facilities and other public residential settings. Local health departments work with the Colorado Department of Human Services(CDHS) as well as the Colorado Department of Public Health and Environment (CDPHE) to assess and provide assistance to child care operators and staff as mandated by C.R.S. §25-1.5- 101(1)h. The following services are conducted for CDHS licensed facilities: annual or biennial on-site inspections; investigation of complaints; review and approval of plans for newly constructed or remodeled childcare facilities; and education.

Child Care Program

Funding/Revenue Source(s): General funds, Fees

FY21 Program FTE: 3.00
FY21 Program Budget: $267,077

Child Care Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total Child Care Facilities					
Adams	228	345	246	246	216
Arapahoe	364	370	376	371	351
Douglas	198	201	208	208	204
Total Child Care Facility Inspections					
Adams	279	289	336	289	100
Arapahoe	493	430	524	427	199
Douglas	229	206	277	198	126
Total Child Care Facility Routine Inspections					
Adams	225	205	230	201	96
Arapahoe	402	319	378	276	169
Douglas	195	224	203	140	115
Total Child Care Facility Follow-Up Inspections					
Adams	68	53	73	50	17
Arapahoe	135	93	111	52	25
Douglas	37	56	35	34	7
Total Number of Child Care Facility Complaints					
Adams	7	3	0	3	1
Arapahoe	13	10	5	9	4
Douglas	5	7	3	5	3
Total Number of Child Care Facility Plan Reviews					
Adams	3	10	2	4	9
Arapahoe	1	3	0	6	15
Douglas	1	1	1	15	10

General Environmental Health Services

The General Environmental Health Services category includes crosscutting Disease Prevention program activities and a combination of various division programs due to their relatively small budgets. Programs included are: Animal Control; Body Art; and Marijuana Infused Product Manufacturer. The following services are conducted: education on the risk of contracting rabies from domestic and wildlife animals; investigation of disease outbreaks and food-borne illness complaints; annual inspections of marijuana infused product manufacturer under an intergovernmental agreement with Cities of Aurora and Commerce City; annual inspection of body art facilities. Additionally, TCHD's Institutions and Public Accommodations Program includes activities concerning mobile home parks, private housing, penal institutions, and public accommodations. These program components are addressed on a complaint basis only.

General Environmental Health Services

Funding/Revenue Source(s): Fees, General Funds

FY21 Program FTE: 1.30
FY21 Program Budget: $136,624

Body Art Inspections Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total Body Art Facilities					
Adams	21	20	20	29	27
Arapahoe	30	32	34	37	40
Douglas	9	13	14	14	13
Total Body Art Facility Routine Inspections					
Adams	35	34	34	41	13
Arapahoe	53	62	65	60	12
Douglas	14	24	24	18	3
Total Body Art Facility Complaints					
Adams	2	2	1	2	1
Arapahoe	2	6	2	2	3
Douglas	1	2	1	1	2

Animal Control Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total Animal Control-Related Complaints					
Adams	125	98	124	148	22
Arapahoe	141	162	188	129	2
Douglas	79	61	100	99	1
Total Number of Animal Specimens Tested for Rabies					
Adams	55	47	48	59	49
Arapahoe	90	84	74	45	49
Douglas	34	36	73	34	27

Water Program

The Water Program includes water quality, onsite wastewater treatment systems (OWTS, i.e., septic systems), and recreational water (pools, spray pads, spas, and beaches). The goal of this program is to prevent disease transmission introduced into ground, surface, or recreational waters. The Water program addresses all aspects of water supplies including, but not limited to, drinking water, private well water, reclaimed water, gray water, and storm water, and emerging contaminants such as per- and polyfluoroalkyl substances (PFAS).

Water Program

Funding/Revenue Source(s): Fees, State Restricted Funds, County Restricted Funds, General Funds

FY21 Program FTE: 8.79

FY21 Program Budget: $827,529

The OWTS program assures that wastewater from homes and businesses not served by a public sewer is adequately treated to prevent contamination of surface and groundwater. The following services are conducted:

- Permit and inspect all new and repair OWTS
- Issue use permits after inspections are completed on existing systems by qualified wastewater professionals
- Investigate malfunctioning systems
- Consult with planning departments, homeowners, engineers, and installers
- Train and license OWTS contractors and cleaners

Recreational water features at aquatic venues and swim beaches have long been recognized as an efficient medium for the transmission of communicable diseases and are also subject to a variety of accidents/injuries. The following services are conducted:

- Bi-annual inspections of all public and semi□public swimming pools, spray pads, and spas
- Complaint investigations
- Plan reviews and opening inspections of newly constructed or remodeled pools, spray pads and spas

The following services are conducted:

- Responding to citizen complaints or concerns
- Providing guidance/support to contamination incidents
- Participating in key watershed and stakeholder meetings
- Inspection of bio-solids land application sites.
- Emerging contaminant investigations in collaboration with state and federal partners

PFAS are human-made chemicals which have heat and stain resistant properties and are found in Teflon and Scotchgard products and were widely used in firefighting foams, which is a major source of groundwater contamination at airports and military bases where firefighting training occurs. Called "forever chemicals", these chemicals are very persistent in the environment and have been found in groundwater in Adams and Arapahoe Counties as well as other areas around the state. In 2018, TCHD worked with CDPHE, EPA, and the South Adams Water and Sanitation District (SACWSD) on a source investigation in the Commerce City area after the SACWSD detected PFAS contamination in multiple samples tested from raw water wells and treated water served to customers. While multiple sources appear to be contributing to the groundwater contamination, no private wells that are used for drinking have been found to be contaminated and the levels in the treated water served to the SACWSD customers are below the Health Advisory of 70 ppt (parts per trillion). TCHD continues to work with CDPHE to investigate other areas of Adams County based on a recent CDPHE statewide survey/testing of public water systems and fire district facilities. As a result of this survey/testing effort, CDPHE has identified 10 preliminary areas to target for additional PFAS investigation and testing. The investigation in other areas throughout Adams County will provide a greater understanding of where PFAS contamination is present in Adams County.

Water Program cont.

Recreational Water Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total Recreational Water Facilities - Annual					
Adams	36	41	42	42	43
Arapahoe	66	66	69	74	69
Douglas	35	37	38	41	37
Total Recreational Water Facilities - Seasonal					
Adams	49	49	48	48	48
Arapahoe	63	63	62	61	61
Douglas	22	24	24	25	26
Total Number of Recreational Water Facility Inspections					
Adams	213	231	241	228	216
Arapahoe	336	323	314	326	274
Douglas	147	150	145	174	141
Total Recreational Water Facility Plan Reviews					
Adams	15	4	2	0	8
Arapahoe	2	6	0	9	4
Douglas	4	0	1	7	1
Total Recreational Water Facility Ordered Closures					
Adams	24	33	39	23	17
Arapahoe	36	37	42	35	14
Douglas	12	19	20	11	5
Total Recreational Water Facility Complaints					
Adams	6	5	2	6	2
Arapahoe	15	22	15	16	3
Douglas	7	4	5	7	1

** Temporary closures due to failed chemical check, typically resolved within one business day.*

Water Program cont.

Waste Water Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Number of Waste Water Permit Applications					
Adams	482	404	403	412	422
Arapahoe	287	294	309	297	331
Douglas	748	767	714	682	807
Number of New Septic Permits					
Adams	203	155	111	120	94
Arapahoe	65	75	69	54	56
Douglas	139	127	131	123	132
Number of Expansion Permits					
Adams	0	0	2	1	2
Arapahoe	0	1	3	0	0
Douglas	7	2	3	1	9
Number of Repair Permits					
Adams	46	47	50	55	63
Arapahoe	37	39	51	49	54
Douglas	94	111	139	107	127
Number of Use Permits					
Adams	233	202	240	236	251
Arapahoe	185	179	186	194	170
Douglas	508	527	441	451	538
Total Waste Water Complaints					
Adams	32	33	27	29	42
Arapahoe	24	24	37	38	27
Douglas	7	18	10	9	11

Land Use

The goal of the Land Use and Built Environment Program is to bring effective public and environmental health strategies into the development of policy, system, and environmental changes that shape the way we build communities. Since chronic diseases associated with physical inactivity, poor nutrition, and exposure to poor air quality rank among the greatest public health risks in communities, the design of communities is one of the most strategic ways to address population health.

Land Use Program

Funding/Revenue Source(s): Restricted grant funding

FY21 Program FTE: 6.10
FY21 Program Budget: $657,374

The Land Use and Built Environment team brings expertise in the areas of environmental health, community epidemiology, food systems analysis, air quality, and housing and homelessness to TCHD's work across the three counties. The program engages in community design discussions and processes through the development of data and informatics, the provision of technical review and assistance, the promotion of best practices and model policies, and the facilitation of cross-sector collaborations to assess TCHD's built environment and develop solutions for improvements. Through TCHD's three-county approach, TCHD has brought public health considerations and recommendations to approximately 25 comprehensive plan processes, 6 oil and gas regulations, 45 land development code reviews, 2,800 land development proposals, and 20 state policies over the last five years. In addition, the team has led the development of built environment assessment tools that have been used by local jurisdictions and community partners across the three counties including the Boomer Bond Assessment Tool and four Health Impact Assessments.

As key staff engaged in TCHD's Public Health Improvement Plan's Health and Housing work, the Land Use and Built Environment Team have assisted local communities in the development of regulations to remove barriers to housing options such as the allowance of accessory dwelling units on single-family residential properties, reviewed existing local policies across 29 jurisdictions to understand what local regulations exist to promote healthy housing, and developed community data dashboards to assist housing partners in identifying and leveraging community-based health resources.

For the coming year, the program has attracted over $275,000 of grant funding to support program activities in the area of community-based food systems improvements and air quality education. In addition, the program has leveraged over $300,000 in private and philanthropic funding for community food system improvements as a result of this team's facilitation of community-based coalitions and community food action plans over the last two years.

In 2020, Adams County approved funding for an air quality position to support and advance the goals and objectives in Adams County related to improving air quality. This position works with Adams County environmental program staff, and community partners on county related air quality strategies and policy matters. These strategies address a broad array of emissions sources including but not limited to oil and gas development and other industrial sources. Through the support of Adams County, this position is able to:

AIR QUALITY SUPPORT

- Enhance regional coordination on air quality matters that impact Adams County
- Work with county staff to implement strategies to increase local air pollution monitoring in the most populated areas of the county and around areas of increased air pollution sources
- Assist county staff in addressing public concerns and anticipate/mitigate potential risks associated with air emissions from oil and gas development around populated areas

Land Use cont.

Land Use Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total Number of Land Use Plan Reviews					
Adams	212	249	345	460	358
Arapahoe	101	121	139	137	106
Douglas	135	142	142	123	158
Number of Plan Review Cases Referred to TCHD from County Governments					
Adams	93	128	163	187	115
Arapahoe	61	79	86	69	61
Douglas	75	70	82	70	89
Number of Plan Review Cases Referred from City Governments					
Adams	119	121	182	273	243
Arapahoe	40	42	53	68	45
Douglas	60	72	60	53	69

Solid and Hazardous Waste Program

Solid and Hazardous Waste Program

Funding/Revenue Source(s): Fees, Restricted State Funds, Donations, Contract Funds, General Funds

FY21 Program FTE: 3.02
FY21 Program Budget: $484,482

The goal of this program is to control the impacts of solid and hazardous wastes on human health and the environment. Local health departments are authorized by Colorado law to assist in compliance activities for solid waste sites. TCHD performs oversight of solid waste disposal sites to ensure that these facilities are properly constructed and operated to protect public health and the environment. The following services are conducted: investigate solid and hazardous waste complaints; monitor construction activities at hazardous waste disposal sites; monitor construction and operational activities at non-hazardous waste disposal sites; participate on the technical advisory committees for designated Superfund sites; serve as a community liaison to responsible parties and regulatory agencies for hazardous waste sites; respond to spills and emergencies involving hazardous materials to support local fire and law enforcement agencies 24/7; provide household chemical waste collection (Douglas County only) and education programs; inspection of waste tire generators; and perform methamphetamine lab cleanup oversight. The Lowry Landfill Oversight Program is included within the broader Solid and Hazardous Waste Program. TCHD has provided oversight of the Lowry Superfund site for decades in many different capacities such as responding to citizen complaints, conducting site inspections, sampling of private wells near the site for contamination, reviewing technical documents in coordination with CDPHE and the EPA, and providing input into the EPA Superfund Five-Year Review process. The Superfund Five-Year Reviews are prepared by the EPA to evaluate the implementation and performance of the site remedies to determine they remain protective of human health and the environment.

Solid and Hazardous Waste Program cont.

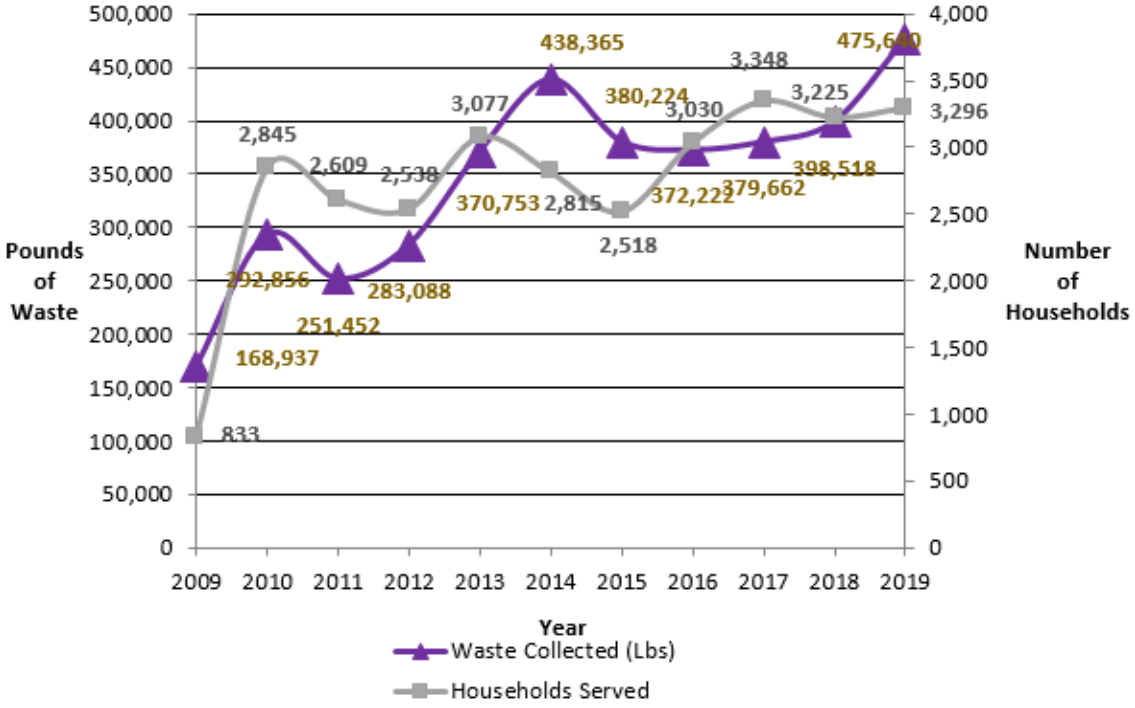
Solid and Hazardous Waste Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total Number of Landfill Inspections					
Adams	33	40	34	23	2
Arapahoe	1	1	1	3	0
Douglas	12	23	19	12	2
Number of Solid or Hazardous Waste Complaints					
Adams	42	36	29	34	20
Arapahoe	46	59	52	61	43
Douglas	12	22	35	20	21
Number of Methamphetamine Labs Cleared					
Adams	12	4	5	10	2
Arapahoe	12	7	12	23	15
Douglas	0	1	0	2	5
Number of Waste Tire Facility Inspections					
Adams	28	60	93	85	12
Arapahoe	25	29	23	43	0
Douglas	3	18	8	18	0
Number of Biosolid Facility Inspections					
Adams	5	7	14	-	4
Arapahoe	11	11	13	-	0
Douglas	0	0	0	-	0
Number of After-Hours Calls Received	70	165	163	193	378

Household Chemical Roundup

The Household Chemical Roundup (HCR) Program serves the residents of Douglas County by providing an opportunity to dispose and recycle hazardous chemicals from residents' homes in a safe, legal, and environmentally-sound manner. The Program provides an appropriate outlet for wastes that might otherwise end up in local creeks, storm water systems, sanitary sewers, and septic systems, or disposed of illegally on public or private property. Additionally, decreasing and removing hazardous products from homes reduces fire hazards and the potential for accidental poisonings. The purpose of the HCR Program is to serve the community of Douglas County by educating residents of the consequences to human health and the environment if hazardous items are improperly disposed of down the drain, on the ground, or in the trash and provide an alternative method of disposal. Throughout the year, the HCR Program provides information to the public regarding best practices in reducing the generation of household hazardous waste, including the most current methods to recycle and dispose of items to prevent improper disposal.

Douglas County Household Chemical Roundup Statistics, Households Served and Waste Collected (Lbs), 2009-2019



Industrial Hygiene Program

Industrial Hygiene Program

Funding/Revenue Source(s): Fees, General Funds, Restricted Grant Funds

FY21 Program FTE: 0.85
FY21 Program Budget: $86,377

The goal of the Industrial Hygiene Program is to reduce indoor air pollution effects and events, workplace health and safety hazards, and workplace injuries and illnesses. Hazards in the workplace have been well documented, which led to the creation of the federal Occupational Safety and Health Act (OSHA) in 1970. According to the Environmental Protection Agency (EPA), indoor air pollution is one of the top five health hazards facing the general population. Major sources of indoor air pollution include combustion sources (i.e., wood and tobacco products), lead, asbestos, outdoor sources (e.g., radon), mold, and various chemicals. The following services are conducted: investigation of complaints or inquiries; assistance in eliminating workplace health and safety hazards; follow up investigation for homes with children and high lead levels; and radon education and testing. For the fourth straight year, TCHD was awarded $5,000 in grant funding from the Colorado Department of Public Health and Environment (CDPHE), which helped support the purchase of 720 at-home radon test-kits in January of 2021 to be distributed to the public. TCHD has leveraged other state grant funding as part of a regional collaboration to enhance awareness and testing of homes for radon as well as work on policy related to radon resistant new construction and building codes to mitigate radon exposure. Radon is a colorless, odorless and tasteless natural gas which seeps into residential homes through the ground regardless of home build, shape or size. Radon has been named as the 2nd leading cause of lung cancer by the U.S. Environmental Protection Agency and the U.S. Surgeon General. The best way to protect the public from radon in residential homes is to test and provide mitigation education and resources. TCHD's Industrial Hygiene staff seek to provide this free testing to any member of the public in the TCHD jurisdiction.

Industrial Hygiene Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total Industrial Hygiene-Related Complaints					
Adams	85	34	39	35	20
Arapahoe	116	88	83	87	36
Douglas	39	40	23	19	15
Total Number of Onsite Investigations Requiring Industrial Hygiene Sampling	101	47	59	26	22

Rocky Mountain Arsenal (RMA) Program Program

Rocky Mountain Arsenal Program

Funding/Revenue Source(s): Restricted Federal Funds

FY21 Program FTE: 1.25
FY21 Program Budget: $206,161

The goal of the RMA program is to protect the community from short and long-term environmental risks associated with the RMA's previous waste disposal activities and during ongoing operations and maintenance of the site. Off-post groundwater quality is monitored to verify there is no risk to the public through consumption of private well water and to verify that RMA cleanup efforts continue to be effective. On-post remediation oversight is provided consistent with the provisions of the Certificate of Designation issued by Adams County on September 29, 1997, and specific agreements TCHD has with Adams County and with the Department of the Army. The following services are conducted: sample and analyze water from selected private wells in the RMA off-post study area for contaminants; oversight of completed on-site waste disposal areas, caps and covers; act as liaison with affected communities in Adams County concerning RMA related issues and the responsible parties (U.S. Army and Shell Oil Co.); and provide oversight of RMA remediation and monitoring activities.

Vector Surveillance Program

Vector Surveillance Program
Funding/Revenue Source(s): General Funds

FY21 Program FTE: 0.65
FY21 Program Budget: $65,700

The goal of the Vector Surveillance program is to reduce exposure and transmission of vector-borne diseases to the public. Vectorborne diseases have been recognized as potentially having fatal consequences. Diseases such as Arboviral Encephalitis (e.g., West Nile virus), plague, Hantavirushantavirus, and tularemia Colorado tick fever are endemic in the TCHD area. Because outbreaks of vector-borne diseases are not predictable, ongoing surveillance of mosquito breeding sites is conducted. Monitoring for the presence of Western Equine Encephalitis, St. Louis Encephalitis, and West Nile virus (WNV) is accomplished through horse, mosquito, and human surveillance and mosquito testing. Prairie dog mapping and die- off investigations are conducted to determine local black-tail prairie dog colony locations and the presence of plague. The following services are conducted: surveillance for arboviruses in the environment; participation in the State Regional Encephalitis Monitoring program where TCHD maintains two sentinel mosquito trapping sites; routine mosquito light trapping and mosquito identification (June through September); collection and transport of animal specimens to the CDPHE laboratory for testing (plague, tularemia, WNV, and rabies); education to the public; prairie dog colony complaint die-off investigation; hantavirus environmental investigations; and flea collection and submission to the Centers for Disease Control and Prevention (CDC) for plague testing. Over the years, TCHD has responded to several significant and high-profile outbreaks of plague and hantavirus in all three counties, most recently was the 2019 plague outbreak amongst prairie dogs at Dicks Sporting Goods Park and the Rocky Mountain Arsenal. TCHD led efforts with state and local partners including CDPHE, Commerce City, and Fish and Wildlife Service to respond to and control the outbreak. Other significant outbreaks include a rare case of human acquired plague in Bennett in 2014 and human hantavirus investigations in Adams County in 2014 and 2012.

Vectorborne Surveillance Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total Number of Vectorborne Complaints					
Adams	59	49	35	34	36
Arapahoe	116	137	126	133	67
Douglas	42	37	24	31	13

Nursing

The Division of Nursing focuses on promoting good health for children and adults through linkages to health insurance and health care services; nurse case management; disease prevention; and clinical, preventive, and health education programs.

Nursing Division

Funding/Revenue Source(s): General Funds, County Restricted Funds, Medicaid Reimbursement, Fees, State Restricted Funds, Federal Restricted Funds, Other Restricted Funds, and In-Kind Revenue

FY21 Division FTE: 136.11
FY21 Division Budget: $15,717,141

Division Operations

This core leadership team is responsible for oversight, planning, implementation, and evaluation of all nursing activities and programs. This division operations team is also responsible for financial oversight, data collection and management, grant and contract management, and program evaluation. This team also assists with quality assurance and improvement processes.

Division Operations

Funding/Revenue Source(s): General Funds

FY21 Program FTE: 8.29
FY21 Program Budget: $1,210,467

Immunizations Program

This program provides immunizations to individuals of all ages to protect them from vaccine-preventable diseases. Immunizations are available every weekday and one Saturday per month. Clinics are held in TCHD offices and at community-based sites around the three-county region and appointments are coordinated through the TCHD Patient Services Call Center. The Immunization Program targets persons who are uninsured or underinsured. There is no residency or income requirement; although a $22 administration fee is requested for each immunization, nobody is turned away for inability to pay.

Immunizations Program

Funding/Revenue Source(s): Restricted Federal Funds, Restricted State Funds, General Funds, Medicaid Reimbursement, Patient Fees, Patient Donations, Private Insurance Billing

FY21 Program FTE: 23.70
FY21 Program Budget: $3,232,583
FY21 In-Kind Revenue (State-provided vaccine): $1,040,000

Immunization Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total Number of Clients Vaccinated					
Adams	1,998	1,878	2,088	2,375	1,435
Arapahoe	3,287	3,549	3,575	4,125	2,389
Douglas	601	675	924	1,129	894
Other*	1,580	1,775	1,601	2,358	1,143

Immunizations and Clinical Outbreak Response cont.

Immunization Program Metrics, 2016-2020 cont.

	2016	2017	2018	2019	2020
Number of Clinic Visits Where Vaccines Were Administered					
Adams	2,328	2,165	2,454	2,769	1,656
Arapahoe	4,006	4,256	4,227	5,028	2,858
Douglas	778	843	1,144	1,472	1,101
Other*	1,952	2,165	1,934	2,770	1,438
Number of Adult Vaccinations Administered					
Adams	898	1,012	1,109	1,330	634
Arapahoe	2,102	2,561	2,183	2,905	1,192
Douglas	446	510	686	937	451
Other*	1,567	1,678	1,563	2,373	833
Number of Child Vaccinations Administered					
Adams	5,048	4,363	4,978	5,049	3,086
Arapahoe	8,169	8,423	8,472	9,326	5,381
Douglas	1,125	1,299	1,583	1,807	1,647
Other*	3,026	3,235	2,915	3,408	2,588
Number of Vaccination Outreach Events					
Adams	1	2	3	35	8
Arapahoe	18	34	11	53	11
Douglas	0	0	0	5	0

** Contractual obligation requires that vaccines are provided to individuals regardless of county of residence. There are insurance status and income guidelines to receive some of the vaccine services.*

Call Center

Clinic and customer support staff in the TCHD Call Center schedule appointments and screen clients for program qualifications pertaining to various nursing programs. These programs include services for Sexual Health, Immunizations, STI/HIV/Hepatitis C prevention, presumptive health insurance eligibility for children or pregnant women, and health insurance enrollment navigation. In addition to processing phone calls, clinic and customer support staff are routinely assigned to immunization clinics where they are responsible for checking clients in/out, pre-screening immunization records, checking insurance eligibility, accurately entering data into an electronic health record, collecting payments, and providing general program referral information.

Number of Calls Received by TCHD Call Center by Type, 2016-2020

	2016	2017	2018	2019	2020
Total Calls	28,013	24,963	25,908	28,707	16,894
Sexual Health	13,845	12,282	11,667	13,494	10,505
Immunizations	10,825	9,945	10,937	11,825	8,972
Presumptive Eligibility (Medicaid)	2,853	2,417	2,701	2,412	1,011
Peak*	490	319	513	524	84
HIV	-	-	90	452	93

** Includes calls for sunsetted programs and services for cancer screening and prevention, cardiovascular disease screening and prevention, diabetes screening and prevention, and related medical records requests.*

Disease Prevention and Clinical Services Program – Sexual Health

The goal of this program is to provide sexual health services and thereby prevent unintended pregnancies and transmission of HIV and sexually transmitted infections (STIs). The Sexual Health program sees women and men and targets at-risk populations, including those who are under-served, low-income and adolescents. The program offers reproductive health exams, contraceptive counseling and supplies, cervical cancer screening, pregnancy testing, HIV testing and STI testing and treatment. The program also offers pre-conception counseling for clients planning a pregnancy. Annually this program also helps to educate thousands of high school students within the TCHD jurisdiction about sexual health. Visit and class numbers in 2020 were affected by the COVID-19 pandemic.

Sexual Health Program

Funding/Revenue Source(s): Restricted Federal Funds, Restricted State Funds, General Funds, Medicaid Reimbursement, Patient Fees, Patient Donation

FY21 Program FTE: 29.41
FY21 Program Budget: $3,232,583
FY21 In-Kind Revenue (State-provided STI tests): $96,000

Sexual Health Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Number of Unduplicated Clients	5,776	5,279	5,397	5,880	3,547
Adams	2,112	1,814	1,782	1,832	1,136
Arapahoe	2,163	2,043	2,134	2,347	1,400
Douglas	292	260	293	324	182
Other*	1,209	1,162	1,188	1,377	829
Birth Control Services by County					
Adams	3,851	3,387	3,220	2,967	1,986
Arapahoe	3,789	3,565	3,532	3,612	2,233
Douglas	526	476	505	468	277
Other*	2,173	2,077	2,048	2,078	1,332
Prescription Services by County					
Adams	1,512	1,407	1,392	1,308	826
Arapahoe	1,568	1,615	1,572	1,701	981
Douglas	217	205	221	215	127
Other*	-	-	-	-	-
STI Testing Services by County					
Adams	826	836	1,074	1,310	555
Arapahoe	674	766	1,107	1,482	644
Douglas	117	124	188	247	113
Other*	470	479	713	1,008	431
LARC Insertion Visits by County	685	768	757	641	93
Adams	260	242	239	188	27
Arapahoe	272	333	314	274	38
Douglas	28	32	43	35	3
Other*	125	161	161	144	25

Disease Prevention and Clinical Services Program – Sexual Health cont.

Sexual Health Program Metrics, 2016-2020 cont.

	2016	2017	2018	2019	2020
Sexual Health Education Classes by County	42	69	91	66	5
Adams	32	50	51	26	5
Arapahoe	8	17	41	40	0
Douglas	2	2	0	0	0
Number of Students Reached in Sexual Health Classes by County	1,333	2,478	2,589	1,960	216
Adams	1,073	1,753	1,363	773	216
Arapahoe	200	670	1,226	1,187	0
Douglas	60	55	0	0	0

** Contractual obligations require services are provided to any individual regardless of age, race, ethnicity, gender, sexual orientation, income, or residency status.*

Senior Dental (Arapahoe County)

The Senior Dental program provides preventative, restorative, and maintenance dental services to income-eligible seniors residing in Arapahoe County. Qualifying adults over 55 can receive care on a sliding fee scale with the majority of funding provided by Arapahoe County. Routine dental care improves the quality of life, general health, and well-being for senior citizens. The Senior Dental Program experienced decreases in visits in 2020 due to the COVID-19 pandemic.

Arapahoe Senior Dental Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Number of people served	384	334	310	284	215
Number of Patient Visits	1,855	1,673	1,337	1,220	752

Senior Dental Program

Funding/Revenue Source(s): Fees, Restricted County Funds, Restricted State Funds, Medicaid Reimbursement

FY21 Program FTE: 3.00
FY21 Program Budget: $422,339

Nurse Home Visiting Program – Nurse Family Partnership

Nurse Family Partnership

Nurse-Family Partnership is a family support program that empowers first time, low-income mothers to create healthy and stable futures for themselves and their babies; its evidence base for cost-effectively preventing a range of adverse health and social conditions and improving family well-being is among the most impressive of any public health program. The program aims to improve pregnancy outcomes, enhance child health and development and increase family self-sufficiency by visiting regularly with families in their home, starting early in pregnancy and continuing until their child's second birthday. Serving as trusted resources, NFP nurses partner with families to provide education, tools, resources and support so that mothers and their partners (if involved) can safely and confidently care for their child and take steps towards achieving their education and employment goals. Promoting long term economic self- sufficiency enhances opportunities for a stable and secure future for families, and potential reduction in use of government services. Due to the COVID-19 pandemic, the Nurse Family Partnership program conducted fewer nurse home visits due to a shift to exclusive telehealth services in mid- March 2020, which has allowed for continuity of services for many families.

Nurse Family Partnership Program

Funding/Revenue Source(s): Restricted Federal Funds, Restricted State Funds, Medicaid Reimbursement

FY21 Program FTE: 31.16

FY21 Program Budget: $4,120,513

Nurse Family Partnership Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total Number of Clients Served	684	790	743	708	716
Adams	212	218	209	204	220
Arapahoe	415	516	490	447	446
Douglas	57	56	44	57	50
Total Caseload	445	522	483	445	487
Adams	100	146	131	136	154
Arapahoe/Douglas	345	376	352	309	333
Total Number of Home Visits	7,567	7,996	7,821	6,692	1,346
Adams	2,228	2,160	2,057	1,802	379
Arapahoe	4,625	5,313	5,197	4,367	866
Douglas	714	523	567	523	101
Total Number of Telehealth Visits	965	1,069	1,033	757	6,447
Adams	339	404	367	215	1,915
Arapahoe	531	621	615	479	4,093
Douglas	35	44	51	63	439
Total Number of Direct Referrals*	2,162	3,037	1,019	1,026	959
Adams	546	1,163	382	344	289
Arapahoe	1,453	1,736	575	618	604
Douglas	163	138	62	64	66

Nurse Home Visiting Program – Nurse Family Partnership cont.

Nurse Family Partnership Program Metrics, 2016-2020 cont.

	2016	2017	2018	2019	2020
Total Number of Medicaid Referrals**	-	-	2,301	2,317	2,101
Adams	-	-	631	767	554
Arapahoe/Douglas	-	-	1,670	1,550	1,547

**Direct referral totals for 2016 and 2017 include Medicaid referrals, while the remaining years represent referrals from direct sources only. This shift in tracking referrals occurred due to a change midway through 2017, when Health Care Policy and Finance no longer filtered their Medicaid lists for only first-time mothers, therefore including multiparious women who are not eligible for the NPF Program.*

*** Depicts Medicaid referrals received in later years. Unable to separate Arapahoe and Douglas County Medicaid referrals.*

Nurse Home Visiting Program

Adams County Nurse Support Contract Program

Funding/Revenue Source(s): Restricted County Funds, Medicaid Reimbursement

FY21 Program FTE: 6.60

FY21 Program Budget: $586,947

This program is a longstanding contract with the Adams County Human Services Department (ACHSD). ACHSD recognizes that public health nursing intervention can result in improved pregnancy outcomes, parenting knowledge, and enhanced self-sufficiency for families receiving benefits or involved with child welfare.

Arapahoe County Nurse Support Contract Program

Funding/Revenue Source(s): Restricted County Funds, Medicaid Reimbursement

FY21 Program FTE: 13.16

FY21 Program Budget: $1,282,556

The Arapahoe County Department of Human Services (ACDHS) recognizes that public health nursing intervention can result in improved pregnancy outcomes, parenting knowledge, and enhanced family self-sufficiency. The County also provides funds for public health nurses to work with child and adult welfare units, to provide professional assessments, and to act as liaison for families referred to human services.

Douglas County Nurse Support Contract Program

Funding/Revenue Source(s): Restricted County Funds, Medicaid Reimbursement

FY21 Program FTE: 1.54

FY21 Program Budget: $143,967

This program is the result of a new contract with the Douglas County Department of Human Services (DCDHS) to provide public health nursing intervention resulting in supporting and helping families stay together, prevention of out-of-home placements, reduction of unintended pregnancies, and provisioning of prenatal education and psychosocial support for pregnant women and their families

Nurse Home Visiting Program – Nurse Family Partnership cont.

Nurse Support Programs Metrics, 2016-2020

	2016	2017	2018	2019	2020*
Number of Referrals Received					
Adams	83	166	229	203	135
Arapahoe	900	910	822	253	136
Douglas	-	-	-	-	82
Number of Nurse Liaison Referrals Received					
Adams	-	-	-	-	-
Arapahoe	960	1,145	1,037	1,145	960
Douglas	-	-	-	-	-
Number of Home Visits Completed					
Adams	389	484	985	1,497	1,072
Arapahoe	1,617	1,599	1,762	1,060	1,014
Douglas	-	-	-	-	128

***2020 services numbers are reduced due to COVID-19 response*

Child Fatality Prevention Review

The Colorado Child Fatality Prevention Act mandates local county review of all preventable child deaths. TCHD coordinates community partners, law enforcement, behavioral health and county officials in all three counties and facilitates case reviews to identify specific policy recommendations to prevent child deaths in Colorado.

The purpose of fatality review teams is to apply a public health approach to prevent child deaths by aggregating data from individual cases, describing trends and patterns of deaths and recommending prevention strategies. Strategies, like those emerging from 2020 data, may include recommendations to increase access to adolescent behavioral health treatment for suicide prevention, parental support to build awareness of warning signs of substance use, or culturally appropriate safe sleep education.

Child Fatality Prevention Review Program

Funding/Revenue Source(s): Restricted State Funds, General Funds

FY21 Program FTE: 0.75
FY21 Program Budget: $66,984

Child Deaths Reviewed by Year, 2018-2020

	2018	2019	2020
Adams	21	23	24
Arapahoe	19	31	20
Douglas	13	5	8

HCP - A Program for Children and Youth with Special Healthcare Needs

The HCP Program provides services to children and youth with special health care needs from birth to 26 years living in Adams, Arapahoe and Douglas County, who have or are at risk of physical, developmental, behavioral or emotional conditions. Registered nurses and a registered nutritionist provide information, referrals and coordination of care for families with children with special needs. The HCP Team engages families to identify and prioritize the needs of the family, develops a plan of care to work on shared goals, and helps family members become strong advocates for their children/youth.

HCP Program

Funding/Revenue Source(s): Maternal Child Health Block Grant, Title V

FY21 Program FTE: 4.86
FY21 Program Budget: $487,864

HCP Program Metrics, 2019-2020

	2019	2020
Total Clients Served	243	131
Adams	85	44
Arapahoe	137	77
Douglas	17	18
Other	4	8
Referrals	298	155
Adams	119	52
Arapahoe	149	77
Douglas	25	18
Other	5	8

Public Health Nursing Clinical Education

TCHD's Public Health Nursing Clinical Education Program is primarily responsible for providing a wide variety of public health clinical education experiences for nursing students, thereby encouraging public health as a career development pathway and assisting in the coordination of professional development for division staff. This program leads student placements for contracted schools of nursing, provides latent tuberculosis case management to referred clients, coordinates ancillary nursing student placements, and participates on internal work groups including the Disease Intervention Field Team and the Public Health Incident Management Team.

Public Health Nursing Clinical Education Program

Funding/Revenue Source(s): Restricted Contracts, General Funds

FY21 Program FTE: 0.60
FY21 Program Budget: $65,664

Public Health Nursing Clinic Education Outcomes, 2019-2020

	2019	2020
Total Number of Students in Program	57	42
Percent of Students with Increase Interest in a Public Health Career	51%	91%
Percent of Students with Demonstrated Increase of Public Health Nursing Knowledge	100%	84%
Percent of Students with Increased Knowledge of Public Health Role within the Community	95%	84%

Regional Health Connectors

A new program, Regional Health Connectors (RHC), was introduced in Colorado beginning in 2016 with TCHD staffing this new program beginning in 2017. Between 2017 and 2019, the program was supported by funding from the Colorado State Innovation Model and EvidenceNOW Southwest. Since July 2019, the program has been supported through a grant from the University of Colorado and TCHD general funds. TCHD's RHC Program includes one RHC for each county.

Very broadly, RHCs are dedicated to improving the coordination of local services to advance health. Their aim is to build and strengthen networks of primary care, public health, human services, and community organizations working to improve health. RHCs do this by:

COORDINATION OF LOCAL SERVICES

- Connecting primary care providers and clinics with behavioral health and human services
- Developing and implementing local projects to advance community health through multi-sector collaborations in local communities
- Partnering with Quality Improvement Teams to help providers in the health care delivery system prepare for new models of care and reach performance goals and
- Recommending reliable community resources to improve health outcomes.

Regional Health Connector Partnership Interactions by County, July 2017-June 2019

County	# Clinical Practices	# Interactions	# Group Interactions	Leadership Role
Adams	32	769	445	31%
Arapahoe	30	460	150	33%
Douglas	12	749	302	50%

Clinical Practices: number of unique clinical practices that RHCs provide technical assistance and resources
Interactions: number of unique activities related to working with individual external partners (meetings, telephone collaboration)

Group Interactions: coalitions, convenings, advisory boards, alliances, etc.
Leadership role: percentage of group interactions where RHC is serving in the leadership role. (convener or facilitator)
Unique to Arapahoe County: RHC provided direct care to clients in the Immunizattion Program at the Aurora East clinic .2 FTE/wk

Since inception, the RHC Program has provided significant staff capacity to respond to agency strategic priorities. First, RHCs working towards the TCHD 2015 Strategic Plan Goal to Increase Interactions with the Health Care Delivery System. Second, RHCs working toward the TCHD PHIP Goal of Improving Access to Physical and Mental Health Care in addition to supporting work in the other PHIP goal areas including Food, Mental Health, and Housing. Most recently, the RHCs have been fully activated in TCHD's COVID-19 Response since March 2020, including supporting work in community testing access, mass vaccination efforts, and community recovery efforts.

The following county specific links provide a more detailed breakdown of each RHC and their contributions (representative of work early 2020, prior to COVID):

REGIONAL HEALTH CONNECTORS ADDITIONAL INFORMATION

- Adams County RHC 1-Pager
- Arapahoe County RHC 1-Pager
- Douglas County RHC 1-Pager

Healthy Communities Program and Health Enrollment Team

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for all residents. Improved access is dependent on a number of important factors including adequate insurance coverage and availability of health services. For almost 30 years, the Healthy Communities Program improved access for children and pregnant women eligible for Medicaid and Child Health Plan Plus (CHP+) by providing application assistance to enroll in insurance and education and navigation on accessing medical care and non-medical services, including food, housing and transportation assistance. The Healthy Communities Program, staffed with 12.0 FTE, ended in July 2020 due to a decision by the state legislature to eliminate funding for the statewide program as part of COVID-19 budget changes.

Regional Health Connectors and Health Enrollment Team Program

Funding/Revenue Source(s): Restricted Federal Funds, Restricted State Funds, General Funds, Medicaid Reimbursement

FY21 Program FTE: 5.9
FY21 Program Budget: $549,169

Having health insurance is one of the 10 leading health indicators in Healthy People 2030, identified as a goal area in TCHD's PHIP, and a critical tool in combatting the impact of COVID-19. Recognizing the importance of health care coverage, in July 2020, TCHD recommitted existing agency funding to sustain a smaller team of 3.0 FTE, including a 1.0 FTE cost share position with Adams County Human Services (90/10 cost share with TCHD at 10%) focused on health insurance enrollment. This smaller team relaunched as the Health Enrollment Team, and works to increase the proportion of persons with medical insurance by providing community members with application assistance to enroll in Medicaid and CHP+. In the Fall of 2020, the team expanded to include assistance with enrollment into Connect for Health Colorado marketplace plans through a partnership with ConnectAurora.

THE HEALTH ENROLLMENT TEAM ACTIVITIES INCLUDE:

- Determining eligibility for different coverage programs based on income and other qualifications;
- Assisting individuals from any county with the application process, reducing the burden of navigating a complex system and ensuring individuals get coverage as quickly as possible;
- Co-locating with other types of organizations to ensure people can get enrollment assistance at a location that is convenient for them; and
- Helping thousands of people get enrolled in Medicaid or CHP+, with an average of 95% of TCHD applications getting approved by the County.

Healthy Communities Program Metrics, 2016-2019

	2016	2017	2018	2019
Number of Medicaid/CHP+ Applications	1,659	1,897	1,288	1,204
Number of Medicaid Linkage and Educational Interactions	45,252	65,401	47,912	58,184

Health Enrollment Team, Quarter 3 and Quarter 4 2020

	2020
Medicaid application assistance provided by TCHD (PE, EMK, or Adult)	206
Number of Medicaid enrollment assistance calls, non-application (i.e., change forms, look ups)	684

Harm Reduction and HIV Prevention Program

This program focuses on the prevention and education of Human Immunodeficiency Virus (HIV) and Hepatitis C Virus. Providers in this program focus on individual screening, community education, and outreach to individuals affected by these infections. Ryan White, Linkage to Care services are provided for individuals who have been newly diagnosed or have fallen out of HIV care. This program also includes syringe access services (SAS); provision of sterile syringes, syringe disposal, safe injection supplies, referrals, and naloxone for individuals that use intravenous drugs and who are at-risk for HIV and Hepatitis C infection and overdose death. In May 2019, TCHD's Syringe Access Program was awarded the National Association of County and City Health Officials (NACCHO) Model Practice Award. This award is granted to programs demonstrating exemplary qualities in response to a critical local public health need. In January 2020, syringe access services were expanded to serve Adams County residents. Decrease in numbers in 2020 are due to COVID-19 restrictions.

Harm Reduction and HIV Prevention Program

Funding/Revenue Source(s): Restricted Federal Funds, Restricted State Funds, Medicaid Reimbursement

FY21 Program FTE: 7.10
FY21 Program Budget: $764,691

The Harm Reduction and HIV Prevention team has prioritized mobile/outreach-based interventions, actively removing barriers to care by meeting the most vulnerable residents where they are. This program delivers testing and prevention services in public libraries, shelters, correctional facilities, treatment centers, and encampments. Decreased numbers in 2020 are due to COVID-19 restrictions.

Disease Prevention Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Number of HIV Tests Performed	636	547	595	425	112
Adams	191	164	178	128	34
Arapahoe	445	383	417	297	78
Number of Hepatitis C Tests Performed	68	70	90	186	39
Adams	20	21	27	56	12
Arapahoe	48	49	63	130	27

Naloxone Reversal Rate, 2017-2020

	2017	2018	2019	2020
Number of Naloxone Kits Given	129	154	191	201
Number of Reversals Reported	16	22	24	30
Naloxone Reversal Rate	12%	14%	13%	15%

Harm Reduction and HIV Prevention Program cont.

Syringe Access Program Metrics, 2018-2020

	2018	2019	2020
Number of unique participants	176	295	210
Adams	15	17	56
Arapahoe	52	117	143
Douglas	1	3	5
Other	108	158	6
Number of Syringe Access Encounters	534	1,112	1,009
Adams	37	102	125
Arapahoe	122	490	528
Douglas	1	11	14
Other	374	509	342
Number of Syringes Dispensed	44,151	77,645	85,574
Adams	1,550	4,850	8,499
Arapahoe	7,630	28,840	43,202
Douglas	10	340	1,130
Other	34,961	43,615	32,743
Number of Syringes Returned	39,621	68,403	80,300
Adams	1,186	3,916	8,086
Arapahoe	6,687	24,664	41,308
Douglas	0	232	1,015
Other	31,748	39,591	29,891
Percent of Syringes Returned	90%	88%	94%
Adams	77%	81%	95%
Arapahoe	88%	86%	96%
Douglas	0%	68%	90%
Other	91%	90%	91%
Naloxone Kits Provided	154	191	201
Adams	12	9	38
Arapahoe	22	76	88
Douglas	1	0	3
Other	120	106	75

Nutrition

TCHD's Nutrition Division is comprised of five distinct programs, including Women, Infants, and Children (WIC); Hunger Free Outreach SNAP; Food Security; Bringing WIC 2 U; Baby and Me Tobacco Free; Breastfeeding Peer Counselors; and the Dietetic Internship. The Division staff serve all TCHD clinic locations and six additional sites.

Nutrition Division

Funding/Revenue Source(s): Restricted County Funds, Fees, Restricted Federal Funds, State Restricted Funds, General Funds

FY21 Division FTE: 68.41
FY21 Division Budget: $6,397,257

Nutrition Division Administration

This core leadership team is responsible for oversight, planning, implementation, and evaluation of all Nutrition activities and programs. This team is also responsible for financial oversight, data collection and management, grant and contract management, and program evaluation. This team also assists with quality assurance and improvement processes and leads efforts for the Public Health Improvement Plan around Health and Food.

Nutrition Division Administration

Funding/Revenue Source(s): County Restricted Funds, State Restricted Funds

FY21 Program FTE: 1.90
FY21 Program Budget: $167,408

The Supplemental Nutrition Program for Women, Infants, and Children (WIC)

The WIC program at TCHD provides monthly nutrition education, breastfeeding support, referrals and food benefit to over 20,500 women, infants, and children in TCHD's three counties through individual and group counseling sessions. There are 11 WIC clinic locations as well as a WIC presence with community partners (Children's Health Clinic and Stride), Human Services, housing authorities and food pantries. Over $13.7 million is added to the local economy of TCHD's three counties each year through the foods WIC clients purchase directly, which include fresh fruits and vegetables and whole grains. It is estimated that for every WIC dollar spent, clients spend an additional four dollars while at the store. WIC increases access to fresh fruits and vegetables through three community gardens with local partners to promote healthy eating and physical activity: Adams County School District 27J in Brighton, and Amazing Meadows Garden in Thornton. TCHD also helps to host two Healthy Farmers' Markets in Adams County with Anythink Libraries, American Heart Association, City of Thornton and local farmers. The WIC program's primary focus areas are providing nutritious supplemental foods, nutrition education, breastfeeding promotion and support, education on healthy eating, and referrals to community partners to healthcare and critical social services, and obesity prevention. By providing preventive health services during critical periods of growth and development, WIC helps to lower healthcare costs and improve health outcomes for its participants. In addition, by reducing the number of pre-term births and low birthweight babies, WIC is contributing to substantial healthcare cost savings. Numerous studies show that WIC is effective and helps:

The Supplemental Nutrition Program for Women, Infants, and Children (WIC)

Funding/Revenue Source(s): Restricted County Funds, Restricted Federal Funds, State Restricted Funds

FY21 Program FTE: 61.13
FY21 Program Budget: $5,768,434

**Includes WIC, WIC Central Pilot Referral Pilot, Hunger Free Colorado Outreach Program, and DRCOG Accountable Health Communities grant.*

The Supplemental Nutrition Program for Women, Infants, and Children (WIC) cont.

WOMEN, INFANTS, AND CHILDREN (WIC) HELPS:

- Reduce premature babies
- Reduce low and very low birthweight babies
- Reduce fetal and infant deaths
- Reduce the incidence of iron-deficiency anemia
- Increase the access to prenatal care earlier in pregnancy
- Increase pregnant women's consumption of key nutrients, such as iron, protein, and calcium and Vitamins A and C
- Increase immunization rates
- Improve diet quality
- Increase access to regular health care

The TCHD WIC Program participates in a number of outreach programs aimed at increasing engagement and enrollment in WIC programs across the TCHD jurisdiction. Additional funding from the Colorado WIC State Office at the Colorado Department of Public Health and Environment allowed TCHD to hire and supervise WIC Engagement Specialists who aim to improve and centralize processes for referrals from healthcare and community partners that screen for food insecurity and to equitably maximize program access for eligible participants. Additionally, TCHD was awarded funding from Hunger Free Colorado to cross train two WIC Educators (2 FTE total) to assist individuals in completing SNAP applications. These WIC educators provide remote and face-to-face SNAP application assistance at TCHD WIC offices, in grocery stores, and in medical provider offices. TCHD's goal for this grant is to complete 636 SNAP applications per year. This project aligns with TCHD's Public Health Improvement Plan (PHIP) Food Access priority area to increase enrollment in Federal nutrition programs in Adams, Arapahoe and Douglas counties. Finally, as part of the DRCOG Accountable Health Communities (AHC) project, TCHD is screening Medicaid clients seen in TCHD's Nutrition programs for health-related social needs (i.e., housing, food, utilities, transportation and safety needs). Clients are provided appropriate referrals and patient navigation services and will enter data into the AHC Portal.

In 2016, TCHD's WIC program earned a NACCHO Model Practice award for its work in assessing and providing marijuana education to WIC clients. TCHD conducted a survey of WIC clients to assess marijuana use and to gain understanding regarding the educational needs around the health effects of marijuana use. As a result of the survey, TCHD developed a website with marijuana resources and information, a brochure that focuses on marijuana use during pregnancy, breastfeeding and parenting; and a resource and referral guide for TCHD staff if they receive questions from the public regarding marijuana.

The Supplemental Nutrition Program for Women, Infants, and Children (WIC) cont.

WIC Benefits Spent by County and Number of Stores, TCHD Jurisdiction, 2017-2020

	2017	2018	2019	2020
WIC Dollars Spent				
Adams	$7,226,086.87	$7,004,876.54	$6,408,764.80	$5,980,622.77
Arapahoe	$8,122,294.98	$8,122,294.98	$7,380,169.25	$7,084,995.00
Douglas	$613,059.11	$779,573.61	$822,685.64	$823,574.97
No. of Stores Participating				
Adams	37	37	37	37
Arapahoe	51	51	51	51
Douglas	22	22	22	22

WIC Client Caseload by Office Location, TCHD Jurisdiction, 2016-2020

Office Location	2016	2017	2018	2019	2020
Westminster	3,609	3,533	3,309	3,022	3,034
Commerce City	1,881	1,796	1,784	1,676	1,431
Brighton	1,262	1,187	1,165	1,068	1,055
Every Child Pediatrics – Thornton	-	-	248	298	205
Salud	-	-	-	137	101
North Broadway	2,853	2,885	2,758	2,551	2,607
Aurora East	3,062	2,978	3,079	3,030	3,072
Englewood	1,311	1,291	1,238	1,175	1,112
Bennet	110	123	107	93	96
Aurora West	3,221	3,019	2,764	2,563	2,244
Aurora South	4,501	4,375	4,206	4,032	4,006
Aurora Stride Del Mar	-	-	-	110	127
Child Health Clinic	-	-	-	16	135
Castle Rock	469	434	479	511	524
Lone Tree	601	637	722	781	816
Elizabeth	54	56	69	57	37

The Supplemental Nutrition Program for Women, Infants, and Children (WIC) cont.

WIC Clients by Race/Ethnicity, by County, 2017-2020

		2017	2018	2019	2020
Total Women (Pregnant, Breastfeeding, Not Breastfeeding)					
Adams	All Races	6,433	6,027	5,569	5,520
	American Indian or Alaska Native (Non Hispanic)	95	105	94	76
	Asian (Non Hispanic)	231	208	181	191
	Black (Non Hispanic)	312	332	303	329
	Native Hawaiian or Pacific Islander (Non Hispanic)	31	31	28	19
	Hispanic (Any Race)	4,142	3,846	3,624	3,574
	Two or More Races (Non Hispanic)	61	59	54	50
	Unknown Race	3	2	1	1
	White (Non Hispanic)	1,558	1,444	1,284	1,280
Arapahoe	All Races	5,341	5,069	4,903	4,772
	American Indian or Alaska Native (Non Hispanic)	88	92	66	67
	Asian (Non Hispanic)	308	304	292	268
	Black (Non Hispanic)	1,148	1,104	1,070	1,068
	Native Hawaiian or Pacific Islander (Non Hispanic)	52	61	58	52
	Hispanic (Any Race)	2,217	2,111	2,051	2,067
	Two or More Races (Non Hispanic)	177	154	155	142
	Unknown Race	1	3	2	
	White (Non Hispanic)	1,350	1,240	1,209	1,108
Douglas	All Races	504	597	557	572
	American Indian or Alaska Native (Non Hispanic)	3	8	3	4
	Asian (Non Hispanic)	22	30	37	27
	Black (Non Hispanic)	17	26	31	29
	Native Hawaiian or Pacific Islander (Non Hispanic)	2	3	3	5
	Hispanic (Any Race)	134	159	155	168
	Two or More Races (Non Hispanic)	10	16	20	18
	Unknown Race				
	White (Non Hispanic)	316	355	308	321

The Supplemental Nutrition Program for Women, Infants, and Children (WIC) cont.

WIC Clients by Race/Ethnicity, by County, 2017-2020 cont.

		2017	2018	2019	2020
Total Infants and Children					
Adams	All Races	13,892	13,775	12,916	12,415
	American Indian or Alaska Native (Non Hispanic)	252	304	286	247
	Asian (Non Hispanic)	479	481	428	389
	Black (Non Hispanic)	671	728	719	692
	Native Hawaiian or Pacific Islander (Non Hispanic)	69	57	48	42
	Hispanic (Any Race)	9,502	9,296	8,734	8,349
	Two or More Races (Non Hispanic)	217	215	220	228
	Unknown Race	1		4	5
	White (Non Hispanic)	2,701	2,694	2,477	2,463
Arapahoe	All Races	11,550	11,325	11,139	10,832
	American Indian or Alaska Native (Non Hispanic)	234	253	249	260
	Asian (Non Hispanic)	700	647	590	566
	Black (Non Hispanic)	2,408	2,449	2,477	2,361
	Native Hawaiian or Pacific Islander (Non Hispanic)	97	117	113	111
	Hispanic (Any Race)	5,358	5,125	4,948	4,890
	Two or More Races (Non Hispanic)	565	554	569	553
	Unknown Race		4	5	
	White (Non Hispanic)	2,188	2,176	2,188	2,091
Douglas	All Races	1,163	1,289	1,379	1,418
	American Indian or Alaska Native (Non Hispanic)	7	13	8	8
	Asian (Non Hispanic)	33	38	57	53
	Black (Non Hispanic)	34	46	59	64
	Native Hawaiian or Pacific Islander (Non Hispanic)	3	2	4	10
	Hispanic (Any Race)	369	400	435	453
	Two or More Races (Non Hispanic)	71	82	105	109
	Unknown Race				
	White (Non Hispanic)	646	708	711	721
Total Participants					
Adams	All Races	20,325	19,802	18,485	17,935
Arapahoe	All Races	16,891	16,394	16,042	15,604
Douglas	All Races	1,667	1,886	1,936	1,990

The Supplemental Nutrition Program for Women, Infants, and Children (WIC) cont.

Low Birth Weight Status (Low, Normal, High) by Prenatal WIC Participation and by County, TCHD Jurisdiction, 2017-2020

	2017		2018		2019	
Prenatal WIC Participation	Yes	No	Yes	No	Yes	No
Adams County						
Low	196 (8.6%)	118 (11.1%)	165 (8.0%)	142 (14.4%)	171 (8.9%)	136 (13.5%)
Normal	1983 (86.6%)	897 (84.7%)	1811 (87.6%)	807 (81.7%)	1666 (86.5%)	826 (82.0%)
High	112 (4.9%)	44 (4.2%)	91 (4.4%)	39 (3.9%)	89 (4.6%)	45 (4.5%)
Arapahoe County						
Low	159 (9.3%)	157 (15.7%)	182 (10.9%)	137 (15.2%)	173 (10.9%)	143 (14.6%)
Normal	1469 (86.4%)	797 (79.7%)	1405 (84.0%)	729 (3.8%)	1340 (84.6%)	806 (82.4%)
High	73 (4.3%)	46 (11.1%)	86 (5.1%)	34 (3.8%)	70 (4.4%)	29 (3.0%)
Douglas County						
Low	15 (11.1%)	19 (13.8%)	15 (8.9%)	16 (12.0%)	16 (9.6%)	28 (20.1%)
Normal	115 (85.2%)	109 (79.0%)	150 (89.3%)	114 (85.7%)	142 (85.5%)	108 (77.7%)
High	5 (13.8%)	10 (7.2%)	3 (2.3%)	3 (2.3%)	8 (4.8%)	3 (2.2%)

Food Security

This Adams County-specific funding supports 1.0 FTE and operational costs to coordinate and participate in multiple programs to increase access to food and improve coordination and systems. In 2020, the position helped to lead and coordinate weekly produce boxes with a local farmer to 51 WIC families out of the North Broadway location. The Food Security position also coordinates and markets the TCHD Community Gardens and helps to lead, implement, coordinate the Healthy Farmer's Markets in collaboration with American Heart Association, Anythink Libraries, City of Thornton and Lulu's Farms (including Adams County CARES dollars). This position is also helping with dual enrollment into WIC and SNAP through community hubs and community-based organizations and has begun work with local community colleges. This position will continue to coordinate across community based programs and aims to develop programming and services to reach community members who may be experiencing food insecurity.

Food Security Program

Funding/Revenue Source(s): Restricted County Funds

FY21 Program FTE: 0.95

FY21 Program Budget: $80,000

Breastfeeding Peer Counselors

Breastfeeding rates among WIC participants are lower than average non-WIC participants. The Breastfeeding Peer Counselors Program continues to find innovations to provide education, resources, pumps, and tools to help WIC mothers reach their breastfeeding goals. Breastfeeding Peer Counselor programs have proven to be successful in providing breastfeeding support and increasing initiation and duration rates. In an effort to increase breastfeeding initiation and duration rates in the WIC program, TCHD began a Breastfeeding Peer Counselor Program in April 2005. Each of the 10 WIC clinics has at least one designated breastfeeding peer counselor. Peer counselors are available to support pregnant and breastfeeding mothers 24 hours a day by phone, text, email or in-person sessions. They teach breastfeeding classes, lead support groups, organize Facebook Live presentations, find community resources, and coordinate client care with WIC educators and dietitians. Peer counselors utilize an automated texting platform to send educational texts at regular intervals throughout the prenatal and postpartum periods and allows two-way texting between the peer counselors and program participants.

Breastfeeding Peer Counselors
Funding/Revenue Source(s): Restricted Federal Funds

FY21 Program FTE: 3.28
FY21 Program Budget: $224,067

Breastfeeding Peer Counselors Metrics, 2016-2020

	2016	2017	2018	2019	2020
Total Monthly Contacts	10,523	11,124	10,664	12,726	15,136
Total Caseload	2,502	2,473	2,312	2,195	2,215
Number of Electric Breast Pumps Loaned	1,332	1,381	1,339	1,350	1,168
Number of Single User Pumps Distributed	152	125	154	168	106

WIC Program Breastfeeding Initiation and Duration, TCHD Jurisdiction, 2016-2020

	2016	2017	2018	2019	2020
Breastfeeding initiation rate among WIC participants	84.0%	84.0%	84.0%	84.0%	84.0%
Rate of breastfeeding at 3mo postpartum among WIC participants	36.0%	36.0%	38.0%	39.0%	39.0%
Rate of breastfeeding at 6mo postpartum among WIC participants	26.0%	27.0%	27.0%	27.0%	29.0%

Baby and Me Tobacco Free

The Baby and Me Tobacco Free Program is an evidence-based, smoking cessation program created to reduce the burden of tobacco on the pregnant and postpartum population. By providing counseling support and resources to pregnant women, the program helps women quit smoking and stay quit throughout the postpartum period and beyond, or major benefit to both themselves and their children. Program participants receive smoking cessation information at four prenatal education sessions and take a carbon monoxide breath test to verify smoking status. If a woman quits smoking before delivery, she is eligible to take a breath test monthly and receive $50 worth of diapers each month up to six months postpartum as long as she stays quit. Participants have the option of enrolling one partner as a support person who is also eligible for $50 worth of diapers each month as long as they stay quit. Helping women quit smoking results in improved birth outcomes and long-term positive health benefits for themselves and their families.

Baby and Me Tobacco Free Program
Funding/Revenue Source(s): Restricted Grant Funds

FY21 Program FTE: 0.185
FY21 Program Budget: $20,852

Baby and Me Tobacco Free cont.

Baby and Me Tobacco Free Program Metrics, 2016-2020

	2016	2017	2018	2019	2020
Prenatal tobacco quit rate among participants*	88.9%	68.1%	88.7%	97.4%	79.5%
Number of new enrollments	147	115	110	72	46
Number of prenatal education sessions completed	433	339	310	56	161
Number of postpartum education sessions completed	428	269	264	76.5	203
Number of e-vouchers (program incentive) distributed	524	377	363	86	258

**Percent of women who pass CO test (≤6 ppm) at last prenatal session in third trimester among number of women tested in the third trimester*

Dietetic Internship

The Dietetic Internship, started in 1980 and is a public health-based program accredited by the Accreditation Council for Education in Nutrition and Dietetics of the Academy of Nutrition and Dietetics. TCHD's internship is the only program in the region to offer a public health emphasis and hence has played an important role in Colorado in enhancing the public health nutritionist workforce. The ten and one half month tuition-based program trains six nutrition professionals each year, many of whom seek subsequent employment at TCHD and other Colorado health departments. Dietetic interns increase TCHD's community nutrition outreach, partnerships, and education. TCHD is proud of the 100% pass rate on the registration examination for dietitians. Graduates have career opportunities in a variety of positions in public health, community, healthcare, and business areas; hiring graduates when possible saves recruitment and training dollars. The dietetic internship has been nationally recognized for fiscal responsibility by being awarded a National Association of County and City Health Officials (NACCHO) Model Practice Award for the cost/benefit analysis of the internship and training interns on financial analysis. Six Dietetic Interns graduate each year. The chart below indicates the percentage of interns who work in the public health sector after graduation. Currently, six of 30 graduates from the past five years are working for TCHD.

Dietetic Internship

Funding/Revenue Source(s): General Funds, Tuition/Fees, In-Kind Services

FY21 Program FTE: 1.00
FY21 Program Budget: $136,496

Dietetic Internship and Retention in the Field of Public Health by Year, 2016-2020

	2016	2017	2018	2019	2020
Percentage of interns with public health sector jobs after graduation	50%	50%	50%	33%	67%

Appendix A: Resolutions Forming TCHD

STATE OF COLORADO)
COUNTY OF ADAMS)

At a regular meeting of the Board of County Commissioners for Adams County, Colorado, held at the Administration Building in Brighton, Colorado on the 4th day of March, 2009 there were present:

Larry W. Pace	Chairman
Alice J. Nichol EXCUSED	Commissioner
W.R. "Skip" Fischer	Commissioner
Hal B. Warren	County Attorney
Kristen Hood, Deputy	Clerk of the Board

when the following proceedings, among others were held and done, to-wit:

RESOLUTION RE-ESTABLISHING THE TRI-COUNTY HEALTH DEPARTMENT AS THE PUBLIC HEALTH AGENCY OF ADAMS COUNTY, AND RE-APPOINTING THE MEMBERS OF THE BOARD OF HEALTH

WHEREAS, the Board of County Commissioners of Adams County recognizes the vital importance of having a public health agency to protect the health of all our people; and

WHEREAS, the Tri-County Health Department is the district health department which currently provides the public health services for Adams County, Arapahoe County and Douglas County, Colorado; and

WHEREAS, the Tri-County Health Department has been the district health department for Adams County since 1947; and

WHEREAS, public health services in Colorado have been restructured with the passage of the Colorado Public Health Reauthorization Act, as set forth in Senate Bill 08-194, which was signed into law on June 3, 2008; and

WHEREAS, the Colorado Public Health Reauthorization Act requires the re-establishment of the Tri-County Health Department as Adams County's public health agency, and the re-appointment of Adams County's members serving on the re-organized Board of Health of the Tri-County Health Department; and

WHEREAS, upon re-establishment by Adams County, Arapahoe County and Douglas County, Tri-County Health Department shall function as a District Public Health Agency pursuant to §25-1-506 of the Colorado Revised Statutes.

NOW, THEREFORE, BE IT RESOLVED that the Board of Commissioners of Adams County, Colorado, does hereby re-establish the Tri-County Health Department as the public health agency of Adams County, with all the powers and duties of a District Public Health Agency as set forth in the statutes of the state of Colorado, including but not being limited by, the powers and duties as set forth in §25-1-506 of the Colorado Revised Statutes, as amended, or hereafter amended.

BE IT FURTHER RESOLVED that pursuant to the provisions of §25-1-508 of the Colorado Revised Statutes, that the District Board of Health for the Tri-County Health Department shall be composed of nine members and that each County member of the Tri-County Health Department shall have the authority to appoint three members to said Board of Health

Appendix A: Resolutions Forming TCHD cont.

BE IT FURTHER RESOLVED that the Board of Health of the Tri-County Health Department shall have all powers and duties set forth in the statutes of the state of Colorado, including but not being limited by, the powers and duties as set forth in §25-1-508 of the Colorado Revised Statutes, as amended, or as hereafter amended;

BE IT FURTHER RESOLVED that the re-establishment of the Tri-County Health Department pursuant to the action mandated by the provisions of §25-1-506 of the Colorado Revised Statutes shall not be deemed to be a termination of any pre-existing contract, the cessation of any existing legal obligation or the abandonment of any existing legal right of the Tri-County Health Department.

Upon motion duly made and seconded the foregoing resolution was adopted by the following vote:

Pace _____ Aye
Nichol _____ Excused
Fischer _____ Aye
Commissioners

STATE OF COLORADO)
County of Adams)

I, Karen Long, County Clerk and ex-officio Clerk of the Board of County Commissioners in and for the County and State aforesaid do hereby certify that the annexed and foregoing Order is truly copied from the Records of the Proceedings of the Board of County Commissioners for said Adams County, now in my office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County, at Brighton, Colorado this 4th day of March, A.D. 2009.

County Clerk and ex-officio Clerk of the Board of County Commissioners
Karen Long:

By:



Deputy

Appendix A: Resolutions Forming TCHD cont.

STATE OF COLORADO
COUNTY OF ARAPAHOE } *ss.*

At a regular meeting of the Board of County Commissioners for Arapahoe County, Colorado held in the Administration Building, Littleton, Colorado on Tuesday the 24th day of February 2009, there were present:

Susan Beckman, Chair	Present
Jim Dyer, Chair Pro-Tem	Present
Rod Bockenfeld, Commissioner	Present
Frank Weddig, Commissioner	Present
Pat Noonan, Commissioner	Present
Kathryn L. Schroeder, County Attorney	Present
John E. Bush, Jr., Deputy County Attorney	Present
Nancy A. Doty, Clerk to the Board	Absent & Excused
Joleen Sanchez, Assistant Clerk to the Board	Present

when the following proceedings, among others, were had and done, to-wit:

RESOLUTION NO. 090190 It was moved by Commissioner Dyer and duly seconded by Commissioner Weddig to adopt the following resolution:

WHEREAS, the Board of County Commissioners of Arapahoe County recognizes the vital importance of having a public health agency to protect the health of all our people; and

WHEREAS, the Tri-County Health Department is the district health department which currently provides the public health services for Adams County, Arapahoe County and Douglas County, Colorado; and

WHEREAS, the Tri-County Health Department has been the district health department for Arapahoe County since 1948; and

WHEREAS, public health services in Colorado have been restructured with the passage of the Colorado Public Health Reauthorization Act, as set forth in Senate Bill 08-194, which was signed into law on June 3, 2008; and

WHEREAS, the Colorado Public Health Reauthorization Act requires the re-establishment of the Tri-County Health Department as Arapahoe County's public health agency, and the re-appointment of Arapahoe County's members serving on the re-organized Board of Health of the Tri-County Health Department; and

WHEREAS, upon re-establishment by Adams County, Arapahoe County and Douglas County, Tri-County Health Department shall function as a District Public Health Agency pursuant to §25-1-506 of the Colorado Revised Statutes.

Appendix A: Resolutions Forming TCHD cont.

NOW, THEREFORE, BE IT RESOLVED that the Board of Commissioners of Arapahoe County, Colorado, does hereby re-establish the Tri-County Health Department as the public health agency of Arapahoe County, with all the powers and duties of a District Public Health Agency as set forth in the statutes of the state of Colorado, including but not being limited by, the powers and duties as set forth in §25-1-506 of the Colorado Revised Statutes, as amended, or hereafter amended.

BE IT FURTHER RESOLVED that pursuant to the provisions of §25-1-508 of the Colorado Revised Statutes, that the District Board of Health for the Tri-County Health Department shall be composed of nine members and that each County member of the Tri-County Health Department shall have the authority to appoint three members to said Board of Health

BE IT FURTHER RESOLVED that the Board of Health of the Tri-County Health Department shall have all powers and duties set forth in the statutes of the state of Colorado, including but not being limited by, the powers and duties as set forth in §25-1-508 of the Colorado Revised Statutes, as amended, or as hereafter amended;

BE IT FURTHER RESOLVED that the re-establishment of the Tri-County Health Department pursuant to the action mandated by the provisions of §25-1-506 of the Colorado Revised Statutes shall not be deemed to be a termination of any pre-existing contract, the cessation of any existing legal obligation or the abandonment of any existing legal right of the Tri-County Health Department.

The vote was:

Commissioner Beckman, Yes; Commissioner Bockenfeld, Yes; Commissioner Dyer, Yes; Commissioner Noonan, Yes; Commissioner Weddig, Yes.

The Chair declared the motion carried and so ordered.

I, Nancy A. Doty, County Clerk and ex-officio Clerk of the Board of County Commissioners in and for the County and State aforesaid, do hereby certify that the annexed and foregoing Order is truly copied from the records of the proceedings of the Board of County Commissioners for said Arapahoe County, now in my office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County, at Littleton, Colorado this 11th day of March 2009.

Nancy A. Doty, Clerk to the Board

ARAPAHOE COUNTY COLORADO SEAL

Appendix A: Resolutions Forming TCHD cont.

OFFICIAL RECORDS
DOUGLAS COUNTY CO
JACK ARROWSMITH
CLERK & RECORDER
RECORDING FEE: $0.00
2 PGS
2009012247
02/25/2009 09:19 AM

RESOLUTION NO. R-009- 039

2009012247 2 PGS

THE BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF DOUGLAS, COLORADO

RESOLUTION RE-ESTABLISHING THE TRI-COUNTY HEALTH DEPARTMENT AS THE PUBLIC HEALTH AGENCY OF DOUGLAS COUNTY, AND RE-APPOINTING THE MEMBERS OF THE BOARD OF HEALTH

WHEREAS, the Douglas County Board of Commissioners recognizes the vital importance of having a public health agency to protect the health of all our people; and

WHEREAS, the Tri-County Health Department is the district health department which currently provides the public health services for Adams County, Arapahoe County and Douglas County, Colorado; and

WHEREAS, the Tri-County Health Department has been the district health department for Douglas County since 1966; and

WHEREAS, public health services in Colorado have been restructured with the passage of the Colorado Public Health Reauthorization Act, as set forth in Senate Bill 08-194, which was signed into law on June 3, 2008; and

WHEREAS, the Colorado Public Health Reauthorization Act requires the re-establishment of the Tri-County Health Department as Douglas County's public health agency, and the re-appointment of Douglas County's members serving on the re-organized Board of Health of the Tri-County Health Department; and

WHEREAS, upon re-establishment by Adams County, Arapahoe County and Douglas County, Tri-County Health Department shall function as a District Public Health Agency pursuant to §25-1-506 of the Colorado Revised Statutes.

NOW, THEREFORE, BE IT RESOLVED that the Douglas County Board of Commissioners does hereby re-establish the Tri-County Health Department as the public health agency of Douglas County, with all the powers and duties of a District Public Health Agency as set forth in the statutes of the state of Colorado, including but not being limited by, the powers and duties as set forth in §25-1-506 of the Colorado Revised Statutes, as amended, or hereafter amended;

BE IT FURTHER RESOLVED that pursuant to the provisions of §25-1-508 of the Colorado Revised Statutes, that the District Board of Health for the Tri-County Health Department shall be composed of nine members and that each County member of the Tri-County Health Department shall have the authority to appoint three members to said Board of Health

BE IT FURTHER RESOLVED that the Board of Health of the Tri-County Health Department shall have all powers and duties set forth in the statutes of the state of Colorado,

Appendix A: Resolutions Forming TCHD cont.

including but not being limited by, the powers and duties as set forth in §25-1-508 of the Colorado Revised Statutes, as amended, or as hereafter amended;

BE IT FURTHER RESOLVED that the re-establishment of the Tri-County Health Department pursuant to the action mandated by the provisions of §25-1-506 of the Colorado Revised Statutes shall not be deemed to be a termination of any pre-existing contract, the cessation of any existing legal obligation or the abandonment of any existing legal right of the Tri-County Health Department.

PASSED AND ADOPTED this 24th day of February, 2009, in Castle Rock, Douglas County, Colorado.

THE BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF DOUGLAS, COLORADO

BY: _____
JACK A. HILBERT, Chair

ATTEST:

_____
Melissa Pelletier, Deputy Clerk to the Board

DOUGLAS COUNTY, COLORADO SEAL EST. 1874

Appendix A: Resolutions Forming TCHD cont.

AGREEMENT RELATING TO

ENLARGEMENT OF THE TRI-COUNTY

DISTRICT HEALTH DEPARTMENT

THIS AGREEMENT is made and entered into by the Board of County Commissioners of the County of Adams, the Board of County Commissioners of the County of Arapahoe and the Board of County Commissioners of the County of Douglas, all of the State of Colorado,

WITNESSETH,

WHEREAS the Tri-County District Health Department has been established and maintained by the said Boards of Commissioners of the Counties of Adams and Arapahoe as a district health department pursuant to the resolutions of such boards and in accordance with the provisions of Article 2 of Chapter 66, Colorado Revised Statutes of 1963, and

WHEREAS the said Board of Commissioners of the County of Douglas has heretofore determined that it is in the best interests of the County of Douglas to become a part of such Tri-County District Health Department, and

WHEREAS 66-2-11 (1), Colorado Revised Statutes of 1963 provides,

> "Any county adjacent to a district maintaining a district health department may become a part of such district by agreement between its board of county commissioners and the boards of county commissioners of the counties comprising the district. Any such county upon being accepted into the district, shall thereupon become subject to all the provivions of this article as though it were originally a part of the district."

and,

WHEREAS each of the said Boards of County Commissioners have by separate resolutions determined that it is in the best interests of their respective counties and for the general public welfare, health and safety of the inhabitants thereof that the Tri-County District Health Department be enlarged to include the adjacent County of Douglas,

NOW, THEREFORE, in consideration of the premises and by virtue of the statutory provisions providing for the same, it is hereby agreed by the Boards of County Commissioners of the Counties of Adams and Arapahoe comprising the Tri-County District Health Department and the Board of County Commissioners of the County of Douglas that the County of Douglas shall be and become as of the first day of January, 1966, a part of the Tri-County District Health Department, and thereupon subject to all of the provisions of Article 2, Chapter 89, of the

Appendix A: Resolutions Forming TCHD cont.

Colorado Revised Statutes of 1963, as amended, and as though and to the extent that the County of Douglas were originally a part of the Tri-County District Health Department.

This Agreement shall be deemed as made and entered into on the date of the execution hereof by the last Board of County Commissioners being a party hereto, and pursuant to the authority and direction of separate Resolutions duly and regularly adopted by such Boards of Commissioners.

Executed this 15th day of December, 1965, by

ATTEST:

County Clerk

BOARD OF COUNTY COMMISSIONERS
County of Adams

By _____
Chairman

Executed this 20th day of December, 1965, by

ATTEST:

County Clerk

BOARD OF COUNTY COMMISSIONERS
County of Arapahoe

By _____
Chairman

Executed this 20th day of December, 1965, by

ATTEST:

C. A. Prescott
County Clerk

BOARD OF COUNTY COMMISSIONERS
County of Douglas

By Russell E. Hagginson
Chairman

Appendix A: Resolutions Forming TCHD cont.

Public Health 21hA
October 7, 1953

Sherman Warburton

SEMINAR IN SANITATION

The Organization and Authority
Under Which the Tri-County District Health Department
Within the State of Colorado Was Created

The Tri-County District Health Department in Colorado was organized under the authority as established by Senate Bill 83, enacted by the 36th (1948) General Assembly of the State of Colorado.

In short review this bill established the right of any county or any two or more adjacent counties to create a county or district health department, whichever the case may be, by resolution of the Boards of County Commissioners of the respective counties. The departments created must consist of a Board of Health, a Public Health Officer, and all other personnel employed under the provision of the Act.

The Act provides that every District Board of Health shall consist of a seven member Board to be appointed by a committee composed of one member of each of the Boards of County Commissioners. Each member of the Board must be a resident of any one of the counties comprising the district. Appointments must be made so that no one business or professional group shall constitute a majority.

The Board at its organization meeting shall elect from its members a president and other such officers as determined. The officers and members of the Board shall serve without compensation but can be reimbursed for actual expenses. Regular meetings of the Board must be held at least once every three months and at such times and places as fixed by resolution of the Board. Special meetings can be called on twenty-four hour's notice and a majority shall constitute a quorum.

Appendix A: Resolutions Forming TCHD cont.

The jurisdiction of any District Health Department extends over all unincorporated areas and over all municipal corporations within the territorial limits of the counties comprising the District, but not over municipal corporations which have a population in excess of 25,000 and which maintain its own Health Department unless the governing body of the corporation makes an agreement with the District Board of Health to merge its department with the District Health Department.

The administrative and executive head of each District Health Department is the Public Health Officer who shall be appointed by the Board of Health and will be employed full-time and receive such compensation and expense allowances as fixed by the Board. All other personnel required by the Department shall be appointed, compensated and shall perform such duties as prescribed by the Public Health Officer.

The powers and duties of a District Health Department are imposed upon it by law.

The powers and duties of a District Board of Health are imposed upon it by law.

The powers and duties of a Public Health Officer are:

1. To administer and enforce all public health laws of the State; the orders, rules, regulations and standards of the State Board of Health; and the orders, rules and regulations of the District Board of Health.

2. To exercise all powers and duties conferred and imposed upon District Health Departments.

3. To hold hearings, administer oaths, subpoena witnesses and take testimony in matters relating to the exercise and performance of the powers imposed upon him.

4. Act as the local Registrar of Vital Statistics.

Appendix A: Resolutions Forming TCHD cont.

District Health Department funds may come from the general funds of counties comprising the District, from monies received from State, Federal or other grants or donations for local health purposes, or from monies received from a mill levy which is authorized by the Act.

If cause for legal action is necessary to bring about enforcement of any provision of the Act, such action must be requested by the Public Health Officer and the District Attorney of the judicial district in which a cause for action may arise, shall bring the action either civil or criminal. Judicial review of all decisions is provided for if any person or persons is aggrieved by a Board of Health or Public Health Officer acting under the provisions of the Act.

The Tri-County District Health Department was created and organized on January, 1948 under the provisions of this Act. The Department serves an area which covers 2,961 square miles with an estimated population of 200,000. There are 38 members on the staff, including a Medical Director, 21 Public Health Nurses, 11 Sanitarians and five Secretaries; working from a central office and four branch offices. The Public Health Nursing program includes family health, child health conferences, tuberculosis (including traveling diagnostic clinics), crippled children clinics, prenatal and maternal clinics, and convalescent home supervision. Sanitation programs include water and sewage (both community and individual), milk and food, plumbing, swimming pools, trailer camps, schools, insect and rodent control, rabies control, stream pollution, garbage and refuse, civil defense and education.

The Tri-County District Health Department is required by law to enforce all orders, rules, regulations, and standards of the State Health Department but has the authority to supersede any one or all providing any order, rule, regulation, or standard superseded is for the general welfare and health of

Appendix A: Resolutions Forming TCHD cont.

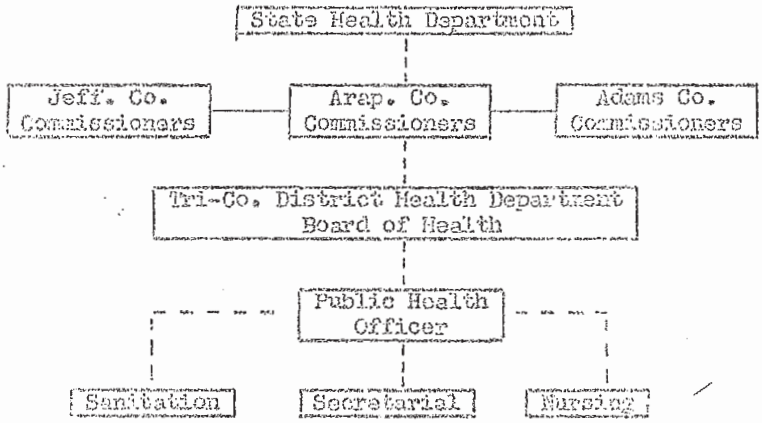
the populous as a whole.

The State Health Department provides consulting services to the local units and such direct services as requested, and is required by law to provide direct services to all areas of the State not under the jurisdiction of local health units.

Appendix A: Resolutions Forming TCHD cont.

Public Health 21bA
October 7, 1953 -5- Sherman Warburton

TRI-COUNTY DISTRICT HEALTH DEPARTMENT
ORGANIZATION CHART



Appendix A: Resolutions Forming TCHD cont.

Resolution forming Tri-County Health Dept.

RESOLUTION

D. V. Peer, offered the following Resolution and moved its adoption, seconded by Mr. Bradley, to wit:

RESOLUTION OF THE BOARD OF HEALTH OF THE TRI-COUNTY DISTRICT HEALTH DEPARTMENT WITHIN THE AREAS OF THE COUNTIES OF ADAMS, ARAPAHOE AND JEFFERSON IN THE STATE OF COLORADO, PROVIDING FOR RULES AND REGULATIONS NECESSARY FOR THE IMMEDIATE PROTECTION OF THE PUBLIC HEALTH AGAINST NUISANCES, SOURCES OF FILTH AND CAUSES OF SICKNESS AND THE CONTROL OF DISEASE

The following resolution was unanimously adopted by the affirmative vote of all the members of the Board of Health of the Tri-County District Health Department, this 18 day of December, 1947.

WHEREAS, the Board of Health of the Tri-County District Health Department is by virtue of the statutes of the State of Colorado, empowered to make such regulations respecting nuisances, sources of filth, causes of epidemics and diseases, sources of filth, and to initiate and carry out health programs necessary for the protection of the public health and safety, and

WHEREAS, it is the opinion of all the members of the Board that an emergency exists in the proper protection of the public health and the control of diseases and that regulations respecting these matters should be immediately enacted for the preservation and protection of the public health,

NOW, THEREFORE, BE IT RESOLVED by the Board of Health of the Tri-County District Health Department that the following rules and regulations from this time shall be in full force and effect:

That each and every regulation, ordinance, rule, resolution or other health enactment pretaining to the public health, respecting nuisances, sources of filth, causes and control of epidemics and diseases of any City, Town, County or Municipality within the Counties of Adams, Arapahoe, or Jefferson, in the State of Colorado, which was in effect and force at the time of the creation of The Tri-County Health Department, and all of the rules and regulations of local boards of health existing therein at such time and which were then in full force and effect, are hereby adopted and made as the rules and regulations of this Board for the areas in which the same were adopted and prescribed.

BE IT FURTHER RESOLVED that such rules and regulations shall remain in full force and effect until by this Board specifically amended, altered, repealed or changed, either separately or en toto, and shall be enforced by the Public Health Officer of the Tri-County District Health Department in and for the areas in which the same were originally enacted.

Appendix B: TCHD Core and Foundational Services

2008 Public Health Act Core Services *

Types of Tri-County Health Department Programs	Assessment, Planning and Communication	Vital Records and Statistics	Communicable Disease Prevention, Investigation and Control	Prevention and Population Health Promotion	Emergency Preparedness and Response	Environmental Health	Administration and Governance	Adopted FY19Budget	
Core Programs and Functions provided across all counties	Community Health Assessment	Vital Records	Communicable Disease Surveillance	Child Fatality Review	Emergency Preparedness and Response	Onsite Waste Water Treatment	Administration	Total $	Total $ by County~:
	Public Health Improvement Plan		HIV Prevention and Harm Reduction Program	Community Nutrition (Early Childhood, Schools and Community)	Safety & Security	Retail Food Safety	Accounting, Budget & Business Support		Adams: $ 3,635,084
	Communication & Social Marketing		Immunization and Clinical Outbreak Response	Sexual Health (Family Planning and STI Screening and Treatment)		Childcare Inspections	Information Technology		Arapahoe: $ 4,557,245
	Planning and Evaluation			Health Care Enrollment/Regional Health Connectors		Land Use Cases	Facilities & Purchasing	$39,422,152	Douglas: $ 2,367,338
	Assessment / Performance Improvement			Workforce Training (Nursing and Registered Dietitians)		Vector Control	Human Resources		3 County Total: 10,559,667
	Public Health Accreditation			Worksite Wellness Programs (staff and community**)		Body Art Facilities	HIPAA Compliance		
				Substance Abuse Prevention (multiple programs - mix of grant funds and general funds)		Pool and Spa Inspections	Board of Health		
				Suicide Prevention Program**					
				Mental Health Promotion		Solid and Hazardous Waste (Landfills and spills) programs			
				Syndromic Surveillance		Water Quality			
				Tobacco Education and Prevention**		Industrial Hygiene			
				Maternal Child Health Programs**		Meth Lab Clean-up Oversight			
				Nurse Family Partnership Programs**		Radon policy/ public awareness			
				Special Supplemental Nutrition Program for Women Infants and Children (WIC)**		Waste Tires**			
				Breastfeeding Peer Counselor Program**					
				Policy: Healthy Beverage Partnership; Advancing Breastfeeding**					
				Diabetes Education Program**					

Appendix B: TCHD Core and Foundational Services

2008 Public Health Act Core Services *

Types of Tri-County Health Department Programs	Assessment, Planning and Communication	Vital Records and Statistics	Communicable Disease Prevention, Investigation and Control	Prevention and Population Health Promotion	Emergency Preparedness and Response	Environmental Health	Administration and Governance	Adopted FY19Budget	
Adams County Only Programs				Nurse Support Home Visit Programs**		Food in Communities Grant (CCPD)**		Total $	Total $ by County
				Food Security**		Landfill Operation/ Construction Oversight**		$611,114	Adams: $ 611,114
				Diabetes Prevention and Self Management grant**		Air Quality**			
						Private Water Well Oil and Gas project**			
						Biosolids**			
						Rocky Mountain Arsenal Project**			
Arapahoe County Only Programs				Nurse Support Home Visit Programs**		Lowry Landfill Superfund Site**		Total $	Total $ by County
				Arapahoe Senior Dental**		Food in Communities Grant (CCPD)**		$1,937,735	Arapahoe: $ 1,937,735
				Diabetes Prevention and Self Management grant**		Biosolids**			
						Air Quality**			
Douglas County Only Programs				Nurse Support Home Visit Program**		Household Chemical Collection**		Total $	Total $ by County
				Youth Substance Abuse Prevention (SAMHSA) grant**		Landfill Operation/Construction Oversight**		$254,882	Douglas: $ 254,882

*** The 2008 Public Health Act Core Services were replaced in 2020 by Core Public Health Services that include foundational capabilities and organizational competencies**

**** Fully Funded with Grants, Fees or Contract Funds**

~ Not all programs budget by county/ therefore county-specific figures will not match total

Appendix C: Code of Colorado Regulations State Board of Health Core Public Health Services

Code of Colorado Regulations
Secretary of State
State of Colorado

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

State Board of Health

CORE PUBLIC HEALTH SERVICES

6 CCR 1014-7

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

Adopted by the Board of Health on April 17, 2019; Effective date January 1, 2020

Section 1 - Authority for Rules

1.1 This regulation is adopted pursuant to the authority in Section 25-1-503 et seq., C.R.S.

Section 2 - Definitions

2.1 All definitions that appear in Section 25-1-502, C.R.S., shall apply to these rules.

A. "Agency" means a county or district public health agency established pursuant to Section 25-1-506, C.R.S., or a municipal public health agency established pursuant to Section 25-1-507, C.R.S.

B. "Department" means the Colorado Department of Public Health and Environment.

C. "Local Board of Health" means a county of district board of health established pursuant to Section 25-1-508, C.R.S., or a municipal board of health established pursuant to Section 25-1-507, C.R.S.

D. "Public health" means the prevention of injury, disease, and premature mortality; the promotion of health in the community; and the response to public and environmental health needs and emergencies in the community and is accomplished through the provision of essential public health services and activities.

E. "Governmental public health system" includes the Colorado Department of Public Health and Environment and all agencies as defined in Rule 2.1(A).

Section 3 - Core Public Health Services

3.1 Core public health services are comprised of foundational capabilities and foundational public health services.

A. Foundational capabilities in Colorado shall include, but need not be limited to the following:

Appendix C: Code of Colorado Regulations State Board of Health Core Public Health Services cont.

1. Assessment and Planning: Colorado's governmental public health system will apply the principles and skilled practice of epidemiology, laboratory investigation, surveillance, and program evaluation to support planning, policy and decision making in Colorado. The public health system will monitor, diagnose, and investigate health problems and hazards in communities including public health emergencies, outbreaks, and epidemics, and collect and analyze data.

2. Communications: Colorado's governmental public health system will be a trusted source of clear, consistent, accurate, and timely health and environmental information. The system will consistently use equitable, multi-directional communication strategies, interventions, and tools to support all public health goals.

3. Policy Development and Support: Colorado's governmental public health system will inform and implement policies to meet the community's changing health needs. Public health policies will aim to eliminate health disparities, reduce death and disability, and improve environmental quality and health outcomes for all people in Colorado.

4. Partnerships: Colorado's governmental public health system will create, convene, and support strategic partnerships, engage community members and cross-sectoral partners, agencies, and organizations to achieve public health goals.

5. Organizational competencies

    a. Accountability, Performance Management and Quality Improvement: Colorado's governmental public health system will be accountable and transparent in such a way that the general public can understand the value received from investments made in the system. Accountability, organizational performance management and quality improvement are essential to creating a system that provides high-quality public health services regardless of location. To sustain the culture of quality, performance will be tied to improvements in public health outcomes and other measures, the public health system will be monitored, and public health service delivery will be tracked.

    b. Human Resources: Colorado's governmental public health system will develop and maintain a competent workforce and provide adequate human resources support to ensure the Public Health Director meets minimum qualifications, and staff are able to perform the functions of governmental public health.

    c. Legal Services and Analysis: Colorado's governmental public health system will access and appropriately use legal services and tools to plan, implement and analyze public health activities, including due process requirements as necessary. The system will understand, communicate and utilize appropriate entities in regards to public health's legal authority, and understand and use legal tools such as laws, rules, ordinances and litigation to carry out its duties.

Appendix C: Code of Colorado Regulations State Board of Health Core Public Health Services cont.

d. Financial Management, Contract and Procurement Services and Facilities Management: Colorado's governmental public health system will establish and maintain access to the appropriate systems and facilities necessary to deliver public health services in an efficient and effective manner. The system will establish policies and procedures, and provide financial, procurement, budgeting and auditing services in compliance with federal, state and local standards and laws.

e. Information Technology/Informatics (IT): Colorado's governmental public health system will maintain access to information technology, information management systems and ensure informatics capacities to store, protect, manage, analyze, and communicate data and information to support effective, efficient, and equitable public health decision making.

f. Leadership and governance: Colorado's governmental public health system will serve as the face of public health, lead internal and external stakeholders in consensus development, engage in policy development and adoption.

6. Emergency Preparedness and Response: Colorado's governmental public health system, in coordination with federal, state and local agencies and public and private sector partners, will have the capability and capacity to prepare for, respond to, and recover from emergencies with health, environmental and medical impacts.

7. Health Equity/Social Determinants of Health: Colorado's governmental public health system will intentionally focus on improving systems and institutions that create or perpetuate socioeconomic disadvantage, social exclusion, racism, historical injustice, or other forms of oppression so that all people and communities in Colorado can achieve the highest level of health possible. Governmental public health will have the requisite skills, competencies, and capacities to play an essential role in creating comprehensive strategies needed to address health inequities, and social and environmental determinants of health.

B. Foundational public health services in Colorado shall include, but need not be limited to the following:

1. Communicable Disease Prevention, Investigation and Control: Colorado's governmental public health system will carry out state and locally coordinated surveillance, disease investigation, laboratory testing, and prevention and control strategies to monitor and reduce the incidence and transmission of communicable diseases. Programs will target illnesses that are vaccine-preventable, zoonotic, vector-borne, respiratory, food- or water-borne, bloodborne, healthcare associated, and sexually transmitted as well as emerging threats. Communicable Disease Control will collaborate with national, state, and local partners to ensure mandates and guidelines are met and timely, actionable information is provided to the public and to health professionals.

Appendix C: Code of Colorado Regulations State Board of Health Core Public Health Services cont.

2. Environmental Health: Colorado's governmental public health system will use evidence-informed practices to understand the cause and effect relationships between environmental changes and ecological and human health impacts, to protect, promote, and enhance the health of the community and environment. Agencies will participate in the protection and improvement of air quality, water, land, and food safety by identifying, investigating, and responding to community environmental health concerns, reducing current and emerging environmental health risks, preventing communicable diseases, and sustaining the environment in a coordinated manner with agencies at the federal, state, and local levels as well as industry stakeholders and the public.

3. Maternal, Child, Adolescent and Family Health: Colorado's governmental public health system will develop, implement and evaluate state-wide, regional and local strategies related to maternal, child, adolescent and family health to increase health and wellbeing, reduce adverse health outcomes and advance health equity across the life course. Strategies may include but are not limited to identifying and providing information, promoting evidence-informed and multi-generational approaches, identifying community assets, advocating for needed initiatives, and convening partners.

4. Chronic Disease and Injury Prevention and Behavioral Health Promotion: Colorado's governmental public health system focuses on common risk and protective factors that affect social, emotional and physical health and safety. To prevent chronic disease and injuries and promote behavioral health, Colorado's governmental public health system will use policy, systems and environmental change strategies to comprehensively address the root causes of poor health outcomes and advance health equity. Priority areas include, but are not limited to, nutrition, physical activity, oral health, access to care and disease management, injury prevention, violence prevention, suicide prevention, mental health and substance use (including tobacco, alcohol and other substances).

5. Access to/Linkage with Clinical Health Care: All Coloradans should be connected with and have access to needed personal health care services that include primary care, maternal and child health care, oral health care, specialty care, and mental health care. Colorado's governmental public health system will coordinate governmental and community partners to link individuals to and ensure the provision of health care within their jurisdictions.

C. Nothing in this section should be interpreted to limit a local agency or local board of health's ability to obtain additional resources to expand local public health services beyond the core services identified in this rule.

Section 4 - Exemption from the Provision of Core Public Health Services:

4.1 Pursuant to Section 25-1-506(3)(b)(iii), C.R.S., an agency has the duty to provide or arrange for the provision of quality, core public health services deemed essential by the State Board and the comprehensive statewide public health improvement plan. The agency shall be deemed to have met this requirement if the agency can demonstrate to the local board of health that:

A. Other providers offer core public health services that are sufficient to meet the local need as determined by a local public health plan.

Appendix C: Code of Colorado Regulations State Board of Health Core Public Health Services cont.

4.2 Pursuant to Section 25-1-506(3)(c), C.R.S., when a local board of health does not receive sufficient appropriations to fulfill all of the duties delineated in Section 25-1-506(3)(b), C.R.S., the local board of health shall set priorities for fulfilling the duties and shall include the list of priorities in the local public health plan submitted pursuant to Section 25-1-505, C.R.S. The local board of health may choose to limit the scope of the core public health services identified in Section 3 when:

A. There is limited need for the core public health services in the community, or

B. Other providers offer core public health services that are sufficient to meet the local need.

Section 5 - Agency or Local Board of Health Unable or Unwilling to Act

5.1 Pursuant to Section 25-1-510(3), C.R.S., the department may reallocate monies from an agency that is not able to provide core public health services to another entity to deliver public health services in that agency's jurisdiction:

A. If a core service is not being provided within the jurisdiction, the department will first work with the agency and the local board of health to address how the agency has prioritized the core public health services, and to ensure the statutory and regulatory requirements are understood. The department will also work with the agency, the local board of health, and as applicable, agencies in neighboring counties, local health providers, appropriate stakeholders, and other organizations to determine how best to provide or ensure core public health services and/or foundational capabilities within that agency's jurisdiction.

Editor's Notes

History

Entire rule eff. 11/30/2011.

Entire rule eff. 01/01/2020.

Appendix D: List of Partnerships and Coalitions by County

Total number
303
partners

Public Health Improvement Plan Priority Areas

Access to Care	Mental Health	Health and Food	Health and Housing
102 partners	**45** partners	**83** partners	**25** partners

Organization Name	County	Sector	PHIP Access to Care	PHIP Mental Health	PHIP Health and Food	PHIP Health and Housing	Other Topic Areas
A Precious Child	Adams , Arapahoe	Non-Profit – Community-Based Organization					■
Aetna	Statewide	Healthcare-Payers and Administrative Service Organizations	■				
Access Housing	Statewide	Non-Profit – Community-Based Organization				■	■
Adams 12 Five Star Schools	Adams	Special District- School					■
Adams County Collaborative Management Program	Adams	Government County		■			■
Adams County Health Alliance	Adams	Non-Profit – Community-Based Organization	■	■	■		■
Adams County Health and Human Services	Adams	Government County	■		■		■
Adams County School District 14	Adams	Special District- School					■
Adams County Sheriff's Office	Adams	Government County					■
Addiction Research and Treatment Services	Adams , Arapahoe	Behavioral Health Provider		■			■
Adventure Dental	Adams , Arapahoe	Healthcare - Medical Practice	■				
Adelante Community Development	Adams	Non-Profit – Community-Based Organization			■		■
Advanced Urgent Care	Adams, Arapahoe	Healthcare - Medical Practice	■				■
All Health Network	Arapahoe, Douglas	Community Mental Health Center	■	■			■
Alliance for HPV Free Colorado	Metro-wide	Non-Profit – Community-Based Organization	■				■
Amazing Grace Church	Adams	Non-Profit - Faith			■		
American Heart Association	Statewide	Non-Profit – Policy, Advocacy, Research			■		■
American Lung Association	Statewide	Non-Profit – Policy, Advocacy, Research					■
American Red Cross	Statewide	Non-Profit – Policy, Advocacy, Research					■
Amigas de Mexico		Non-Profit – Community-Based Organization			■		
Anythink Wright Farms Library	Adams	Special District– Libraries			■		■
Anythink Huron Street Library	Adams	Special District– Libraries			■		■
Aurora Community Connection	Adams, Arapahoe	Non-Profit – Community-Based Organization					■
Arapahoe County Department of Human Services	Arapahoe	Government County	■		■		■
Arapahoe County Detention Facility	Arapahoe	Government County	■	■			■
Arapahoe County Early Childhood Council	Arapahoe	Non-Profit – Community-Based Organization			■		■
Arapahoe County Justice Coordinating Committee	Arapahoe	Government County		■		■	■
Arapahoe County Libraries	Arapahoe	Government County					■
Arapahoe County Sheriffs Office	Arapahoe	Government County , Law Enforcement					■
Asian Pacific Development Center	Metro-wide	Non-Profit – Community-Based Organization					■
Aurora Action Coalition for Community Services	Arapahoe, Adams	Non-Profit – Community-Based Organization			■	■	
Aurora Chamber of Commerce	Adams , Arapahoe, Douglas	Professional Association			■		
Aurora Day Resource Center	Arapahoe	Non-Profit – Community-Based Organization					■
Aurora Family YMCA	Adams , Arapahoe, Douglas	Non-Profit – Community-Based Organization					■
Aurora Fire Rescue	Arapahoe, Adams	Special District– other					■
Aurora Health Alliance	Adams , Arapahoe, Douglas	Non-Profit – Community-Based Organization	■		■		■

Appendix D: List of Partnerships and Coalitions by County cont.

Organization Name	County	Sector	PHIP Access to Care	PHIP Mental Health	PHIP Health and Food	PHIP Health and Housing	Other Topic Areas
Aurora Housing Authority	Adams , Arapahoe, Douglas	Government Municipal				■	■
Aurora Interfaith Community Services	Adams, Arapahoe	Non-Profit – Community-Based Organization			■		
Aurora Mental Health Center	Adams , Arapahoe, Douglas	Healthcare-Medical Practice	■	■			■
Aurora Public Schools	Adams , Arapahoe	Special District- School			■		■
Aurora Partners for Thriving Youth	Adams, Arapahoe	Community Coalition		■			■
Aurora Youth Options	Adams, Arapahoe	Non-Profit – Community-Based Organization		■			
Benefits in Action	Adams, Arapahoe	Non-Profit – Community-Based Organization	■				■
Bennet Parks and Recreation Distrcit	Adams, Arapahoe	Governnment Local					■
Bennett School District 29J	Adams, Arapahoe	Special District- School					■
Bondadosa	Adams, Denver, Jefferson	Non-Profit – Community-Based Organization			■		
Boulder County Department of Housing and Human Services	Boulder	Government County	■				
Boulder County Public Health	Boulder	Government Local	■		■	■	■
Boys and Girls Clubs of Metro Denver	Metro-wide	Non-Profit – Community-Based Organization					■
Brighton Housing Authority	Adams	Non-Profit – Community-Based Organization				■	■
Brighton Pediatrics	Adams, Denver, Jefferson	Healthcare-Medical Practice	■				
Brighton School District 27J	Adams	Special District- School			■		■
Brighton Shares the Harvest	Adams	Non-Profit – Community-Based Organization			■		
Broomfield Pediatrics	Broomfield	Healthcare-Medical Practice	■				
Broomfield Public Health and Enviroment	Broomfield	Government Local		■			■
Buckley Air Force Base	Arapahoe	Government Federal					■
Byers School District 32J	Arapahoe	Special District- School					■
Care Coordination-Community Engagement Task Force	Statewide	Non-Profit – Community-Based Organization	■				
Caring for Colorado Foundation	Statewide	Non-Profit – Community-Based Organization	■				
Catholic Charities of Central Colorado	Douglas	Non-Profit – Community-Based Organization	■	■	■	■	■
Castle Rock Adventist Hospital	Douglas	Healthcare - Hospital	■				■
Castle Rock Pediatrics	Douglas	Healthcare-Medical Practice	■				
Catholic Health Initiatives		Non-Profit – Community-Based Organization					■
Center for African American Health	Metro-wide	Non-Profit – Community-Based Organization			■		■
Center for Health Progress		Non-Profit – Policy, Advocacy, Research	■	■			■
Center for Public Health Practice	Adams , Arapahoe, Douglas	Special District- School					■
Center Pointe Family Medical Group	Douglas	Healthcare-Medical Practice	■				
Central Recreation Center	Arapahoe	Community-based Organization CBO					■
Centura Health	Adams , Arapahoe, Douglas	Healthcare – Hospital	■	■	■	■	■
Cherry Creek School District	Arapahoe	Special District- School					■
Cherry Hills Community Church	Arapahoe, Douglas	Non-Profit - Faith					■
Child Health Advocacy Institute	Statewide	Healthcare – Hospital					■
Child Health Clinic	Statewide	Healthcare – Hospital			■		■
Children's Hospital Colorado	Adams	Healthcare – Hospital	■		■		■
City of Aurora	Adams , Arapahoe, Douglas	Government Local			■	■	■
City of Brighton	Adams	Government Local					■
City of Commerce City	Adams	Government Local					■
City of Englewood	Arapahoe	Government Local					■
City of Littleton	Arapahoe	Government Local					■

Appendix D: List of Partnerships and Coalitions by County cont.

Organization Name	County	Sector	PHIP Access to Care	PHIP Mental Health	PHIP Health and Food	PHIP Health and Housing	Other Topic Areas
City of Lone Tree	Douglas	Government Local					■
City of Northglenn	Adams	Government Local					■
City of Sheridan	Arapahoe	Government Local	■				■
City of Thornton	Adams	Government Local	■		■		■
City of Westminster	Adams	Government Local					■
Civic Canopy	Statewide	Non-Profit – Community-Based Organization					■
Clayton Early Learning Center	Statewide	Non-Profit – Community-Based Organization					■
Clinica Family Health	Adams	Healthcare-Medical Practice	■				■
Colorado Academy of Family Physicians	Statewide	Professional Association	■				■
Colorado Access	Adams , Arapahoe, Douglas	Government State , Practice Transformation Organization PTO , Medical Services Organization MSO	■		■		■
Colorado African Organization	Statewide	Non-Profit – Community-Based Organization					■
Colorado Association of Local Public Health Officials	Statewide	Professional Association					■
Colorado Blueprint to End Hunger	Statewide	Non-Profit-Policy Advocacy, Research			■		
Colorado Breastfeeding Coalition	Statewide	Non-Profit – Community-Based Organization			■		
Colorado Center for Nursing Excellence	Statewide	Non-Profit-Policy Advocacy, Research					■
Colorado Center on Law and Policy	Statewide	Community-based Organization CBO	■				■
Colorado Childrens Healthcare Access Program	Statewide	Non-Profit-Policy Advocacy, Research	■				■
Colorado Consortium for Prescription Drug Abuse	Statewide	Non-Profit-Policy Advocacy, Research					■
Colorado Cosumer Health Initiative	Statewide	Non-Profit-Policy Advocacy, Research	■				
Colorado Crime Survivors Network, Inc	Adams, Arapahoe	Healthcare-Behavioral Health, Non-Profit-Community Based Organization, Non-Profit-Policy, Advocacy, Research		■			
Colorado Criminal Justice Reform Coalition	Statewide	Non-Profit – Policy, Advocacy, Research		■		■	
Colorado Department of Education	Statewide	Government State			■		■
Colorado Department of Health Care Policy and Fi	Statewide	Government State	■				■
Colorado Department of Human Services	Statewide	Government State					■
Colorado Department of Local Affairs, State Demography Office	Statewide	Government State	■	■	■	■	■
Colorado Department of Public Health and Environ	Statewide	Government State	■	■	■		■
Colorado Children's Immunization Coalition	Statewide	Non-profit - Policy, Advocacy, Research	■				
Colorado Department of Transportation (CDOT)	Statewide	Government State					■
Colorado Health Foundation	Statewide	Non-Profit – Foundation					■
Colorado Health Institute (CHI)	Statewide	Non-Profit – Community-Based Organization	■	■	■		■
Colorado Healthy Schools	Statewide	Non-Profit – Community-Based Organization			■		
Colorado Hospital Association	Statewide	Professional Association	■				■
Colorado North Central Region Healthcare Coalition	Adams , Arapahoe, Douglas	Non-Profit – Community-Based Organization					■
Colorado Parks and Wildlife	Adams , Arapahoe, Douglas	Public – State Government					■
Colorado Perinatal Care Quality Collaborative	Statewide	Non-Profit – Community-Based Organization		■			■
Colorado Primary Care Clinic	Arapahoe	Healthcare-Medical Practice	■	■			
Colorado Refugee Services Program	Adams, Arapahoe, Douglas	Government State	■				■
Colorado School of Public Health	Statewide	Special District- School					■
Colorado Trust	Statewide	Non-profit - Policy, Advocacy, Research					■
Community College of Aurora	Arapahoe	Special District- School					■
Community Reach Center	Adams	Healthcare – Specialty	■	■			■
Community Resource Network	Adams	Non-Profit – Community-Based Organization	■				■

Appendix D: List of Partnerships and Coalitions by County cont.

Organization Name	County	Sector	PHIP Access to Care	PHIP Mental Health	PHIP Health and Food	PHIP Health and Housing	Other Topic Areas
Community Resources & Housing Development Corpor	Adams	Non-Profit – Community-Based Organization				■	
Connect for Health Colorado	Statewide	Non-Profit – Community-Based Organization	■				■
Cooking Matters Colorado	Statewide	Non-Profit – Community-Based Organization			■		■
CORHIO	Statewide	Non-Profit – Community-Based Organization					■
Covering Kids and Families	Statewide	Non-Profit – Community-Based Organization	■				
CovidCheckColorado	Metro-wide	Healthcare – Specialty	■				■
Creative Options	Adams, Arapahoe, Denver	Child Care, Special District-School			■		
Creative Treatment Options	Adams	Behavioral Health Provider		■			■
Cultivando	Adams	Non-Profit – Community-Based Organization					■
Deer Trail School District 26J	Arapahoe	Special District- School					■
Delta Dental of Colorado Foundation	Statewide	Non-Profit – Foundation	■				
Denver Department of Public Health and Environment	Denver	Government State		■			■
Denver Health and Hospitals	Denver	Healthcare – Hospital	■				■
Denver Public Health	Denver	Government Local	■	■	■		■
Denver Regional Council of Governments (DRCOG)	Metro-wide	Government Local	■		■		
Denver South Economic Development Partnership	Arapahoe, Douglas	Community Coalition					■
Denver Springs	Adams, Arapahoe, Douglas	Healthcare-Medical Practice		■			■
Department of Housing and Urban Development (HUD	Statewide	Government Federal				■	
Developmental Pathways	Arapahoe, Douglas	Non-Profit – Community-Based Organization	■				■
Doctors Care	Arapahoe, Douglas	Non-Profit – Community-Based Organization	■				■
Douglas County Child Care Association	Douglas	Professional Association					■
Douglas County Collaborative Management Program	Douglas	Community Coalition			■		■
Douglas County Department of Human Services	Douglas	Government County	■				■
Douglas County Early Childhood Council	Douglas	Non-Profit – Community-Based Organization	■		■		■
Douglas County Health Alliance	Douglas	Non-Profit – Community-Based Organization	■				■
Douglas County Health Youth Coalition	Douglas	Community Coalition		■			■
Douglas County Housing Partnership	Douglas	Housing Authority					■
Douglas County Mental Health Initiative	Douglas	Community Coalition		■			■
Douglas County School District	Douglas	Special District- School		■			■
Douglas County Sheriffs Office	Douglas	Government County					■
Douglas Senior Council (Council on Aging)	Douglas	Community Coalition					■
DTC Greenwood Village Chamber of Commerce	Arapahoe	Government Local					■
Eagle Point Recreation Center	Adams	Non-Profit – Community-Based Organization			■		
Early Childhood Partnership of Adams County	Adams	Non-Profit – Community-Based Organization	■	■	■	■	■
East Denver Food Hub	Statewide	Private Sector- Business			■		
Elbert County Government	Elbert	Government County	■		■		■
Elena Anisimova, MD, PC	Arapahoe, Denver	Healthcare-Medical Practice	■				
Englewood Housing Authority	Arapahoe	Housing Authority				■	■
Englewood Leadership Academy	Arapahoe	Special District- School					■
Englewood High School	Arapahoe	Special District- School	■				
Englewood Schools	Arapahoe	Special District- School					■
Enterprise Community Partners, Inc.	National	Non-Profit – Community-Based Organization				■	
Euclid Middle School	Arapahoe	Special District- School					■
Every Child Pediatrics	Adams	Medical Practice	■		■		■
Falck Rocky Mountain	Arapahoe, Adams	Private Sector – Business					■

Appendix D: List of Partnerships and Coalitions by County cont.

Organization Name	County	Sector	PHIP Access to Care	PHIP Mental Health	PHIP Health and Food	PHIP Health and Housing	Other Topic Areas
Families Forward Resource Center	Arapahoe, Adams	Non-Profit – Community-Based Organization		■			■
Food in Communities	Adams, Arapahoe	Non-Profit – Community-Based Organization			■		
Front Range Community College	Adams	Special District- School					■
Get Ahead Colorado	Statewide	Non-profit - Policy, Advocacy, Research					■
Giving Heart	Arapahoe	Non-Profit – Community-Based Organization					■
Glendale Sports Center YMCA	Arapahoe	Non-Profit – Community-Based Organization					■
Growing Home	Statewide	Non-Profit – Community-Based Organization					■
Gunnison County Government	Gunnison	Government County					■
Health Integration Action Team	Adams	Community Coalition	■				
Health Links	National	Non-profit - Policy, Advocacy, Research			■		■
Healthier Colorado	Statewide	Non-profit - Policy, Advocacy, Research					■
Healthy Child Care Colorado	Statewide	Non-profit - Policy, Advocacy, Research			■		
Healthy Schools Successful Student Collaborative	Statewide	Community Coalition			■		
Heart-Centered Counseling	Adams , Arapahoe, Douglas	Healthcare - Specialty	■	■			
Heartlight Family Clinic Castle Rock	Douglas	Healthcare - Medical Practice	■	■	■		■
Hermanas de Color	Arapahoe	Non-Profit - Community Based Organization			■		
Home Instruction for Parents of Preschool Youngsters (HIPPY)	Adams	Non-Profit – Community-Based Organization					■
Hunger Free Colorado	Statewide	Non-Profit – Policy, Advocacy, Research			■		■
Hyland Hills Park and Recreation	Adams	Government Local					■
Illuminate Colorado	Statewide	Non-Profit- Policy, Advocacy	■	■			■
Immunize Colorado	Adams, Arapahoe, Douglas	Non-Profit – Policy, Advocacy, Research					■
Impact Charitable	Adams	Foundation					■
Integrated Nutrition Education Program	National	Non-Profit – Policy, Advocacy, Research			■		
Invest in Kids	Statewide	Non-Profit – Community-Based Organization					■
Jefferson County Public Health	Jefferson	Government Local , Health Department	■		■		■
Jewish Family Services	Statewide	Non-Profit – Community-Based Organization					■
Just Between Friends Douglas County	Douglas	Non-Profit – Community-Based Organization					■
John Snow, Inc (JSI)	Statewide	Private Sector - Business	■		■	■	■
Joshua Early Childhood Center	Arapahoe	Child Care					■
Kaiser Permanente	National	Healthcare - Hospital, Healthcare - Payers		■	■		■
Kids First Health Care	Adams	Healthcare – Medical Practice	■				■
Larimer County Deartment of Health and Environment	Larimer	Government Local , Health Department	■				■
Littleton Adventist Hospital	Statewide	Healthcare-Hospital					■
Littleton Public Schools	Arapahoe, Douglas	Special District- School					■
LiveWell Colorado (Now called Nourish)	Adams	Non-Profit – Community-Based Organization			■		
Lulu's Farms	Adams	Private Sector - Business			■		■
Mainstreet Pediatrics	Douglas	Healthcare-Medical Practice					
Maiker Housing Partners	Adams	Government - Housing Authority				■	■
Mako Medical	Statewide	Private Sector - Business	■				■
Mapleton Public Schools	Adams	Special District- School					■
Margaret Carpenter Recreation Center	Adams	Government Local			■		
Medical Center of Aurora	Arapahoe	Healthcare - Hospital	■				■
Mental Health Colorado	Metro-wide	Non-Profit – Policy, Advocacy, Research		■			■
Metro Area Health Alliances	Metro-wide	Non-Profit – Policy, Advocacy, Research	■				■
Metro Denver Homeless Initiative (MDHI)	Metro-wide	Non-Profit – Community-Based Organization				■	■

Appendix D: List of Partnerships and Coalitions by County cont.

Organization Name	County	Sector	PHIP Access to Care	PHIP Mental Health	PHIP Health and Food	PHIP Health and Housing	Other Topic Areas
Metro Denver Partnership for Health	Metro-wide	Non-Profit – Policy, Advocacy, Research		■			■
Mile High Behavioral Healthcare	Adams	Healthcare-Medical Practice					■
Mile High Health Alliance	Denver	Non-Profit - Community Based Organization	■				■
Mile High United Way	Metro-wide	Non-Profit – Community-Based Organization	■				■
Moorhead Recreation Center	Arapahoe	Non-Profit – Community-Based Organization			■		■
Mother's Milk Bank	National	Non-Profit - Foundation			■		
Mountainland Pediatrics	Adams	Healthcare - Medical Practice	■				
New Legacy Charter School	Adams, Arapahoe	Special District- School			■		
North Suburban Medical Center	Adams	Healthcare – Hospital	■				■
Northglenn High School	Adams	Special District - School					■
Northglenn Recreation Center	Adams	Community-based Organization CBO					■
Office of eHealth Innovation	Statewide	Government State					■
OMNI Institute	Adams , Arapahoe, Douglas	Private Sector - Consultant		■			
Operation Nehemiah West	Arapahoe	Non-Profit – Community-Based Organization	■	■			
Parker Adventist Hospital	Douglas	Healthcare - Hospital	■				■
Peak Vista Strasburg Community Health Center	Adams , Arapahoe	Medical Practice					■
Peak Vista Strasburg Community Health Center	Arapahoe, Adams, Elbert	Healthcare - Medical Practice			■		
Pediatric Care Network	Statewide	Healthcare - Medical Practice, Healthcare Practice-Transformation Organization (PTO)	■				
Perl Mack Community Center	Adams	Government Local					■
Platte Valley Medical Center	Arapahoe	Healthcare - Hospital	■				■
Ponderosa Family Physicians	Arapahoe	Medical Practice					
Potomac Square Family Medicine	Adams, Arapahoe, Boulder, Douglas, Jefferson	Healthcare - Medical Practice	■				
Project Angel Heart	Adams , Arapahoe, Douglas	Non-Profit – Community-Based Organization					■
Project Worthmore Dental Clinic	Adams, Arapahoe	Healthcare - Dental					
Rise Above Colorado	Statewide	Non-Profit – Community-Based Organization					■
RK Mechanical	Adams, Arapahoe, Denver, Douglas	Private Sector – Business, Private Sector - Developer			■		
RMC Health	Statewide	Non-Profit – Community-Based Organization			■		■
Rocky Mountain Health Centers Pediatrics	Statewide	Healthcare - Medical Practice			■		
Rocky Mountain Poison and Drug Center	Statewide	Non-Profit – Community-Based Organization					■
Rose Medical Center	Adams , Arapahoe	Healthcare - Hospital	■	■	■		
Rocky Mountain Urgent Care and Family Medicine	Adams	Healthcare-Medical Practice	■				
Rotary Club of Aurora	Adams, Arapahoe	Non-Profit – Foundation					■
Rocky Mountain Welcome Center	Adams, Araphoe	Non-Profit – Community-Based Organization					■
Rocky Mountain Partnership (Formerly "Cradle to Career Partnership")	Adams	Non-Profit – Community-Based Organization					■
Thornton Active Adult Center	Adams	Non-Profit – Community-Based Organization					■
Safe Kids Colorado	Statewide	Non-Profit – Community-Based Organization					■
Saint Joseph Hospital	Statewide	Healthcare - Hospital					■
Salud Family Health Centers	Statewide	Healthcare – Medical Practice	■		■		■
SDOH Learning Network	Adams, Arapahoe, Douglas	Non-profit - Policy, Advocacy, Research	■	■	■	■	■
SECORCares	Douglas	Non-Profit – Community-Based Organization					■
Senior Hub	Adams, Arapahoe	Non-Profit – Community-Based Organization			■		
Seniors' Council Douglas County	Douglas	Non-Profit – Community-Based Organization					■

Appendix D: List of Partnerships and Coalitions by County cont.

Organization Name	County	Sector	PHIP Access to Care	PHIP Mental Health	PHIP Health and Food	PHIP Health and Housing	Other Topic Areas
Servicios De La Raza	Adams, Arapahoe, Douglas	Non-Profit – Community-Based Organization					■
Sheridan CANDO	Arapahoe	Government, Local					■
Sheridan Health Services	Arapahoe	Healthcare – Medical Practice					■
Sheridan SOAR Academy	Arapahoe	Special District- School					■
Sheridan School District No. 2	Arapahoe	Special District- School					■
Signal Behavioral Health Network		Behavioral Health Provider	■	■			■
Sky Ridge Medical Center	Douglas	Healthcare - Hospital					■
Sky Ridge Adult and Pediatric Advisory Councils	Douglas	Non-profit - Policy, Advocacy, Research					■
South Metro Denver Chamber	Arapahoe, Douglas	Professional Association			■		
South Metro Fire Rescue Authority	Arapahoe, Douglas	Government Local					■
South Metro Housing Options	Arapahoe	Government Local				■	■
Spark Policy Institute	Statewide	Non-Profit – Community-Based Organization					■
Spring Institute for Intercultural Learning	Adams, Arapahoe, Douglas	Non-Profit – Community-Based Organization					■
St. Anthony North Health Campus	Adams	Healthcare - Hospital				■	■
Stapleton Foundation for Sustainable Urban Communities	Statewide	Non-profit - Policy, Advocacy, Research				■	
Strasburg School District 31J	Adams	Special District- School	■				■
STRIDE Community Health Center	Metro-wide	Medical Practice	■		■		■
Swedish Medical Center	Arapahoe	Healthcare - Hospital					■
Boulder County Substance Use Advisory Group Meeting	Boulder	Community Coalition					■
Telligen	Statewide	Private Sector - Business	■				■
Thornton Active Adult Center	Adams	Non-Profit – Community-Based Organization					■
Thornton Fire Department	Adams	Public – Municipal Government	■				■
Town of Bennett	Adams, Arapahoe	Government Local	■				■
Town of Castle Rock	Douglas	Government Local					■
Trailhead Institute	Statewide	Non-Profit - Foundation	■				■
Tri-County Overdose Prevention Partnership	Adams , Arapahoe, Douglas	Non-Profit – Community-Based Organization		■			■
UCHealth	Statewide	Healthcare - Hospital	■				■
Unison Housing Partners NOW MAIKER - LISTED ABOVE	Adams	Non-Profit – Community-Based Organization	■		■	■	■
Unite US	Statewide	Private Sector - Business	■	■	■	■	
University of CO School of Medicine, Harris Program	Statewide	Special District- School	■	■			■
University of CO Skaggs School of Pharmacy	Statewide	Special District- School	■				■
University of CO Practice Innovation Program	Statewide	Special District- School	■				■
Village Exchange Center	Adams, Arapahoe	Non-Profit – Community-Based Organization					■
We Don't Waste	Adams, Arapahoe, Denver, Jefferson	Non-Profit - Community Based Organization			■		
Weld County Department of Public Health and Environment	Weld	Government Local , Health Department	■				■
Westminster 50 School District	Adams	Special District- School	■				■
Westminster Fire Department	Adams	Government Local	■				■
Westminster Medical Clinic	Adams, Jefferson	Healthcare - Medical Practice					■
Westminster Swim and Fitness	Adams	Special District – Recreation					■
Whitman Secondary Options School	Arapahoe	Special District - School					■
Workplace Wellbeing - Adams Employers	Adams	Non-profit - Policy, Advocacy, Research			■		
Workplace Wellbeing - Advisory Council	Statewide	Non-profit - Policy, Advocacy, Research			■		
Workplace Wellbeing - Aurora Employers	Arapahoe	Non-profit - Policy, Advocacy, Research			■		
Workplace Wellbeing - Government Employers	Statewide	Non-profit - Policy, Advocacy, Research			■		

Appendix D: List of Partnerships and Coalitions by County cont.

Organization Name	County	Sector	PHIP Access to Care	PHIP Mental Health	PHIP Health and Food	PHIP Health and Housing	Other Topic Areas
Workplace Wellbeing - South Employers	Arapahoe, Denver, Douglas	Non-profit - Policy, Advocacy, Research			■		
Workplace Wellbeing - Workgroup Employers	Metro-wide	Non-profit - Policy, Advocacy, Research			■		
Wynn Health Group	Statewide	Private Sector - Consultant	■				
Yaweh Health Care Castle Rock	Douglas	Healthcare - Medical Practice	■	■	■		■
Youth Initiative of Adams County	Adams	Non-Profit - Community Based Organization					■

COLORADO
LOCAL PUBLIC HEALTH



October 2020

TABLE OF CONTENTS

Introduction 4
Key Points 5
Section 1 – Local Boards of Health 6
Local Board of Health Powers and Duties Summary 6
Local Board of Health Structures/Composition 7
Electing Local Board of Health Officers 7
Board of Health Meetings 7
Adopting Board Bylaws 7
Local Board of Health Appointments 8
Recommendations for Appointing Authorities From the National Association of Local Boards of Health (NALBOH) 8
Board Compensation 8
Section II – The Local Public Health Director 9
Public Health Director Powers and Duties Summary 9
Public Health Director Selection 9
Section III – The Local Public Health Agency 11
Duties 11
Organization and Personnel 11
Funds and Treasurer 12
Section IV – County Decisions and Actions 13
Appendix 14
History 15
Prior to 2008 Public Health Act 15
Senate Bill 08-194 16
Local Public Health Agency After July 1, 2019 16
2009 Douglas County BCC Resolution 18
Public Health Responsibilities 20
Local Boards of Health Powers and Duties 20
Local Public Health Director Powers and Duties 21
Local Public Health Agency Powers and Duties 22
State Powers and Duties 23
CDPHE Powers and Duties 23
State Board of Health Powers and Duties 23
The State Board of Health 23
Membership of the SBOH 23
Statewide and Local Public Health Improvement Plans 24
Statewide Public Health Improvement Plan 24
Local Public Health Improvement Plan 25
Public Health Local Agency Structure 26
Examples of Different Models of Local Boards of Health 27
Public Health Director 28
Core Public Health Services 29

Examples of Board of Health Bylaws 32
Organizational Chart Examples 41
Boulder County Health Department 41
Larimer County Health Department 42
Tri-County Health Department 43
Broomfield County Health and Human Services Department 44
El Paso County Health Department Organizational Chart 45
Northeast Colorado Health Department Organizational Chart 46
Statutes pertaining to LBOH 47
Local Public Health Agency List 48

EXECUTIVE SUMMARY

INTRODUCTION

Under the Colorado Public Health Act of 2008, C.R.S. 25-1-501 et seq., every county in Colorado must provide public health services through a local public health agency. Counties have several options for how to structure their local public health agency – this document provides information on the different options and examples of counties using each. Local public health agencies must have a local board of health. This document provides a detailed discussion of the following topics:

- Responsibilities of counties, local boards of health, public health directors, public health agencies, and the state (in appendix)
- Different structures of local public health agencies across Colorado
- Local board of health composition for different local public health agencies

The purpose of this document is to provide information and a discussion about the different approaches taken by various counties in the provision of public health services, including their structure and the composition of local boards of health.

The Colorado Public Health Act of 2008, C.R.S. 25-1-501 et seq., was intended to improve the performance of the public health system statewide. In general, the Act:

- Restructured the local governmental public health system.
- Defined the duties of a local public health agency.
- Directed the Colorado Board of Health to establish by rule:
    - minimum qualifications for directors
    - core public health services
    - minimum standards for public health services, and
    - a funding formula for allocating moneys to county and district public health agencies.
- Defined new roles for the state board of health and local boards of health.
- Established a collaborative, five-year planning cycle at the state and local levels.

On February 24, 2009, The Board of County Commissioners approved Resolution No. R-009-039 re-establishing the Tri-County Health Department as the public health agency of Douglas County, and re-appointing members of the Board of Health. The Colorado Public Health Act (Section 25-1-508, C.R.S.) required the Commissioners to re-establish their health department, in our case Tri-County, as the County's public health agency and re-appoint the DC members serving on the reorganized BOH of TCHD.

KEY POINTS

1) The County is required by law to have or participate in a public health authority and to do so by formal resolution.
2) The decision as to structure of the local public health agency ~~is that of~~ belongs to??? the Local Board of Health and Public Health Director. Currently there are seven different structures.
3) A newly created public health agency requires the appointment of a new local board of health (LBOH) by resolution within 90 days of formation. For counties with a population over 100,000, the LBOH must consist of at least five commissioner-appointed members so that no business or professional group, or governmental entity shall constitute a majority of the board.
4) The Local Board of Health must conduct and create a public health improvement plan, which must be approved by the State Board of Health.
5) Upon competition of the local public health improvement plan, the Local Board of Health and Public Health Director must determine the services required to carry out the public health laws and rules of the state board of health and CDPHE environmental commissions according to the specific needs and resources available within the community.
6) The county or counties composing the local public health agency are responsible for the provision of funding necessary to carry out the services.

SECTION 1 – LOCAL BOARDS OF HEALTH[1]

LOCAL BOARD OF HEALTH POWERS AND DUTIES SUMMARY

Administrative Oversight

- Select a Public Health Director to serve at the pleasure of the board. Employ/contract with a medical officer to advise the director, if the director is not a physician. In the event of either vacancy, employ/contract with a qualified person, or request temporary assistance from another county or state health department.
- Hold regular Board of Health meetings at least once every three months.
- Request Director, or another, to serve as board secretary, responsible for maintaining all records required by Part 2 of Article 72 of Title 24, C.R.S., and ensuring public notice of meetings in accordance with Part 4 of Article 6 of Title 24, C.R.S.
- Provide, equip and maintain suitable offices and facilities for the proper administration and provision of Core Pubic Health Services.
- Follow orders, rules, and standards of the Colorado Board of Health.
- Hold hearings, administer oaths, subpoena witnesses, and take testimony in all matters related to the respective powers and duties of a local board of health, (e.g., local regulation variances, appeal of a cease and desist order, removal of the license, etc.).
- Act in an advisory capacity to the public health director on all matters pertaining to public health.
- Approve the five-year local public health plan, and then submit to the State Board of Health for review.
- Determine necessary services and set local priorities consistent with state public health laws and rules, according to local needs and the resources available, and consistent with the state and local public health improvement plans.

Policy Making

- Determine general policies to be followed by the public health director, in administering and enforcing public health laws, orders, and rules.
- Develop and promote the public policies needed to secure the conditions for a health community, by considering the advice and expertise of the local public health agency.
- Issue orders and adopt rules consistent with the laws, rules and orders of the state and state board, for public or environmental health issues that pose no immediate health threat (e.g., nuisance abatement).

[1] The majority of the information in this document is from two sources:

The Colorado Public Health Reauthorization Act – SB 08-194 Executive Summary.
https://www.colorado.gov/pacific/sites/default/files/OPP_Public-Health-Act-Summary_0.pdf and

Pocket Guide for Local Board of Health. Dated January 2017.
https://www.colorado.gov/pacific/sites/default/files/OPP_LBOH_Pocket_Guide_Revised%202017%20(4).pdf

Financial Oversight

- Annually review the costs of maintaining the local public health agency for the ensuing year. These estimates shall be submitted in the form of a budget to the board of county commissioners or to a committee made up of the chairs of the board of all counties composing a district agency.
- Assess fees to offset the actual, direct costs of environmental health services, with the exception of any person who has already paid a fee to the state or federal government, and using the already-established fee for annual retail food establishment inspections, set forth in section 25-4-1607.
- Accept and, through the public health director, use, disburse, and administer all appropriate county general funds, federal and state aid or other property and services or money allocated to an agency for county or district public health functions.
- Board President (or designee) and Public Health Director certify that claims or demands made against the local public health agency fund were expended only for the duties of the agency.

LOCAL BOARD OF HEALTH STRUCTURES/COMPOSITION

County Agencies

- Each county board of health shall consist of at least five members.
- The terms of the initial appointments are staggered, and then for five years thereafter.
- Members of the county board of health shall reside within the county where the public health agency is located.
- No business or professional group or governmental entity shall constitute a majority of the board.
- In counties with populations of less than 100,000, a three-member board may be appointed. The board of county commissioners may designate itself as the county board of health if there was not a separate board of health prior to the effective date of the 2008 Act.

District Agencies

- Each district board of health shall consist of a minimum of five members and include at least one representative from each county in the district.
- Members of the district board of health shall be residents of one of the counties within the district.
- No business, professional group or governmental entity shall constitute a majority of the board.

ELECTING LOCAL BOARD OF HEALTH OFFICERS

Once a local board of health is established, a president and other officers should be elected at an organizational meeting. The Public Health Director may serve as secretary, at the board's discretion, but shall not be a member of the board.

BOARD OF HEALTH MEETINGS

Regular meetings of a board of health must be held at least once every three months. Special meetings may be called with three days' notice, or in the case of an emergency twenty-four hours' notice by the public health director, the president of the board, or by the majority of the members of the board.

ADOPTING BOARD BYLAWS

A county or district board may adopt, and at any time, may amend bylaws in relation to its meeting and the transaction of its business. A majority of the board shall constitute a quorum.

Local Board of Health Appointments

The Act (C.R.S. 25-1-508) states that members of a county board of health shall be appointed by the board of county commissioners. Furthermore, members of a district board shall be appointed by an appointments committee, composed of one commissioner from each district comprising the district.

Recommendations for Appointing Authorities From the National Association of Local Boards of Health (NALBOH)

NALBOH recommends that board membership reflect the diversity of the community it serves, and board members have expertise in the areas of:

- Public Health
- Environmental health
- Medicine/Nursing
- Health Promotion/Health Education
- Mental Health/Social Work
- Education
- Community Advocacy
- Media Relations
- Business

Board Compensation

The Act specifies that members of the board shall serve without compensation, with the exception of necessary travel and subsistence expenses to attend meetings.

SECTION II – THE LOCAL PUBLIC HEALTH DIRECTOR

PUBLIC HEALTH DIRECTOR POWERS AND DUTIES SUMMARY

Administrative Oversight

- Act as custodian of all property and records of the agency. Maintain an office location designated by the county or district board.
- Select all personnel required by the agency and prescribe the duties.
- Serve as secretary to the county or district board of health, if requested by the board.
- Administer and enforce 1) the public health laws of the state, 2) the orders, rules, and standards of the state department, commissions and/or board of health; and the orders and rules of the local board of health.
- Hold hearings, administer oaths, subpoena witnesses, and take testimony in all matters relating to the respective powers and duties.
- Act as the local registrar of vital statistics or contract the responsibility. Direct completion of a community health assessment and local/regional public health plan, every five years.

Policy Making

- Issue orders and adopt rules consistent with the laws, rules and orders of the state and the state board in the event of a public health emergency (e.g., quarantine and isolation, water boil, evacuation, closure of a public place).

Financial Oversight

- Annually estimate the total cost of maintaining the local public health agency for the ensuing year, submit the budget to the local board of health for review, and then the board of county commissioners, or a committee composed of the chairs of the boards of all counties comprising a district, for approval.
- Direct the resources necessary to carry out the county or district public health plan, based on ~~serve~~ priorities from the local board of health.
- Along with the Board President or their designee, certify that claims or demands made against the local public health agency fund were expended only for the duties of the Agency.

PUBLIC HEALTH DIRECTOR SELECTION

- The Act directs local boards of health to select a public health director, who meets the following minimum qualifications established in rule (6 CCR 1014-6) as listed below:
  Physician Director Candidate:
  - Licensed to practice in Colorado within six months of hire.
  - Medical school graduate (MD or DO) and preferably board certified in preventive medicine.
  - Within the past ten years, have five years of administrative experience in public health or related field; two years supervising public health professionals.

- A candidate with one year of graduate study in a recognized school of public health is preferred.

Non-physician Director Candidate:

- Master's degree in public health or related discipline.
- Within last ten years, have five years of administrative experience in public health or related field: two years supervising public health professionals.
- If candidate is a nurse, he/she shall have a license to practice in Colorado within six months of hire.

- If the public health director is not a licensed physician, a designated medical officer (advisor) shall be employed or contracted (paid or volunteer) by the district of county board of health to advise the public health director on medical decisions and be available at all time to the public health director. The medical officer must be a graduate from an approved medical school (MD or DO) and licensed to practice medicine in the state of Colorado.
- The local board of health may substitute professional public health work experience for certain academic requirements, or exceptional academic preparation for certain experience requirements when the candidate is otherwise prepared to fulfill the duties.
- Under certain conditions, the local board of health may waive the minimum requirements set forth in 6 CCR 1014-6 under the following criteria (as approved by the State Board of Health):
  - The population of the jurisdiction for the county or district served and its ability to recruit a qualified candidate.
  - Whether the candidate for public health director will seek to obtain additional public health education and experience within five years of the waiver; and
  - The county or district board of health has explored joining with a county or establishing a district public health agency with a qualified public health director.

SECTION III – THE LOCAL PUBLIC HEALTH AGENCY

DUTIES

- The Act defines a public health agency as an organization operated by a federal, state, or local government or its designees that acts principally to protect and preserve the public's health. The Act established the duties of all local public health agencies, including carrying out the public health laws and rules of the state board and commissions.
- In addition to other powers and duties, an agency shall:
    - Complete a community health assessment and create a county or district public health plan at least every five years.
    - Advise the local board of health on public policy issues necessary to protect public health and the environment.
    - Provide or arrange for the provision of quality, core public health services as defined by the Colorado Board of Health.
- Core Public Health Services and minimum quality standards for providing core public health services were established by Colorado Board of Health rules (6 CCR 1014-7 and 6 CCR 1014-9).
    - Assessment, Planning, and Communication
    - Vital Records and Statistics
    - Communicable Disease Prevention, Investigation, and Control
    - Prevention and Population Health Promotion
    - Emergency Preparedness and Response
    - Environmental Health
    - Administration and Governance.
- The local public health agency can provide the service itself, refer to another organization, or contract with another agency or organization to provide the services, including neighboring counties. The agency has met this requirement if it can demonstrate that other providers offer this service sufficient to meet the local need.

ORGANIZATION AND PERSONNEL

- The Act requires that each county establish and maintain a county public health agency or participate in a district public health agency. Any two or more contiguous counties may establish a district public health agency.
- An agency shall consist of a county or district board of health, a public health director and a medical offer (if the director is not a physician), and other relevant personnel necessary to carry out the duties of the agency. The type of personnel will vary, given community needs and population size. Agencies may choose to employ professionals with specific expertise, share FTEs with other agencies or contract with another agency for services.

- Common positions held within local public health agencies include:
    - Emergency Preparedness Coordinator
    - Environmental Health Specialist
    - Epidemiologist
    - Health Educator
    - Health Planner
    - Nutritionist
    - Public Health Nurse

FUNDS AND TREASURER

- The Act states that the county treasurer shall serve as the treasurer of the county public health agency. In the case of a district agency, the treasurer of the county having the largest population shall serve as treasurer to the agency. The agency treasurer shall create a public health agency fund, to which shall be credited:
    - Any moneys appropriated form a county general fund.
    - Any moneys received from state or federal appropriations or any other gifts, grants, donations or fees for local public health purposes.

SECTION IV – COUNTY DECISIONS AND ACTIONS

1) As stated, the County is required by law to have or participate in a public health authority and to do so by formal resolution.
2) Decide the structure of the local public health department. These are the current public health structures in place in Colorado's 64 counties:
    a. Single County Agency
    b. District Local Public Health Agency
    c. Contractual arrangement with another county to provide services[2]
    d. Health and Human Services with separate Public Health Director
    e. Health and Human Services directed by Human Services Director
    f. Majority of public health services delegated to non-profit
    g. Two coordinating Local Public Health Agencies (city/county structure of government)
3) Establish by resolution a county public health agency or participate in a district public health agency.
    a. Once the new health authority officially comes into existence, all prior arrangements automatically end, and the new entity has full responsibility and authority.
    b. The new entity could form upon a date certain in the future or upon the successful fulfillment of certain necessary milestones or other events. (i.e., the resolution does not have to take effect immediately upon approval by the BCC).
4) A newly created public health agency structure requires the appointment of a new local board of health by resolution within 90 days of formation.
    a. Regardless of when it forms, even if all duties and responsibilities are contracted out with other agencies or private companies, the new health authority must still have a board appointed.
    b. For counties with a population over 100,000, the LBOH must consist of at least five commissioner-appointed members so that no business or professional group, or governmental entity shall constitute a majority of the board.
    c. Jurisdiction shall include the county or counties within a district and all municipalities therein unless a municipal public health agency is established.
5) Decide on the size (five or more) and composition of the LBOH within statutory and CCR requirements.
6) Determine the services to carry out the public health laws and rules of the state board of health and CDPHE environmental commissions according to the specific needs and resources available within the community and as set out in both the Statewide and Local Public Health Improvement Plans.
7) Provide any moneys necessary – over estimated moneys from surpluses, grants and donations – to cover the total cost of maintaining the agency for the ensuing year by an appropriation from the county general fund.
8) Once appointed, the LBOH must perform the Administrative Oversight, Policy Making and Financial Oversight Powers and Duties described Section I.

[2] There are currently no examples in Colorado, but a county could contract with a district public health agency.

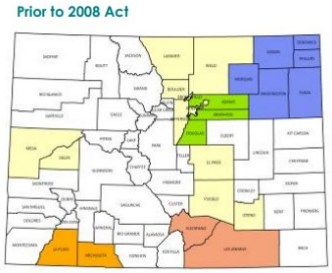
APPENDIX

HISTORY

The Colorado Public Health Reauthorization Act (S.B. 08-194) reconfigured the structure of public health services in Colorado. This discussion will focus on the structure of local public health services in Colorado prior to the 2008 legislation, what was included in the 2008 legislation, and how local public health services were structured and delivered after the 2008 legislation.

PRIOR TO 2008 PUBLIC HEALTH ACT

In 1924, local public health departments began to develop in more populated areas. By 1948, following the passage of the Sabin bills, eight single or multiple county health units were providing basic public health services to 18 counties. Prior to the passage of the Public Health Act of 2008, fifteen "Organized Health Departments," serving 24 counties and 85% of the state's population, had been formed. These agencies were responsible for the provision of a broad scope of public health services within their jurisdiction. The map to the right titled "Prior to 2008 Act" indicates, with color, the location of the agencies formerly called "Organized Health Departments." The multi-county, or district, public health agencies are shown in unique color on the map.



In the remaining 40 counties, only those public health services deemed necessary by the local board of health (fulfilled by the board of county commissioners and one physician) and falling within the scope of the practice of nursing were required by statute (Section 25-1-601, C.R.S., which was repealed by the 2008 legislation). These counties are shown in white on the map. The table below summarizes when health departments were created prior to the 2008 legislation.

HEALTH DEPARTMENT FORMATIONS PRIOR TO 2008 LEGISLATION	YEAR ESTABLISHED
Otero	1924
Weld	1938
El Paso	1939
Denver	1939
Tri County (Arapahoe/Adams/Douglas)	1948
Mesa	1948
Northeast (Logan/Morgan/Philips/Sedgwick/Washington/Yuma)	1948
San Juan Basin (La Plata and Archuleta)	1948
Pueblo	1952
Boulder	1954
Jefferson	1958
Larimer	1968
Delta	1981
Broomfield	2001

Before 2008, whether a county had an organized health department, or a nursing service was based on history and did not necessarily reflect current needs or population size. This is evidenced by the fact that eight of the counties with former "Nursing Services" had populations larger than four counties with former "Organized Health Departments." The primary difference was the scope of public health services provided. In at least ten of the counties formerly served by "Nursing Services," there was no direct provision of environmental health services.

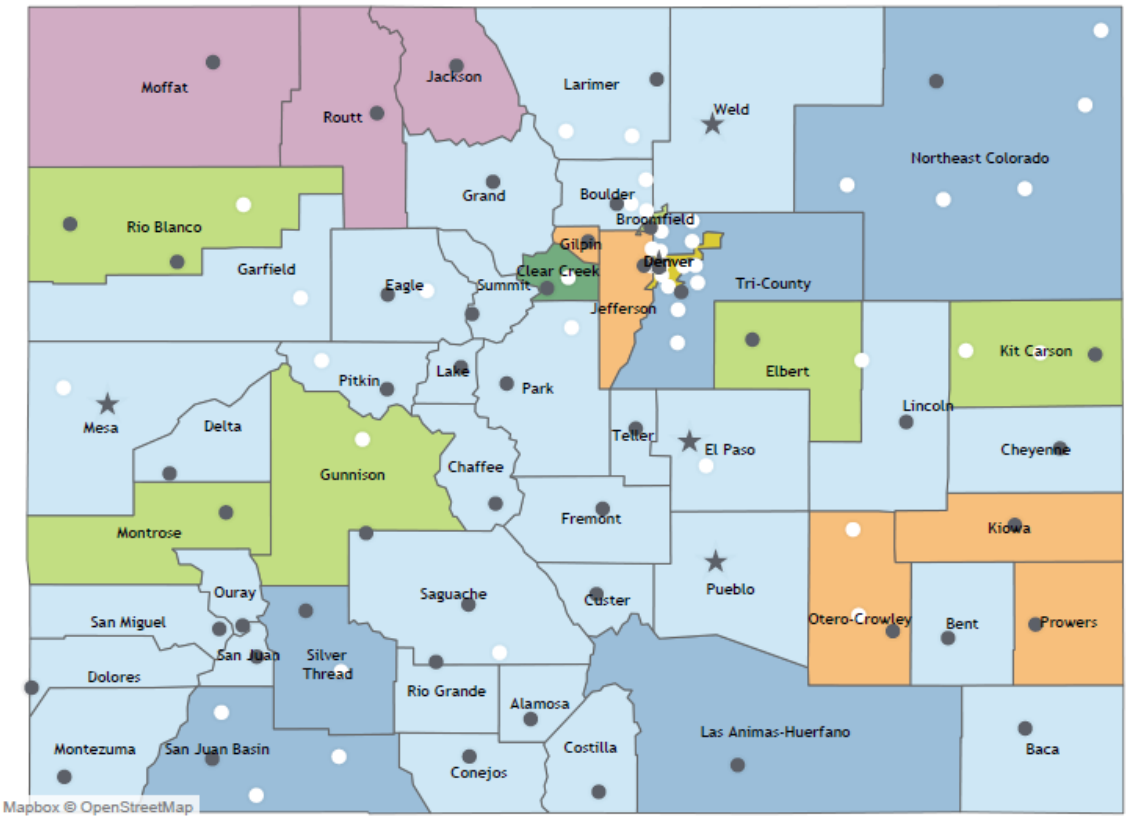
SENATE BILL 08-194

On June 4, 2008, Governor Bill Ritter signed S.B. 08-194 Colorado Public Health Reauthorization Act that requires identified boards, agencies, and public officials to collaboratively develop state and local public health plans that set priorities for the public health system in Colorado. The primary purpose of the Act is to ensure that core public health services are available to every person in Colorado with a consistent standard of quality. Under the new law, each county must establish – or be part of – a local public health agency organized under a local board of health with a public health director and other staff necessary to provide public health services.

LOCAL PUBLIC HEALTH AGENCY AFTER JULY 1, 2019

The organized health departments followed different statutory requirements prior to the Act and were encouraged through funding incentives to provide additional services outside of their jurisdiction to counties that did not provide the full range of public health services. The Public Health Act of 2008 established a system of local public health agencies with a goal of providing uniform services throughout the state. The Colorado Local Public Health Agencies map on the next page illustrates the various structures of the local public health agencies across the state in 2020.

Colorado Local Public Health Agencies



- Single County Agency
- District Local Public Health Agency
- Contractual arrangement with another county to provide services
- Health and Human Services with separate Public Health Director
- Health and Human Services directed by Human Services Director
- Majority of public health services delegated to non-profit
- Two Coordinating Local Public Health Agencies

Physical ●
Satellite ○
PHAB Accredited ★

PHAB = National Public Health Accreditation Board
www.phaboard.org

You can save this map as an image or pdf using the download options at on the bottom-right.

COLORADO
Office of Planning, Partnerships & Improvement
Department of Public Health & Environment

2009 DOUGLAS COUNTY BCC RESOLUTION

OFFICIAL RECORDS
DOUGLAS COUNTY CO
JACK ARROWSMITH
CLERK & RECORDER
RECORDING FEE: $0.00
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RESOLUTION NO. R-009-039

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THE BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF DOUGLAS, COLORADO

RESOLUTION RE-ESTABLISHING THE TRI-COUNTY HEALTH DEPARTMENT AS THE PUBLIC HEALTH AGENCY OF DOUGLAS COUNTY, AND RE-APPOINTING THE MEMBERS OF THE BOARD OF HEALTH

WHEREAS, the Douglas County Board of Commissioners recognizes the vital importance of having a public health agency to protect the health of all our people; and

WHEREAS, the Tri-County Health Department is the district health department which currently provides the public health services for Adams County, Arapahoe County and Douglas County, Colorado; and

WHEREAS, the Tri-County Health Department has been the district health department for Douglas County since 1966; and

WHEREAS, public health services in Colorado have been restructured with the passage of the Colorado Public Health Reauthorization Act, as set forth in Senate Bill 08-194, which was signed into law on June 3, 2008; and

WHEREAS, the Colorado Public Health Reauthorization Act requires the re-establishment of the Tri-County Health Department as Douglas County's public health agency, and the re-appointment of Douglas County's members serving on the re-organized Board of Health of the Tri-County Health Department; and

WHEREAS, upon re-establishment by Adams County, Arapahoe County and Douglas County, Tri-County Health Department shall function as a District Public Health Agency pursuant to §25-1-506 of the Colorado Revised Statutes.

NOW, THEREFORE, BE IT RESOLVED that the Douglas County Board of Commissioners does hereby re-establish the Tri-County Health Department as the public health agency of Douglas County, with all the powers and duties of a District Public Health Agency as set forth in the statutes of the state of Colorado, including but not being limited by, the powers and duties as set forth in §25-1-506 of the Colorado Revised Statutes, as amended, or hereafter amended;

BE IT FURTHER RESOLVED that pursuant to the provisions of §25-1-508 of the Colorado Revised Statutes, that the District Board of Health for the Tri-County Health Department shall be composed of nine members and that each County member of the Tri-County Health Department shall have the authority to appoint three members to said Board of Health

BE IT FURTHER RESOLVED that the Board of Health of the Tri-County Health Department shall have all powers and duties set forth in the statutes of the state of Colorado,

including but not being limited by, the powers and duties as set forth in §25-1-508 of the Colorado Revised Statutes, as amended, or as hereafter amended;

BE IT FURTHER RESOLVED that the re-establishment of the Tri-County Health Department pursuant to the action mandated by the provisions of §25-1-506 of the Colorado Revised Statutes shall not be deemed to be a termination of any pre-existing contract, the cessation of any existing legal obligation or the abandonment of any existing legal right of the Tri-County Health Department.

PASSED AND ADOPTED this 24th day of February, 2009, in Castle Rock, Douglas County, Colorado.

THE BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF DOUGLAS, COLORADO

BY: _____
JACK A. HILBERT, Chair

ATTEST:

_____
Melissa Pelletier, Deputy Clerk to the Board

DOUGLAS COUNTY, COLORADO SEAL EST. 1874

PUBLIC HEALTH RESPONSIBILITIES

LOCAL BOARDS OF HEALTH POWERS AND DUTIES[3]

a) Establish a local public health agency in accord with the Act
b) Hire a local public health director. If the public health director does not meet the requirements in statute, the local board of health must also hire a medical officer that meets the requirements of statute.
c) Determine the services to carry out the public health laws and rules of the state board of health and CDPHE's environmental commissions according to the specific needs and resources available within the community and as set out in the state and local plans
d) Direct the local public health agency to complete a community health assessment and local plan every five years.
e) Approve the local public health plan and submit to the state board of health for review
f) Consider advice from the local public health agency regarding policy issues necessary to protect public health and the environment
g) If there are insufficient funds to provide the above services, set priorities for providing services and include the list in the local plan
h) Elect from its members a President and other officers as it determines
i) Hold regular meetings, at least every three months, as established by resolution; as well as special meetings called by the president or majority of members of the board with three-day notice or 24-hours' notice for emergencies
j) Develop and promote the public policies needed to secure the conditions necessary for a healthy community
k) Certify that claims or demands against the local public health agency fund shall be expended only for purposes outlined in statute
l) Annually estimate the total cost of maintaining the local public health agency for the ensuing year and submit a budget to the county commissioners

[3] Information is from the Colorado Public Health Reauthorization Act – SB 08-194 Executive Summary. https://www.colorado.gov/pacific/sites/default/files/OPP_Public-Health-Act-Summary_0.pdf

LOCAL PUBLIC HEALTH DIRECTOR POWERS AND DUTIES

a) Select all personnel required by the agency
b) In the event of a public health emergency, issue orders and adopt rules consistent with the laws and rules of the state as the public health director may deem necessary for the proper exercise of the powers and duties vested in or imposed upon the agency or the local board of health
c) Administer and enforce:
    i. Public health laws of the state and CDPHE environmental commissions, and orders of the state board of health
    ii. Orders and rules of the local board of health
d) Exercise all powers and duties conferred and imposed upon agencies not expressly delegated by the provisions of Part 5 of Title 25 to a local board of health
e) Hold hearings, administer oaths, subpoena witnesses and take testimony in all matters relating to the exercise and performance of his or her powers and duties
f) Act as the local registrar of vital statistics or to contract out the responsibility of registrar in the area over which the agency has jurisdiction
g) Direct the resources needed to carry out the local public health plan
h) Serve as Secretary to the local board of health if requested and as custodian of all properties and records of the agency
i) Certify that claims or demands against the fund shall be expended only for purposes outlined in statute

LOCAL PUBLIC HEALTH AGENCY POWERS AND DUTIES

a) Complete a community health assessment and create the local public health plan consistent with the statewide improvement plan every five years (after the statewide plan) and submit to the local and state boards of health for review
b) Provide or arrange for services to carry out the public health laws and rules of the state board of health and CDPHE environmental commissions according to the specific needs and resources available within the community as determined by the local board of health or the board of county commissioners as set out in the state and local plans
c) Advise the local board of health on public policy issues necessary to protect public health and the environment
d) Provide or arrange for the provision of quality, core public health services deemed essential by the state board and the comprehensive, statewide public health improvement plan
e) Administer and enforce laws pertaining to public health, air, waste, water quality, vital statistics, and orders and standards of the state board of health
f) Investigate and control causes of epidemic or communicable diseases and conditions affecting public health
g) Establish and maintain quarantines for the protection of public health
h) Close schools and public places, when appropriate, to protect public health
i) Investigate and abate nuisances
j) Establish and maintain or make available chemical, bacteriological and biological laboratories
k) Purchase and distribute to physicians and veterinarians approved biological or therapeutic products necessary for the protection of public health
l) Initiate and carry out health programs consistent with state law that are necessary or desirable by the county or local board of health
m) Collect, compile and tabulate reports of marriages, dissolutions of marriage, and declarations of invalidity of marriage, births, deaths and morbidity
n) Make necessary sanitation and health investigations and inspections, on its own initiative or in cooperation with the CDPHE for matters affecting public health
o) Collaborate with the CDPHE, state board of health, and the state's environmental commissions in all matters pertaining to public and environmental health
p) In the event of a public health emergency, the agency shall issue orders and adopt rules consistent with the laws and rules of the state as the public health director may deem necessary for the proper exercise of the powers and duties vested in or imposed upon the agency or the local board of health
q) If there are insufficient funds to provide the above services, set priorities for providing services and include the list in the local plan

STATE POWERS AND DUTIES

CDPHE Powers and Duties

a) Develop a Statewide Public Health Improvement Plan by December 31, 2009 and every five years thereafter
b) Make the plan available to the Governor, the General Assembly, the State Board of Health, local public health agencies and other partners
c) Allocate any moneys that the state general assembly may appropriate for distribution to local public health agencies for the provision of local health services, in accord with the state board of health approved funding formula (beginning July 1, 2009)
d) Provide technical assistance to local public health agencies requesting assistance with generating their local plans
e) Abate local public health nuisances with all the powers given to a local board of health when notified by a local board of health that it is unable to act
f) Reallocate state moneys from an agency that is not able to provide core public health services or standards to another entity to deliver services in that agency's jurisdiction

State Board of Health Powers and Duties

a) Establish by rule:
    i. Core public health services that local public health agencies must provide
    ii. Minimum quality standards for public health services
    iii. Minimum qualifications for local public health directors and medical officers
    iv. Minimum qualifications for county and district public health directors and medical officers
    v. By July 1, 2009, if practicable, a formula for allocating appropriated state funds to local public health agencies based on input from the CDPHE and from local public health agencies
    vi. Criteria by which local plans shall be evaluated, taking into account the populations served by each agency, the additional costs involved in operating small or rural agencies, and the scope of services provided by each agency
b) Ensure the development and implementation of a comprehensive, statewide public health improvement plan
c) Review all county and district public health agency public health plans

The State Board of Health

The nine-member State Board of Health (SBOH) was established in 1877 by act of Colorado's first General Assembly. The responsibilities of the first State Board of Health mirrored the public health issues of the time. The Board was charged with the collection and study of vital statistics as a means of determining the causes of illness and death, the control of epidemics and contagious disease, and advice on proper sources of water supplies and places of sewage disposal.

Membership of the SBOH

Currently, State Board of Health members are appointed to staggered, four-year terms by the Governor. One member is appointed from each of Colorado's seven Congressional districts and two members are from the state-at-large. One of the board members must be a county commissioner and no more than five members can be from the same political party.

STATEWIDE AND LOCAL PUBLIC HEALTH IMPROVEMENT PLANS

STATEWIDE PUBLIC HEALTH IMPROVEMENT PLAN

Section 25-1-504, C.R.S. outlines the requirements of the statewide comprehensive public health improvement plan. The statewide plan must assess and establish priorities for the public health system using available data and other available information and national guidelines and recommendations on public health outcomes and improvements. Specifically, the statewide public health improvement plan must assess and set priorities for the public health system. Section 25-1-504 (2)(a), C.R.S. requires the statewide public health plan to do the following:

I. Guide the public health system in targeting core public health services and functions through program development, implementation, and evaluation;
II. Increase the efficiency and effectiveness of the public health system;
III. Identify areas needing greater resource allocation to provide essential public health services;
IV. Incorporate, to the extent possible, goals and priorities of public health plans developed by county or district public health agencies; and
V. Consider available resources, including but not limited to state and local funding, and be subject to modification based on actual subsequent allocations.

Pursuant to Section 25-1-504 (2)(b), C.R.S. the statewide public health improvement plan must include, at a minimum, the following elements:

I. Core public health services and standards for county and district public health agencies;
II. Recommendations for legislative or regulatory action, including but not limited to updating public health laws, eliminating obsolete statutory language, and establishing an effective and comprehensive state and local public health infrastructure;
III. Identification and quantification of existing public health problems, disparities, or threats at the state and county levels;
IV. Identification of existing public health resources at the state and local levels;
V. Declaration of the goals of the plan;
VI. Identification of specific recommendations for meeting these goals;
VII. Development of public and environmental health infrastructure that supports core public health functions and essential public health services at the state and local levels;
VIII. Explanation of the prioritization of one or more conditions of public health importance;
IX. Detailed description of strategies to develop and promote culturally and linguistically appropriate services;
X. Development, evaluation, and maintenance of, and improvements to, an information infrastructure that supports essential public health services;
XI. Detailed description of the programs and activities that will be pursued to address existing public and environmental health problems, disparities, or threats;
XII. Detailed description of how public health services will be integrated, and public health resources shared to optimize efficiency and effectiveness of the public health system;
XIII. Detailed description of how the plan will support county or district public health agencies in achieving the goals of their county or district public health plans;
XIV. Estimation of costs of implementing the plan;
XV. A timeline for implementing various elements of the plan;
XVI. A strategy for coordinating service delivery within the public health system; and

XVII. Measurable indicators of effectiveness and successes.

The current Statewide Public Health Improvement Plan can be accessed here:
https://www.colorado.gov/pacific/sites/default/files/OPP_2015-CO-State-Plan.pdf

LOCAL PUBLIC HEALTH IMPROVEMENT PLAN

Section 25-1-505, C.R.S. requires each county or district to prepare a county or district public health plan that is not inconsistent with the comprehensive, statewide public health improvement plan. The local public health improvement plan must, at a minimum:

a) Examine data about health status and risk factors in the local community;
b) Assess the capacity and performance of the county or district public health system;
c) Identify goals and strategies for improving the health of the local community;
d) Describe how representatives of the local community develop and implement the local plan;
e) Address how county or district public health agencies coordinate with the state department and others within the public health system to accomplish goals and priorities identified in the comprehensive, statewide public health improvement plan; and
f) Identify financial resources available to meet the public health needs identified and to meet the requirements for the provision of core public health services.

PUBLIC HEALTH LOCAL AGENCY STRUCTURE

There are seven different structures of local public health agencies within Colorado. They are:

LPHA STRUCTURE	NUMBER OF COUNTIES
Single County Agency	33
District Local Public Health Agency	15
Contractual agreement with another county to provide services	5
Health and Human Services with a separate public health director[4]	6
Health and human services directed by human services director	1
Majority of public health services delegated to a non-profit	3
Two coordinating local public health agencies City and County of Denver	1

[4] The City and County of Broomfield currently has a Health and Human Services Department with a separate public health director but is moving toward a single county agency structure.

EXAMPLES OF DIFFERENT MODELS OF LOCAL BOARDS OF HEALTH

The following are examples of board compositions for different models by county. Additional information on these various local boards of health are included as appendices.

BOARD OF HEALTH COMPOSITIONS			
LPHA STRUCTURE	COUNTY OR COUNTIES	BOARD SIZE	COUNTY COMMISSIONERS ON BOARD?
Single County Agency			
	Boulder County	5	No
	El Paso County	9	Yes - 2 Members
	Garfield County	3	Yes – All Commissioners
	Larimer County	5	No
	Mesa County	5	No
	Weld County	9	No
	Gunnison County	3	Yes - All Commissioners
District Local Public Health Agency			
	Tri-County Health Department	9	No
	Northeast Colorado	8	6 - one commissioner from each county
	Las Animas-Huerfano	5	No
	Silver Thread	6	Yes – 2 members
	San Juan Basin	7	2 Commissioners (ex-officio voting members)
Contractual agreement with another county to provide services			
	Jefferson County	5	No
	Gilpin County (contract with Jefferson)	3	Yes – All Commissioners
	Otero and Crowley Counties	5	No
Health and Human Services with a separate public health director			
	Broomfield	7	Broomfield City Council
Health and human services directed by human services director			
	Clear Creek County	3	All Commissioners
Majority of public health services delegated to a non-profit			
	Moffat	3	All Commissioners
	Routt County	3	All Commissioners
	Jackson County	3	All Commissioners
Two coordinating local public health agencies			
	City and County of Denver	8	No

PUBLIC HEALTH DIRECTOR

Section 25-1-508 (5)(c)(I), C.R.S. states that a public health director may be a physician, a public health nurse, or other qualified public health professional. A public health director may practice medicine or nursing within his or her license and scope of practice, as necessary, to carry out the functions of the office of the public health director. The qualifications shall reflect the resources and needs of the county or counties covered by the agency. If the public health director is not a physician, the county or district board shall employ or contract with at least one medical officer to advise the public health director on medical decisions. Specifically, Rule 6 CCR 1014-6 requires the following:

Physician Director candidate shall:

- Be licensed to practice medicine in the state of Colorado within six months of hire;
- Have graduated from an approved medical school (MD or DO) and preferably be certified by the American Board of Preventive Medicine or American Board of Osteopathic Preventive Medicine; and
- Have five years, within the past ten years, of successful and responsible administrative experience in public health or a closely related field, including at least two years' experience in supervising public health professionals.
- A candidate with one year of graduate study in a recognized school of public health is preferred.

A Non-Physician Director candidate shall:

- Have a master's degree in a public health discipline such as environmental health, health education, epidemiology, health administration/policy, biostatistics, nursing, public administration, health administration or a closely related discipline; and
- Have five years, within the past ten years, of successful and responsible administrative experience in public health or a closely related field, including at least two years' experience in supervising public health professionals.
- A nurse candidate shall be licensed to practice in the state of Colorado within six months of hire.

If the public health director is not a licensed physician, a designated medical officer (advisor) shall be employed or contracted (paid or volunteer) by the district or county board of health to advise the public health director on medical decisions and be available at all times to the public health director. The medical officer must be a graduate from an approved medical school (MD or DO) and licensed to practice medicine in the state of Colorado.

CORE PUBLIC HEALTH SERVICES

Colorado Code of Regulations 6 CCR 1014-7 establishes the core public health services in accordance with statute. Core public health services are defined in rule as follows:

1. Assessment and Planning: Colorado's governmental public health system will apply the principles and skilled practice of epidemiology, laboratory investigation, surveillance, and program evaluation to support planning, policy and decision making in Colorado. The public health system will monitor, diagnose, and investigate health problems and hazards in communities including public health emergencies, outbreaks, and epidemics, and collect and analyze data.
2. Communications: Colorado's governmental public health system will be a trusted source of clear, consistent, accurate, and timely health and environmental information. The system will consistently use equitable, multi-directional communication strategies, interventions, and tools to support all public health goals.
3. Policy Development and Support: Colorado's governmental public health system will inform and implement policies to meet the community's changing health needs. Public health policies will aim to eliminate health disparities, reduce death and disability, and improve environmental quality and health outcomes for all people in Colorado.
4. Partnerships: Colorado's governmental public health system will create, convene, and support strategic partnerships, engage community members and cross- sectoral partners, agencies, and organizations to achieve public health goals.
5. Organizational competencies
    a. Accountability, Performance Management and Quality Improvement: Colorado's governmental public health system will be accountable and transparent in such a way that the general public can understand the value received from investments made in the system. Accountability, organizational performance management and quality improvement are essential to creating a system that provides high-quality public health services regardless of location. To sustain the culture of quality, performance will be tied to improvements in public health outcomes and other measures, the public health system will be monitored, and public health service delivery will be tracked.
    b. Human Resources: Colorado's governmental public health system will develop and maintain a competent workforce and provide adequate human resources support to ensure the Public Health Director meets minimum qualifications, and staff are able to perform the functions of governmental public health.
    c. Legal Services and Analysis: Colorado's governmental public health system will access and appropriately use legal services and tools to plan, implement and analyze public health activities, including due process requirements as necessary. The system will understand, communicate and utilize appropriate entities in regard to public health's legal authority, and understand and use legal tools such as laws, rules, ordinances and litigation to carry out its duties.
    d. Financial Management, Contract and Procurement Services and Facilities Management: Colorado's governmental public health system will establish and maintain access to the appropriate systems and facilities necessary to deliver public health services in an efficient and effective manner. The system will establish policies and procedures, and provide financial, procurement, budgeting and auditing services in compliance with federal, state and local standards and laws.

   e. Information Technology/Informatics (IT): Colorado's governmental public health system will maintain access to information technology, information management systems and ensure informatics capacities to store, protect, manage, analyze, and communicate data and information to support effective, efficient, and equitable public health decision making.
   f. Leadership and governance: Colorado's governmental public health system will serve as the face of public health, lead internal and external stakeholders in consensus development, engage in policy development and adoption.
6. Emergency Preparedness and Response: Colorado's governmental public health system, in coordination with federal, state and local agencies and public and private sector partners, will have the capability and capacity to prepare for, respond to, and recover from emergencies with health, environmental and medical impacts.
7. Health Equity/Social Determinants of Health: Colorado's governmental public health system will intentionally focus on improving systems and institutions that create or perpetuate socioeconomic disadvantage, social exclusion, racism, historical injustice, or other forms of oppression so that all people and communities in Colorado can achieve the highest level of health possible. Governmental public health will have the requisite skills, competencies, and capacities to play an essential role in creating comprehensive strategies needed to address health inequities, and social and environmental determinants of health.

Foundational public health services in Colorado shall include, but need not be limited to, the following:

1. Communicable Disease Prevention, Investigation and Control: Colorado's governmental public health system will carry out state and locally coordinated surveillance, disease investigation, laboratory testing, and prevention and control strategies to monitor and reduce the incidence and transmission of communicable diseases. Programs will target illnesses that are vaccine-preventable, zoonotic, vector-borne, respiratory, food- or water-borne, bloodborne, healthcare associated, and sexually transmitted as well as emerging threats. Communicable Disease Control will collaborate with national, state, and local partners to ensure mandates and guidelines are met and timely, actionable information is provided to the public and to health professionals.
2. Environmental Health: Colorado's governmental public health system will use evidence-informed practices to understand the cause and effect relationships between environmental changes and ecological and human health impacts, to protect, promote, and enhance the health of the community and environment. Agencies will participate in the protection and improvement of air quality, water, land, and food safety by identifying, investigating, and responding to community environmental health concerns, reducing current and emerging environmental health risks, preventing communicable diseases, and sustaining the environment in a coordinated manner with agencies at the federal, state, and local levels as well as industry stakeholders and the public.
3. Maternal, Child, Adolescent and Family Health: Colorado's governmental public health system will develop, implement and evaluate state-wide, regional and local strategies related to maternal, child, adolescent and family health to increase health and wellbeing, reduce adverse health outcomes and advance health equity across the life course. Strategies may include but are not limited to identifying and providing information, promoting evidence-informed and multi-generational approaches, identifying community assets, advocating for needed initiatives, and convening partners.

4. Chronic Disease and Injury Prevention and Behavioral Health Promotion: Colorado's governmental public health system focuses on common risk and protective factors that affect social, emotional and physical health and safety. To prevent chronic disease and injuries and promote behavioral health, Colorado's governmental public health system will use policy, systems and environmental change strategies to comprehensively address the root causes of poor health outcomes and advance health equity. Priority areas include, but are not limited to, nutrition, physical activity, oral health, access to care and disease management, injury prevention, violence prevention, suicide prevention, mental health and substance use (including tobacco, alcohol and other substances).
5. Access to/Linkage with Clinical Health Care: All Coloradans should be connected with and have access to needed personal health care services that include primary care, maternal and child health care, oral health care, specialty care, and mental health care. Colorado's governmental public health system will coordinate governmental and community partners to link individuals to and ensure the provision of health care within their jurisdictions.

Nothing in the rules should be interpreted to limit a local agency or local board of health's ability to obtain additional resources to expand local public health services beyond the core services identified in this rule.

EXAMPLES OF BOARD OF HEALTH BYLAWS

El Paso County
https://www.elpasocountyhealth.org/board-of-health/regulations

Jefferson County
https://www.jeffco.us/DocumentCenter/View/14944/Board-of-Health-Bylaws-

Larimer County
https://www.larimer.org/boards/board-health

Weld County
https://www.weldgov.com/UserFiles/Servers/Server_6/File/Departments/Health%20and%20Environment/Enrivonmental%20Health/Board%20of%20Public%20Health/BOH%20BYLAWS.pdf

Tri-County Health Department bylaws are included on the next eight pages.

AMENDED AND RESTATED BYLAWS
of the
BOARD OF HEALTH
of the
TRI-COUNTY HEALTH DEPARTMENT

ARTICLE 1
ORGANIZATION AND BOARD

SECTION 1. ORGANIZATION NAME

The official name of this organization is the Board of Health of the Tri-County Health Department.

SECTION 2. PRINCIPAL OFFICE

The principal office of this organization is hereby designated as 6162 South Willow Drive, Suite 100, Greenwood Village, Colorado 80111.

SECTION 3. BOARD OF HEALTH

The duly authorized and governing body of the Tri-County Health Department (hereinafter "the Department") shall be the Board of Health (hereinafter "the Board"). The Board shall consist of nine (9) members to be appointed pursuant to Section §25-1-508 of the Colorado Revised Statutes (C.R.S.).

SECTION 4. OBJECTIVES AND PURPOSES

The general objective and purpose of the Board shall be to oversee the operations and activities of the Department, and to exercise the powers and duties imposed upon the Board of Health as set forth in C.R.S. §25-1-508.

ARTICLE 2
DIRECTORS

SECTION 1. NUMBER AND TERMS OF OFFICE

The Board shall consist of nine (9) members. Memberships shall consist of an equal number of members from each county. Each member shall be appointed to serve a full term of five (5) years.

SECTION 2. QUALIFICATIONS

Each member shall reside in Adams County, Arapahoe County or Douglas County.

SECTION 3. DUTIES AND POWERS

Powers and duties conferred and imposed upon the Board by the provisions of C.R.S. §25-1-501 through C.R.S. §25-1-519 include, but are not limited to:

(a) To develop and promote the public policies needed to secure the conditions necessary for a healthy community;

(b) To approve the local public health plan completed by the Department, and to submit the local public health plan to the State Board of Health for review;

(c) To select a Public Health Director, and if necessary, a medical officer, to serve at the pleasure of the Board.

(d) To provide, equip and maintain suitable offices and all necessary facilities for the proper administration and provision of core public health services by the Department;

(e) To determine general policies to be followed by the Public Health Director in administering and enforcing the public health laws, the orders, rules and regulations of the Board, and the orders, rules, regulations and standards promulgated by the State Board of Health;

(f) To issue such orders and to adopt such rules and regulations, not inconsistent with the public health laws of this State nor with the orders, rules and regulations of the State Board of Health, as the Board may deem necessary for the proper exercise of the powers and duties vested in, or imposed upon, the Board and the Department;

(g) To act in an advisory capacity to the Public Health Director on all matters pertaining to public health;

(h) To hold hearings, administer oaths, subpoena witnesses, and take testimony in all matters relating to the exercise and performance of the powers and duties vested in, or imposed upon, the Board;

(i) To provide the environmental health services and to assess fees to offset the actual direct cost of such services, except that no fee for a service shall be assessed against any person who has already paid a fee to the state or federal government for the service, and except that the only fee which shall be charged for annual retail food service establishment inspections shall be the fee set forth in C.R.S. §25-4-1607.

(j) To accept and, through the Public Health Director, to use, disburse and administer all federal aid, state aid, or other moneys, property or services allotted to the Department for local public health functions or allotted without designation of a specific agency for purposes which are within the functions of the Department, and to prescribe, by rule or regulation, the conditions under which such moneys, property or services shall be accepted and administered. The Board is empowered to affirm existing agreements, or to make new agreements, that may be required to receive such moneys or other assistance.

SECTION 4. BOARD MEMBER EXPENSE REIMBURSEMENT

Members of the Board shall serve without compensation but shall be reimbursed for their actual and necessary traveling and subsistence expenses when absent from their places of residence in attendance at meetings. In lieu of receipt of written expense statements from each Board member, the Department shall pay each Board member a "per diem" amount for each meeting attended as expense reimbursement (but only to the extent, and in the manner, permitted by the Internal Revenue Code) which shall not exceed $50.00 per meeting. Each Board member may individually elect to either submit a reimbursement statement for actual expenses incurred at each meeting, or submit, in the alternative, a "per diem" payment statement for each meeting.

SECTION 5. VACANCIES

Any vacancy on the Board shall be filled in the same manner as full-term appointments by the appointment of a qualified person for the unexpired term remaining in the vacated position.

SECTION 6. REMOVAL AND RESIGNATION

Any Board member who is absent from three (3) consecutive meetings of the Board without being excused by the President shall be considered to have resigned. The Board may then petition the County Commissioners of Adams, Arapahoe and Douglas counties to request that the individual be removed, and that a replacement be appointed in accordance with C.R.S. § 25-1-508.

SECTION 7. INDEMNIFICATION OF OFFICERS AND DIRECTORS

To the fullest extent permitted or provided by Colorado law, the Department shall indemnify any person against all liability, costs (including attorneys' fees) and amounts paid in settlement incurred by reason of fact that he is or was a director, officer, agent, employee or fiduciary of the Department, he is or was serving at the request of the Department as a director, officer, agent or fiduciary of any other governmental agency, joint venture, trust, or other entity, if he acted in good faith and in a manner he believed, in good faith, to be in and not opposed to the best interests of the Department.

Expenses (including attorneys' fees) incurred in defending a civil or criminal action, suit, or proceeding may be paid by the Department in advance of the final disposition of such action, suit, or proceeding, upon receipt of an undertaking by or on behalf of the person seeking the advance to repay such amount unless it is ultimately determined that he is entitled to be indemnified by the Department as authorized by this Article.

ARTICLE 3
OFFICERS

SECTION 1. DESIGNATION AND TERMS OF OFFICE

The officers of the Board shall be a president, a vice-president and a secretary, each of whom shall be elected annually by the Board's members at the last regular meeting of each calendar year. All officers so elected shall hold office at the pleasure of the Board and shall otherwise serve a one-year term unless such term is altered by the officer's resignation or removal. Officers may be re-elected but may not serve more than three consecutive terms in the same elected office.

SECTION 2. QUALIFICATIONS

Any person who is a member of the Board may serve as an officer of the Board.

SECTION 3. DUTIES

The President shall preside at all meetings of the Board and shall perform all duties incident to his/her office and such other duties as may be required by law, by these Bylaws or which may be prescribed from time to time by the Board.

The Vice-president shall, in the absence of the President, perform the duties of the President, and when so acting shall have all the powers of, and be subject to all the restrictions on, the President.

The Secretary shall keep, at the principal office of the Board and Department, the original, or a copy, of these Bylaws as amended or otherwise altered to date. The Secretary shall also keep at the principal office, a book of minutes of all meetings of the Board, both regular and special, as well as minutes of all meetings of Board committees, if applicable. The Secretary shall further see that all notices are duly given in accordance with the provisions of these Bylaws or as required by law. The Secretary shall, finally, perform all duties incident to his/her office as well as such other duties as may be required by law, by these Bylaws or which may be assigned from time to time by the Board.

SECTION 4. VACANCIES

The Board shall fill any vacancy caused by the resignation or removal of an officer. In the event of a vacancy in any office other than that of President, such a vacancy may be filled temporarily by appointment by the President until such time as the Board shall fill the vacancy.

SECTION 5. REMOVAL AND RESIGNATION

The Board may remove any officer, either with or without cause, at any time. Any officer may resign at any time by giving written notice to the Board or to the Board President or Secretary.

ARTICLE 4
MEETINGS

SECTION 1. REGULAR MEETINGS

Regular meetings of the Board shall be held at the principal office of the Department no less than once every two months at a time designated by resolution of the Board. Meetings may also be held at such other place and time as may be designated by the Board.

SECTION 2. SPECIAL MEETINGS

Special meetings of the Board may be called by the President of the Board, the Public Health Director or by a majority of the members of the Board at any time, for the transaction of any business. Such meetings shall be called upon three (3) days prior written notice given by regular mail or, in the case of an emergency, upon twenty-four (24) hours notice by telephone, facsimile transmission, or electronic mailing, and said written notice shall reasonably, but briefly, describe each agenda item to be considered, transacted or voted upon.

SECTION 3. NOTICE OF MEETINGS

No formal notice need be given of any regular meeting of the Board. The Secretary of the Board may, however, cause written notice of each regular meeting to be given Board members. Formal notice of any special meetings shall be given as indicated in Section 2 directly above. All meetings of three or more members at which any public business is discussed or at which any formal action may be taken are declared to be public meetings requiring full and timely notice to the public pursuant to the Open Meetings Law, C.R.S. §24-6-402. Any formal action undertaken at said meeting shall require a quorum.

SECTION 4. QUORUM FOR MEETINGS

A majority of the Board members shall constitute a quorum for the transaction of business at any regular or special meeting of the Board and no business except a motion to adjourn shall be transacted in the absence of a quorum.

SECTION 5. CONDUCT OF MEETINGS

Meetings of the Board shall be presided over by the President acting as chairperson, or in his/her absence, by the Vice-president. The Secretary of the Board shall act as secretary of all Board meetings, except that, in his/her absence, the presiding officer shall appoint another person to act as secretary.

All meetings of the Board shall be governed by, or conducted in accordance with, the provisions contained in "Roberts Rules of Order."

SECTION 6. VOTING AT MEETINGS

All actions to be taken by the Board shall be submitted to a vote of the members of the Board at a duly convened meeting of the Board, at which a quorum is present. All actions shall require the affirmative vote of a majority of the Board members present, with the exception of actions to be taken to amend these Bylaws, which shall require a majority affirmative vote by the entire membership of the Board as required in Article 7, Section 1. The voting of Board members by proxy shall not be permitted at any Board meeting.

SECTION 7. MINUTES OF MEETINGS

Each member of the Board shall be furnished a copy of the minutes of the preceding Board meeting and such minutes shall be formally adopted, either with or without corrections, at the next ensuing meeting of the Board. Compliance shall be evidenced by the signature of the President of the Board and attested to by the signature of the Secretary of the Board. All original minutes shall be entered into the minute book of the Board. Copies of all approved and adopted minutes of the Board meetings shall be delivered to the County Commissioners of Adams, Arapahoe and Douglas counties.

ARTICLE 5
COMMITTEES

SECTION 1. STANDING COMMITTEES

The Board may designate an Executive Committee or any other standing committee to conduct specific business activities of the Board. Standing committees membership shall be limited to Board members.

SECTION 2. AD-HOC COMMITTEES

The Board may designate an "ad-hoc" or temporary committee to work on a special issue or project. Ad-hoc committees may include both Board members and such other personnel as the Board may deem appropriate to assist in the endeavor at hand.

SECTION 3. MEETINGS AND ACTION OF COMMITTEES

The meetings and action of committees shall be governed by, noticed, and held in accordance with the provisions of these Bylaws concerning meetings of the Board. The Board may also adopt rules and regulations pertaining to the conduct of meetings of committees to the extent that such rules and regulations are not inconsistent with the provisions of these Bylaws.

ARTICLE 6
RECORDS, REPORTS AND APPOINTMENTS

SECTION 1. MAINTENANCE OF RECORDS AND REPORTS

The Board shall retain at the principal office of the organization (a) the minutes of all of the meetings of the Board and its committees, (b) a copy of the Bylaws originally adopted and as amended to date, and (c) a record of its members indicating their names, addresses, phone numbers and related electronic addresses, if applicable.

SECTION 2. MEMBER INSPECTION RIGHTS

Every member of the Board shall have the right at any reasonable time to inspect all records, reports and other documents pertaining to both the Board and the Department unless specifically prohibited from doing so by state or federal law.

SECTION 3. APPOINTMENT OF PUBLIC HEALTH DIRECTOR

The Board shall appoint and employ a Public Health Director in accordance with C.R.S. §25-1-508, who shall possess the qualifications as may be prescribed by rules and regulations of the State Board of Health, and who shall be the appointed Executive Director of the Department.

The Executive Director shall be the administrative and executive head of the Department. The Executive Director shall serve at the pleasure of the Board. It shall be his/her duty to promote, carry out, and accomplish the purpose and objectives for which the Department was created as well as any specific plans, projects or duties assigned to him/her by the Board, and he/she shall be custodian of all property and records of the Department.

In addition to the duties specified in these Bylaws, the Executive Director shall serve as the chief spokesperson for the Department and shall also be responsible for following and implementing all applicable provisions of the statutes of the State of Colorado pertaining to public health.

All other Department personnel and employees shall be appointed by the Executive Director with duties he/she shall prescribe and these employees shall possess qualifications approved by the Board. All personnel shall receive such compensation and expense allowances as fixed by the Executive Director with the approval of the Board.

SECTION 4. APPOINTMENT OF ANCILLARY PERSONS OR FIRMS

The Board shall appoint an accounting firm to conduct an annual audit of the financial records of the Department as well as a law firm to provide legal counsel to the Board and the Department. Both firms so appointed shall serve based upon such terms and conditions as may be mutually agreed upon by the Board and the firms.

ARTICLE 7
AMENDMENT OF BYLAWS

SECTION 1. PROCEDURE FOR AMENDMENT

These Bylaws may be amended at any time by a majority affirmative vote of the entire membership of the Board and any proposed amendment shall be furnished to each member of the Board not less than ten (10) days prior to the meeting at which time such amendment will be considered.

CERTIFICATE

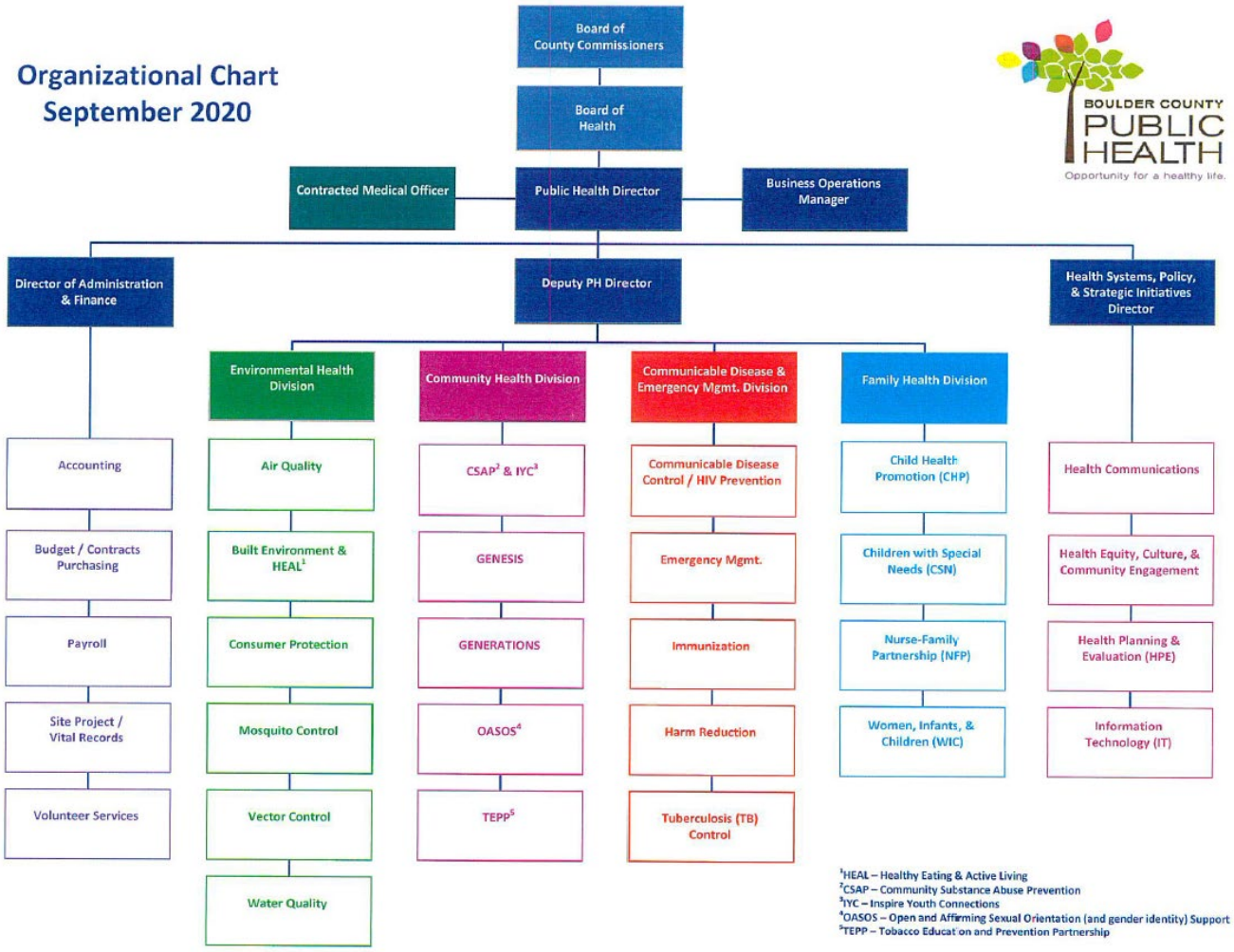
We, Thomas Fawell, MD, President of the Board of Health, and Naomi Steenson, Secretary of the Board of Health, Tri-County Health Department, do hereby certify that at a duly constituted meeting of the Board of Health, held on the 9th day of April, 2019, upon a majority affirmative vote of the entire membership of the Board of Health, these Bylaws were approved as amended.

Thomas Fawell, MD, President

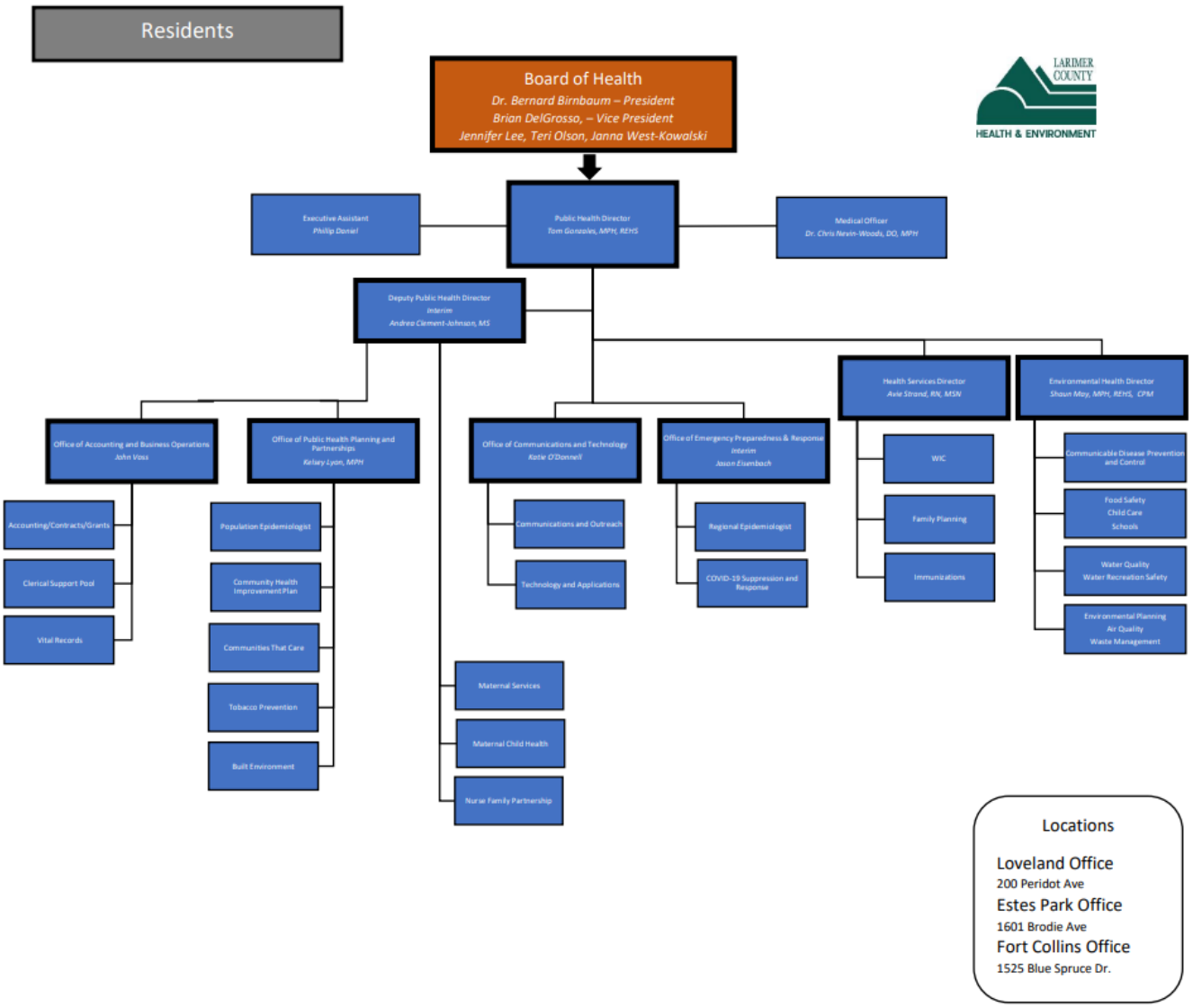
Naomi Steenson, Secretary

ORGANIZATIONAL CHART EXAMPLES

BOULDER COUNTY HEALTH DEPARTMENT

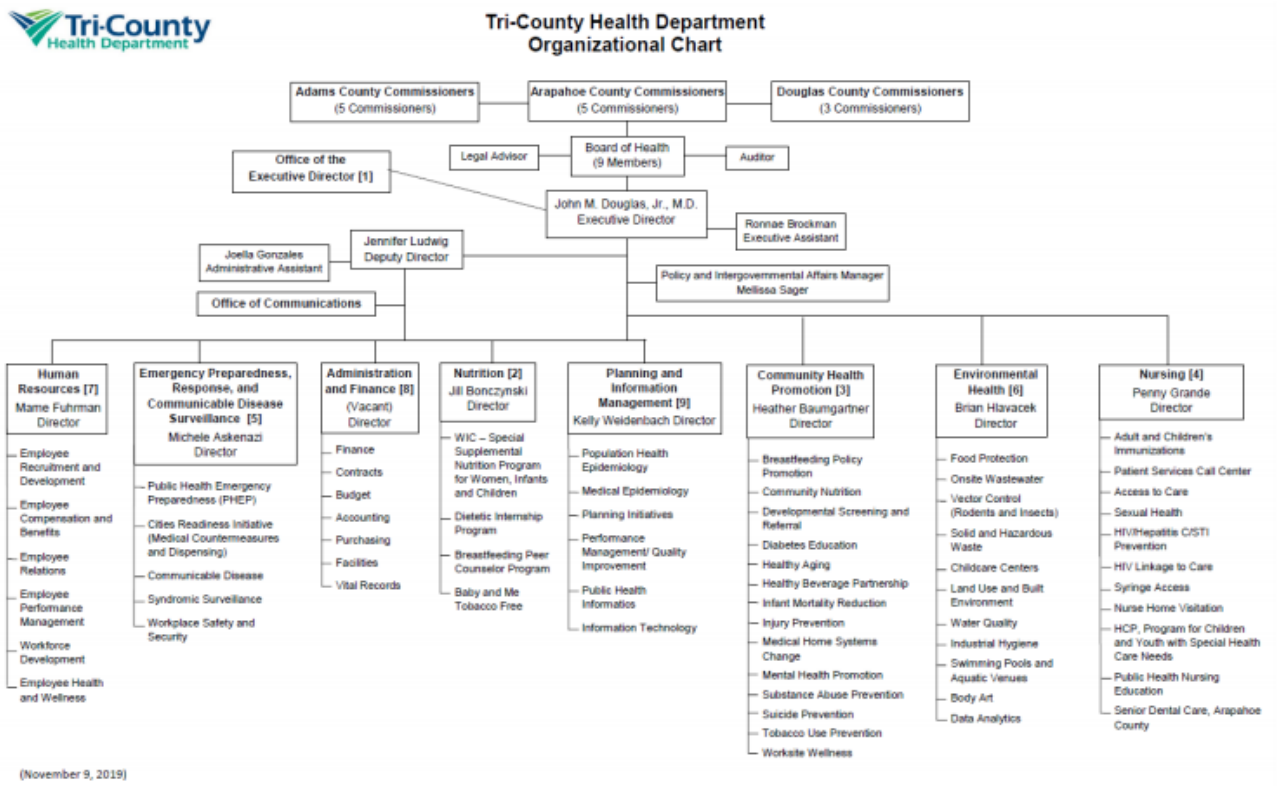


LARIMER COUNTY HEALTH DEPARTMENT



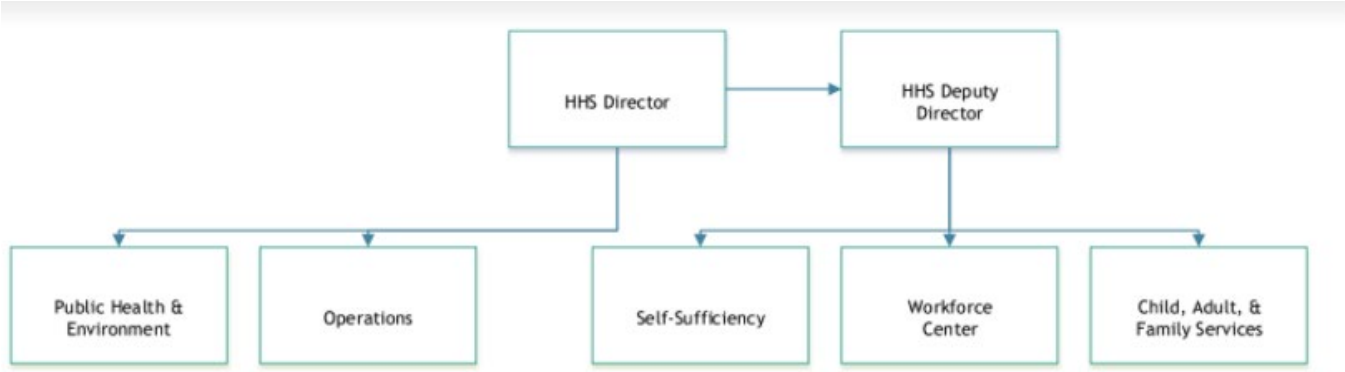
TRI-COUNTY HEALTH DEPARTMENT

TCHD 2020 ORGANIZATIONAL CHART

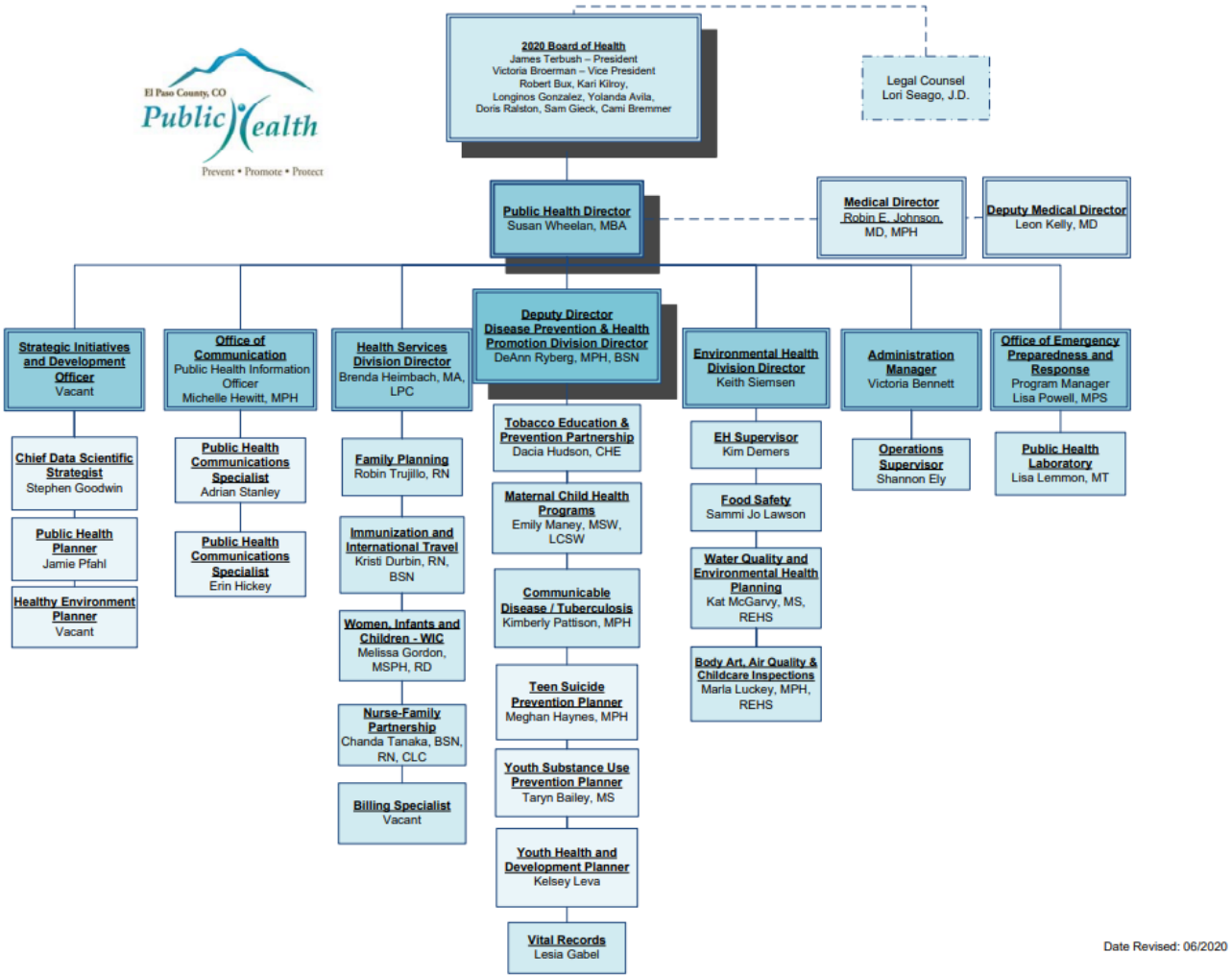


Note: This is the current TCHD Organizational Chart and determines how the subsequent division budgets are organized in this budget book.

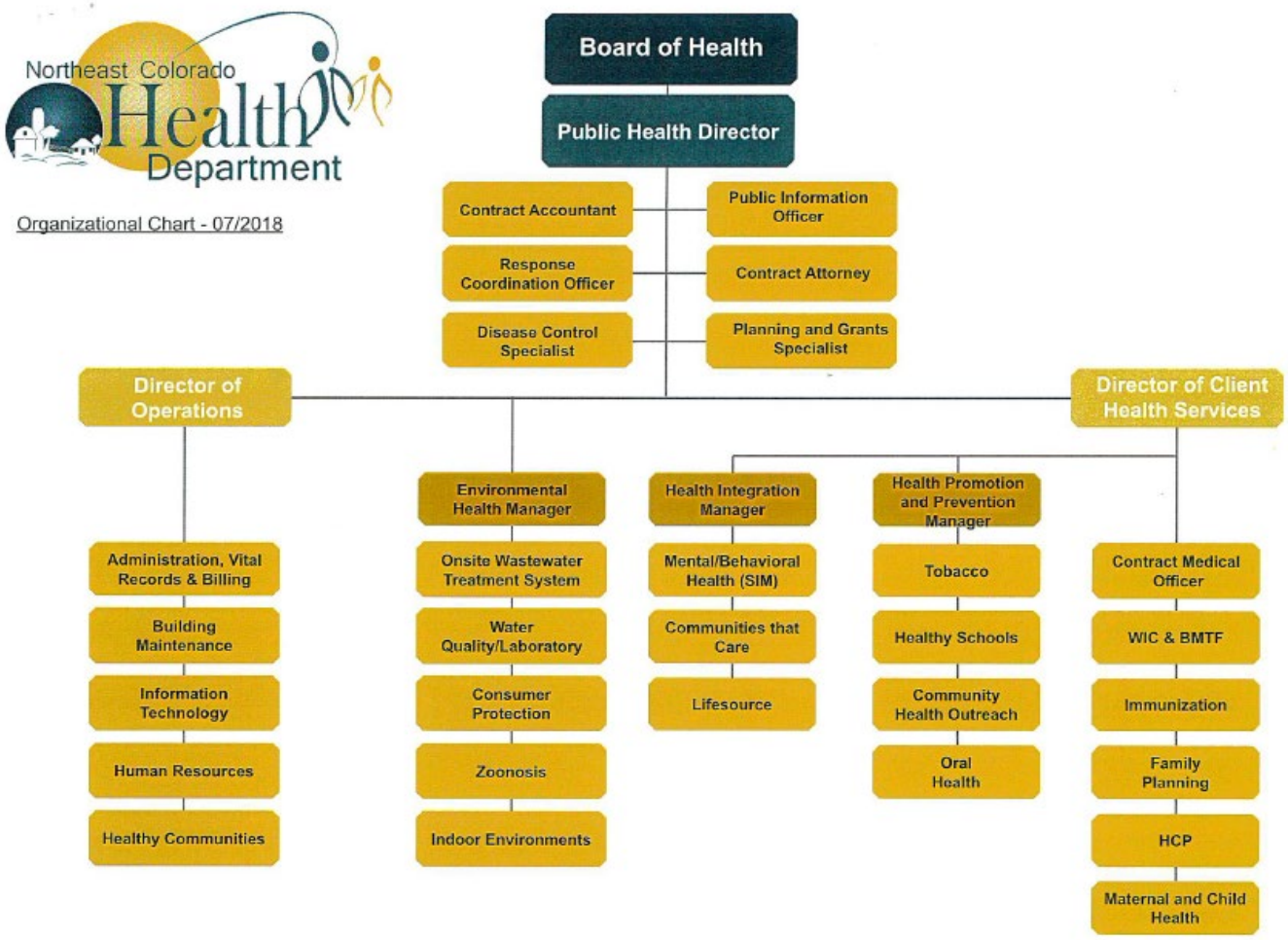
BROOMFIELD COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT



EL PASO COUNTY HEALTH DEPARTMENT ORGANIZATIONAL CHART



NORTHEAST COLORADO HEALTH DEPARTMENT ORGANIZATIONAL CHART



STATUTES PERTAINING TO LBOH

Douglas County is required to have its own health agency or to participate in a regional agency and to make such a decision by formal resolution pursuant to Section 25-1-506 (1), C.R.S.

Participation in a district health agency is automatically dissolved upon the organization of a County health agency and the new entity assumes the "powers and duties" under Sections 25-1-506(2)(b) and (c), C.R.S.

Within 90 days of a resolution establishing a County health agency a Board must be appointed of at least five members who are residents of the County with no "business or professional group or government entity" having a majority pursuant to Sections 35-1-508 (1) and (2), C.R.S.

The local public board of health must select a director and, if necessary, a medical officer. A director vacancy may be filled temporarily by another agency's director or a CDPHE executive pursuant to Sections 25-1-508(5)(c) and (d), C.R.S.

Though the public health agency can contract out the preparation of a local health plan, the Local Board of Health must ultimately approve the plan pursuant to Sections 25-1-505(1) and 25-1-508(5)(b), C.R.S.

LOCAL PUBLIC HEALTH AGENCY LIST

Adams
Tri-County Health Department
Serving Adams, Arapahoe and Douglas counties
6162 S. Willow Drive, Suite 100
Greenwood Village, CO 80111
303-220-9200

Alamosa
Alamosa County Public Health Department
8900 Independence Way
Alamosa, CO 81101
719-589-4848

Arapahoe
Tri-County Health Department
Serving Adams, Arapahoe and Douglas counties
6162 S. Willow Drive, Suite 100
Greenwood Village, CO 80111
303-220-9200

Archuleta
San Juan Basin Public Health
Serving Archuleta and La Plata counties
281 Sawyer Drive, Suite 300
Durango CO 81302
970-247-5702

Baca
Baca County Public Health Agency
741 Main St., Suite 4
Springfield, CO 81073
719-523-6621

Bent
Bent County Public Health Agency
701 Park Ave.
Las Animas, CO 81054
719-456-0517

Boulder
Boulder County Public Health
3450 Broadway
Boulder, CO 80304
303-441-1100

Broomfield
Broomfield Public Health Department
100 Spader Way
Broomfield, CO 80020
720-887-2220

Chaffee
Chaffee County Public Health
448 E. First St., Suite 137
Salida, CO 81201
719-539-4510

Chaffee County Environmental Health
Chaffee County Annex
112 Linderman Ave.
Buena Vista, CO 81211
719-530-5572

Cheyenne
Cheyenne County Public Health Agency
P.O. Box 38
560 W. Sixth St. N
Cheyenne Wells, CO 80810
719-767-5616

Clear Creek
Clear Creek County Public and Environmental Health
P.O. Box 2000
405 Argentine St.
Georgetown, CO 80444
303-670-7946

Conejos

Conejos County Public Health and Nursing Service
P.O. Box 78
19023 Highway 285
La Jara, CO 81140
719-274-4307

Costilla
Costilla County Public Health Agency
P.O. Box 99
233 Main Street, Suite C
San Luis, CO 81152
719-672-3332

Crowley
Otero County Health Department
Serving Crowley and Otero counties
13 W. Third St.
Room 111, County Courthouse
La Junta, CO 81050
719-383-3040

Custer
Custer County Public Health Agency
10 Hermit Lane #5
Silver Cliff, CO 81252
publichealth@custercountygov.com
Phone: 719-783-3369
Fax: 719-783-0959

Delta
Delta County Department of Health and Human Services
255 W. Sixth St.
Delta, CO 81416
970-874-2165

Denver
Denver Department of Public Health and Environment
101 W Colfax Ave, Suite 800
Denver, CO 80202
720-865-5365

Dolores
Dolores County Public Health Agency
P.O. Box 368
425 North Main Street, Suite A
Dove Creek, CO 81324
970-677-2387

Douglas
Tri-County Health Department
Serving Adams, Arapahoe and Douglas counties
6162 S. Willow Drive, Suite 100
Greenwood Village, CO 80111
303-220-9200

Eagle
Eagle County Public Health Agency
P.O. Box 660
551 Broadway
Eagle, CO 81631
970-328-8840

Eagle County Environmental Health Department
P.O. Box 179
500 Broadway
Eagle, CO 81631
970-328-8755

El Paso
El Paso County Public Health
1675 Garden of the Gods Road, Suite 2044
Colorado Springs, CO 80907
719-578-3199

Elbert
Elbert County Health and Human Services
P.O. Box 924
75 Ute Ave.
Kiowa, CO 80117
303-621-3144

Fremont

Fremont County Department of Public Health and Environment
201 N. Sixth Street
Cañon City, CO 81212
719-276-7450

Garfield
Garfield County Public Health
195 W. 14th St.
Rifle, CO 81650
970-625-5200

Gilpin
Gilpin County Public Health Agency
2960 Dory Hill Road, Suite 120
Black Hawk, CO 80422
303-582-5803

Grand
Grand County Public Health
P.O. Box 264
150 Moffat Ave.
Hot Sulphur Springs, CO 80451
970-725-3288

Gunnison
Gunnison County Public Health
225 N. Pine St., Suite E
Gunnison, CO 81230-2333
970-641-0209

Hinsdale
Silver Thread Public Health District
Serving Mineral and Hinsdale counties
304 W. Third St.
Lake City, CO 81235
970-944-0321

Hinsdale County Environmental Health
P.O. Box 277
311 N. Henson St.
Lake City, CO 81235
970-944-2319

Huerfano
Las Animas-Huerfano Counties District Health Department
Serving Huerfano and Las Animas counties
412 Benedicta Ave.
Trinidad, CO 81082
719-846-2213

Jackson
Jackson County Public Health Agency
P.O. Box 1019
Walden, CO 80480
970-723-8572

Jefferson
Jefferson County Public Health
645 Parfet St.
Lakewood, CO 80215
303-232-6301

Kiowa
Prowers County Public Health
Serving Kiowa and Prowers Counties
P.O. Box 414
1309 S. Maine
Eads, CO 81036
719-438-5782

Kit Carson
Kit Carson County Department of Public Health and Environment
P.O. Box 70
252 S. 14th St.
Burlington, CO 80807
Phone: 719-346-7158
Fax: 719-346-8066

La Plata
San Juan Basin Public Health
Serving Archuleta and La Plata counties
P.O. Box 140
281 Sawyer Drive

Durango, CO 81302
970-247-5702

Lake
Lake County Public Health Agency
P.O. Box 626
112 W. Fifth St.
Leadville, CO 80461
719-486-2413

Larimer
Larimer County Health Department
1525 Blue Spruce Drive
Fort Collins, CO 80524
970-498-6700

Las Animas
Las Animas-Huerfano Counties District Health Department
Serving Huerfano and Las Animas counties
412 Benedicta Ave.
Trinidad, CO 81082
719-846-2213

Lincoln
Lincoln County Department of Public Health
P.O. Box 125
326 Eighth St.
Hugo, CO 80821
719-743-2526

Logan
Northeast Colorado Health Department
Serving Logan, Morgan, Phillips, Sedgwick, Washington and Yuma counties
700 Columbine St.
Sterling, CO 80751
970-522-3741

Mesa
Mesa County Health Department
P.O. Box 20000-5033
510 29 1/2 Road
Grand Junction, CO 81502
970-248-6900

Mineral
Silver Thread Public Health District
Serving Mineral and Hinsdale counties
304 W. Third St.
Lake City, CO 81235
970-944-0321

Moffat
Moffat County Public Health Agency
221 W. Victory Way, Suite 130
Craig, CO 81625
970-870-5319

Montezuma
Montezuma County Public Health Agency
106 W. North St.
County Annex Building
Cortez, CO 81321
970-565-3056

Montrose
Montrose County Public Health
1845 S. Townsend Ave.
Montrose, CO 81401
970-252-5000

Montrose County Environmental Health Department
Serving Montrose and Ouray counties
1845 S. Townsend Ave.
Montrose, CO 81401
970-252-5000

Morgan
Northeast Colorado Health Department
Serving Logan, Morgan, Phillips, Sedgwick, Washington and Yuma counties
700 Columbine St.
Sterling, CO 80751
970-522-3741

Otero
Otero County Health Department
Serving Crowley and Otero counties
13 W. Third St.
Room 111, County Courthouse
La Junta, CO 81050
719-383-3040

Ouray
Ouray County Public Health Agency
P.O. Box 670
302 Second St.
Ouray, CO 81427
970-325-4670

Montrose County Environmental Health Department
Serving Ouray and Montrose counties
1845 S. Townsend Ave.
Montrose, CO 81401
970-252-5000

Park
Park County Public Health
P.O. Box 846
825 Clark St.
Fairplay, CO 80440
719-836-4161

Park County Environmental Health
P.O. Box 216
1246 County Road 16
Fairplay, CO 80440
719-836-4252

Phillips
Northeast Colorado Health Department
Serving Logan, Morgan, Phillips, Sedgwick, Washington and Yuma counties
700 Columbine St.
Sterling, CO 80751
970-522-3741

Pitkin
Pitkin County Public Health Agency
0405 Castle Creek Road, Suite 6
Aspen, CO 81611
970-920-5420

Pitkin County Environmental Health
76 Service Center Road
Aspen, CO 81611
970-920-5070

Prowers
Prowers County Public Health
Serving Kiowa and Prowers counties
1001 S. Main St.
Lamar, CO 81052
719-336-8721

Pueblo
Pueblo Department of Public Health and Environment
101 W. Ninth St.
Pueblo, CO 81003
719-583-4300

Rio Blanco
Rio Blanco County Department of Public Health and Environment
101 E. Main St.
Rangely, CO 81648
970-878-9525

Rio Grande
Rio Grande County Public Health Agency
925 Sixth St., Room 101
Del Norte, CO 81132
719-657-3352

Routt
Routt County Public Health Agency
136 6th Street
PO Box 773749
Steamboat Springs, CO 80477

970-870-5319

Saguache
Saguache County Public Health
P.O. Box 68
505 Third St.
Saguache, CO 81149
719-655-2533

San Juan
San Juan County Public Health Service
P.O. Box 619
1315 Snowden St.
Silverton, CO 81433
970-387-0242

San Miguel
San Miguel County Department of Public Health and Environment
Public health:
P.O. Box 949
333 W. Colorado Ave.
Telluride, CO 81435
970-728-4289
Environmental Health
P.O. Box 4130
333 W. Colorado Ave.
Telluride, CO 81435
970-728-0447

Sedgwick
Northeast Colorado Health Department
Serving Logan, Morgan, Phillips, Sedgwick, Washington and Yuma counties
700 Columbine St.
Sterling, CO 80751
970-522-3741

Summit
Summit County Public Health
P.O. Box 2280
360 Peak One Drive, Suite 230
Frisco, CO 80443
970-668-9161

Summit County Environmental Health
P.O. Box 5660
County Road 1005, 0037 Peak One Drive
Frisco, CO 80443
970-668-4070

Teller
Teller County Public Health Department
P.O. Box 928
11115 W. Highway 24, Unit 2C
Divide, CO 80814
719-687-6416

Teller County Environmental Health Department
P.O. Box 928
540 Manor
Woodland Park, CO 80863
719-687-3048

Washington
Northeast Colorado Health Department
Serving Logan, Morgan, Phillips, Sedgwick, Washington and Yuma counties
700 Columbine St.
Sterling, CO 80751
970-522-3741

Weld
Weld County Department of Public Health and Environment
1555 N. 17th Ave.
Greeley, CO 80631
970-304-6420

Yuma
Northeast Colorado Health Department
Serving Logan, Morgan, Phillips, Sedgwick, Washington and Yuma counties
700 Columbine St.
Sterling, CO 80751
970-522-3741

Nursing Division – Programming and Funding Sources (DRAFT)

Nursing Division
Promoting good health for children and adults through linkages to health insurance and health care services; nurse case management; disease prevention; and clinical, preventative, and health education programs. [Clinical vs Non-Clinical Services]

- Funding/Revenue Sources: General Funds, County Restricted Funds, Medicaid Reimbursement, Fees, Restricted Federal and State Funds, Other Restricted Funds and In-Kind Revenue
- FY21 Division: 136.11 FTE
- FY21 Division Budget: $15,717,141
- DC Data: Unavailable

Division Operations
Oversight, planning, implementation, and evaluation of all nursing activities and programs; financial oversight, data collection and management, grant and contract management, program evaluation, quality assurance and improvement processes.

- Funding/Revenue Sources: General Funds
- FY21 Division: 8.29 FTE
- FY21 Division Budget: $1,210,467
- DC Data: Unavailable

Immunizations Program

- Funding/Revenue Sources: General Funds, Medicaid Reimbursement, Patient Fees, Restricted Federal and State Funds, Patient Donations, Private Insurance Billing
- FY21: 23.70 FTE
- FY21 Budget: $3,232,583
- FY21 In-Kind Revenue (State-provided vaccine): $1,040,000
- DC Data: Vaccinations / Available, Call Center / Unavailable

    - Protect individuals of all ages from vaccine-preventable diseases
        - Clinics open weekdays and 1 Saturday per month and community-based sites
        - Targeting uninsured or underinsured; no residency or income requirement; $22 fee requested, but not required

    - Call Center
        - Immunization appointments coordinated through the Call Center for Sexual Health, Immunizations, STI/HIV/Hepatitis C prevention, presumptive health insurance eligibility for children and pregnant women, and health insurance enrollment navigation
        - Screening for cancer, cardiovascular disease and diabetes
        - Staff check clients in/out, pre-screening immunization records, checking insurance eligibility, accurately entering data into an electronic health record, collecting payments, and providing general program referral information

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Disease Prevention and Clinical Services Program – Sexual Health

- Funding/Revenue Sources: General Funds, Medicaid Reimbursement, Patient Fees, Restricted Federal and State Funds, Patient Donations
- FY21: 29.41 FTE
- FY21 Budget: $3,423,688 (corrected)
- FY21 In-Kind Revenue: $96,000

- DC Data: Available
    - Provide services to prevent unintended pregnancies and transmission of HIV and STIs
        - Reproductive health exams, contraceptive counseling and supplies, cervical cancer screening, pregnancy testing, HIV testing and STI testing and treatment, pre-conception counseling and educating high school students

---

Nurse Home Visiting Program – Nurse Family Partnership

- Funding/Revenue Sources: Medicaid Reimbursement, Restricted Federal and State Funds
- FY21: 31.16 FTE
- FY21 Budget: $4,120,513
- DC Data: Available and combined with Arapahoe

    - Family support program for first time, low-income mothers to create healthy and stable futures for themselves and their babies
        - Education, tools, resources and support to promote long-term economic self-sufficiency and potential reduction in use of government services

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Nurse Home Visiting Program - Douglas County Nurse Support Contract Program

- Funding/Revenue Sources: Medicaid Reimbursement, Restricted County Funds
- FY21: 1.54 FTE
- FY21 Budget: $143,967
- DC Data: Available

    - New contract with DCDHS to provide public nursing intervention to help families stay together, prevent out of home placements, reduction of unintended pregnancies, and provision of prenatal education and psychosocial support for pregnant women and their families

---

Child Fatality Prevention Review

- Funding/Revenue Sources: General Funds, Restricted State Funds
- FY21: .75 FTE
- FY21 Budget: $66,984
- DC Data: Available

    - Mandated by the Colorado Child Fatality Prevention Act – coordination of community partners, law enforcement, behavioral health and county officials to review cases and recommend policies to prevent deaths

    - Evaluate aggregated data, describe trends and patterns and recommend prevention strategies such as increase access to adolescent behavioral health treatment for suicide prevention, parental support to build awareness of warning signs of substance use, or culturally appropriate safe sleep education

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HCP – A Program for Children and Youth with Special Healthcare Needs

- Funding/Revenue Sources: Federal Maternal Child Health Block Grant, Title V
- FY21: 4.86 FTE
- FY21 Budget: $487,864
- DC Data: Available

- Services to children and youth from birth to 26 years who have or are at risk of physical, developmental, behavioral or emotional conditions.
- Registered nurses and a registered nutritionist provide information, referrals and coordination of care, identify and prioritize needs of the family, develop a care plan of shared goals, help family members become strong advocates.

Public Health Nursing Clinical Education

- Funding/Revenue Sources: General Funds, Restricted Contracts
- FY21: .60 FTE
- FY21 Budget: $65,664
- DC Data: N/A

  - Provision of a wide variety of public health nursing education experiences for students thereby encouraging public health as a career and professional development for TCHD staff.

Healthy Communities Program and Health Enrollment Team

- Funding/Revenue Sources: General Funds, Medicaid Reimbursement, Restricted Federal and State Funds
- FY21: 5.9 FTE
- FY21 Budget: $549,169
- DC Data: Unavailable

  - Improve access for children and pregnant women eligible for Medicaid and Child Health Plan Plus (CHP+) by providing application assistance to enroll in insurance and education and navigation on accessing medical care and non-medical services including food, housing and transportation assistance.
    - In July 2020, the state eliminated funding to accommodate COVID-19 budget needs. TCHD retained a small Health Enrollment Team to determine eligibility, assist in the application process and enrollment

Regional Health Connectors

- Funding/Revenue Sources: 2017 – 2019: Colorado State Innovation Model, EvidenceNOW Southwest; July 2019 – present: University of Colorado, General Funds
- DC Data: Available

  - New in 2017 - RHCs improve the coordination of local services to advance health by strengthening networks of primary care, public health, human services and community organizations

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Harm Reduction and HIV Prevention Program

- Funding/Revenue Sources: Medicaid Reimbursement, Restricted Federal and State Funds
- FY21: 7.10 FTE
- FY21 Budget: $764,691
- DC Data: Available

  - Prevention and education of HIV and Hepatitis C
    - Screening, community education, syringe access, outreach to infected individuals
    - Testing not offered in Douglas County

Possible Relocation from Community Health Promotion to Nursing

Maternal and Child Health (MCH) Block Grant

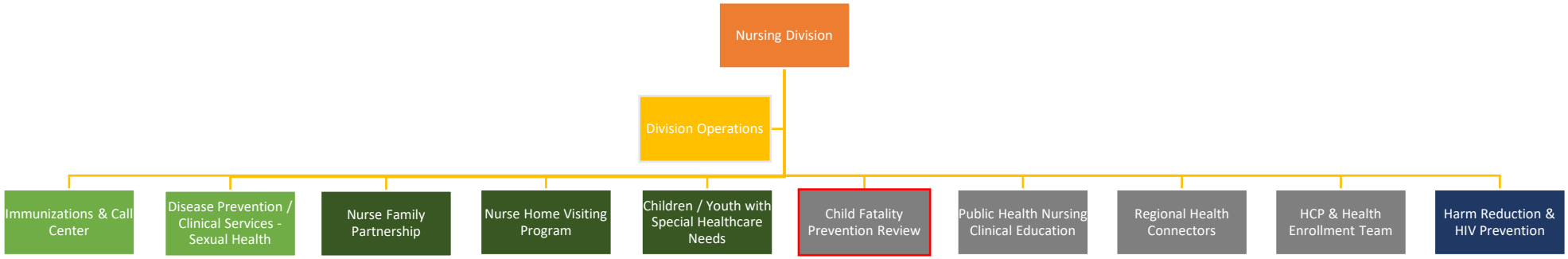
- Restricted Federal and State funds (majority is Federal Maternal Child Health Block Grant, Title V)
- 4.31 FTE
- Budget $671,790

- Child and Adolescent Health
  - Early childhood developmental screening and referral
  - Reduce bullying and suicide, violent and injury prevention, substance abuse, physical and mental health
    - DC Data: Unavailable

- Medical Home for Children and Youth with Special Healthcare Needs
  - Improving access to and coordination across medical care and community resources for children and youth with special healthcare needs and remove barriers to quality care.
    - DC Data: Unavailable

- Perinatal Health
  - Increasing identification, screening and referrals for women experiencing maternal mood disorders, increasing support and services for women who misuse substances in the perinatal period and decreasing the disparities in infant mortality.
  - Collaborative leadership with Denver Public Health
    - DC Data: Available

April 7, 2021



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Potential Scenarios

I. Full Contract with TCHD

Facilities

- No adjustments needed to the county-provided office and clinic space in Lone Tree and Castle Rock.

IT

- TCHD efforts to segregate Douglas from Adams and Arapahoe Counties in their systems.

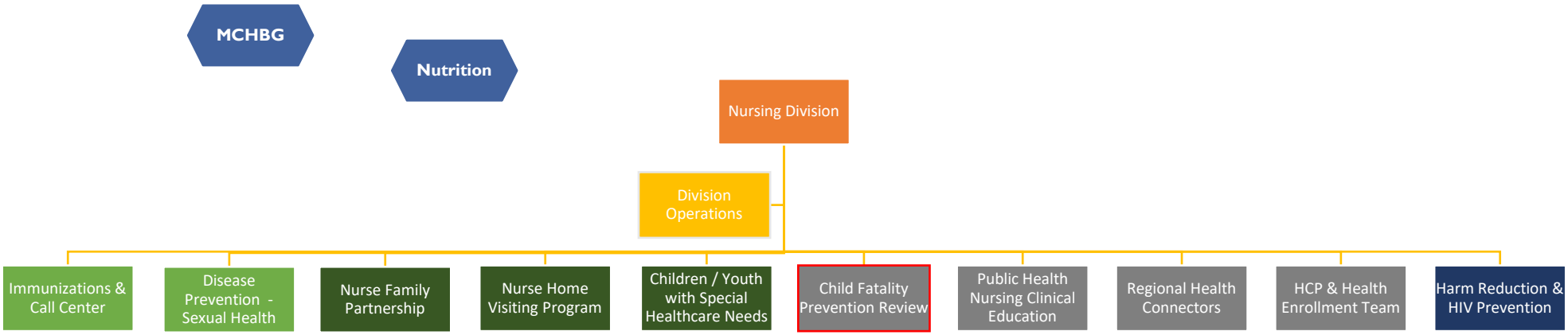
Budget

- Impacts/benefits could result from modifications to programming and TCHD business model, possible loss of large-scale efficiencies.

Considerations

- Retaining an established and accredited public health provider
- Existing relationship and history
- Seamless transition for patients (same locations, staff, expectations, care, etc.)
- Likely not much change in service delivery
- Possible short-term solution
- Full analysis should be conducted to determine if the BCC/BOH/Exec Dir wishes to continue to provide all existing nursing services and programs. Below is the current inventory:
    - Immunizations & Call Center
    - Sexual Health - Disease Prevention and Clinical Services
    - Nurse Family Partnership
    - Nurse Home Visiting Program
    - Child Fatality Prevention Review
    - HCP – Children and Youth with Special Healthcare Needs
    - Public Health Nursing Clinical Education
    - Regional Health Connectors
    - Healthy Communities Program and Health Enrollment Team
    - Harm Reduction and HIV Prevention Program (DC participation is limited)
- Possibly combine Nursing and Nutrition
- Possible Relocation from Community Health Promotion to Nursing
    - Maternal and Child Health (MCH) Block Grant
        - Child and Adolescent Health
            - Early childhood developmental screening and referral
            - Reduce bullying and suicide, violent and injury prevention, substance abuse, physical and mental health
        - Medical Home for Children and Youth with Special Healthcare Needs
            - Improving access to and coordination across medical care and community resources for children and youth with special healthcare needs and remove barriers to quality care.
        - Perinatal Health
            - Increasing identification, screening and referrals for women experiencing maternal mood disorders, increasing support and services for women who misuse substances in the perinatal period and decreasing the disparities in infant mortality.
            - Collaborative leadership with Denver Public Health

April 7, 2021



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II. Full Contract with Kaiser Permanente

Facilities

- Kaiser has four locations in Douglas County: Highlands Ranch, Lone Tree, Parker and Castle Rock (see map below) so no county-provided space would be necessary. The additional patients could be absorbed by the existing infrastructure based on the limited DC data (even if multiplied to be conservative) supplied by TCHD.

IT

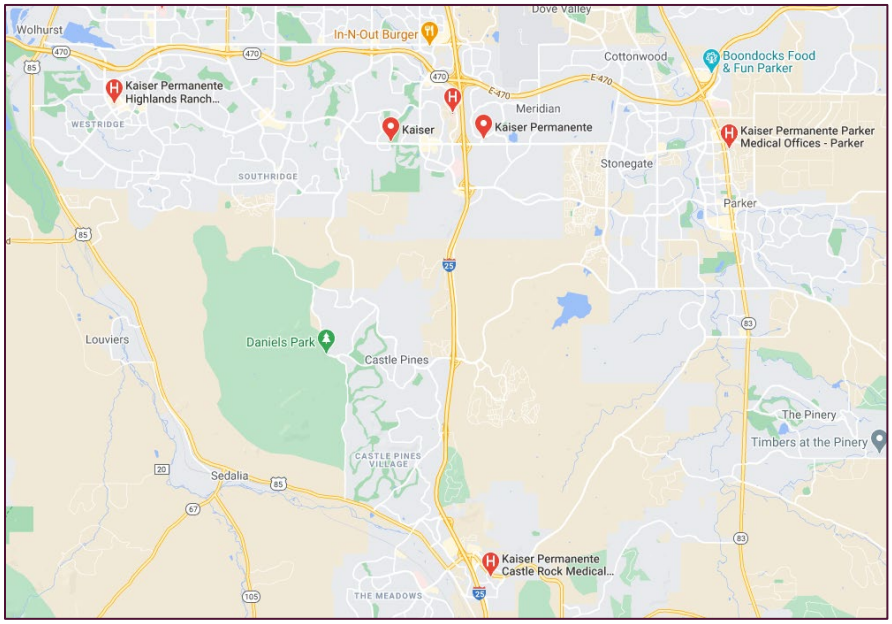
- Kaiser has sophisticated secure systems already in place and can absorb additional patients.

Budget

- Impacts/benefits could result from Kaiser's large-scale efficiencies, established processes, embracement of innovation and years of experience and knowledge.
- Cost savings may be realized from terminating the CR office lease as well as possible consolidation of nursing services and the WIC and Breastfeeding Peer Counselors programs.
- Kaiser may suggest additional compatible services and programs for consideration.

Considerations

- Kaiser has been open to the public since 1945. They are an outstanding non-profit leader originally created to provide economically challenged American workers with high quality, affordable health care. Their community needs assessment illustrates a deep understanding of Colorado and specifically, Douglas County, residents. They have a strong presence across the country and our goal fits nicely with their holistic approach and mission.
- Increased efficacy in meeting Douglas County-specific needs – more resources, specialists
- Securing an established, reputable, and highly capable healthcare provider
- Fresh start, new relationship
- Comprehensive nursing services program provider to include pharmacy
- Substantial service provider to Medicaid clients
- Multiple offices in Douglas County located near public transportation hubs and in CR
- Kaiser may also be able to provide Community Health Promotion and Nutrition Services programming.



April 7, 2021



DRAFT

III. Full Contract with Existing Community Health Care Provider

Hypothetical Example: Community health care provider (CHCP) in the CO Community Health Network (see list below).

Facilities

- No adjustments needed to county-provided office and clinic space in Lone Tree and Castle Rock. The vendor could easily assume occupancy of both spaces.

IT

- The vendor's system would need to be evaluated for expansion capacity and efficacy; however, an established system would already be place and one would not have to be developed.

Budget

- Benefits could be seen from capitalizing upon existing operations, established processes, and years of experience and knowledge as community health care providers.

Considerations

- Securing an established, reputable, and capable community healthcare provider
- Existing relationship and history (if Stride CHC with DC location)
- STRIDE Clinical Services has experienced providers in Family Practice, Geriatrics, Internal Medicine, Midwifery, Obstetrics, Gynecology, Pediatrics, and Specialized Primary Care (HIV Management, Homeless Services, Physical and Intellectual Disabilities, Seizure Disorders, Refugee Health, people desiring assistance with opioid addiction, and Gender affirming and LGBTQ+ care.). All STRIDE locations provide general primary care, physical examinations, well child visits, immunizations, chronic disease management, family planning, limited pharmacy and laboratory support, and referral to outside services.
- Some Nursing Division services are already being provided by Stride. Many more (above) could be made available to more citizens if Stride also provided services in CR and LT. Some services may not be able to be provided (below). Possible inclusion of Nutrition Services and Community Health Promotion.
  - ✓ Immunizations
  - ? Call Center
  - ✓ Sexual Health - Disease Prevention and Clinical Services
  - ? Nurse Family Partnership
  - ? Nurse Home Visiting Program
  - ? Child Fatality Prevention Review
  - ✓ HCP – Children and Youth with Special Healthcare Needs
  - ? Public Health Nursing Clinical Education
  - ? Regional Health Connectors
  - ? Healthy Communities Program and Health Enrollment Team
  - ✓ Harm Reduction and HIV Prevention Program (DC participation is limited)
- Plug and play

Potential Community Health Vendors

COLORADO COMMUNITY HEALTH NETWORK
Access for All Colorado

https://cchn.org/

Tepeyac Community Health Center
(303) 458-5302
www.tepeyachealth.org
Serving Denver, Adams, and Arapahoe counties and neighboring communities

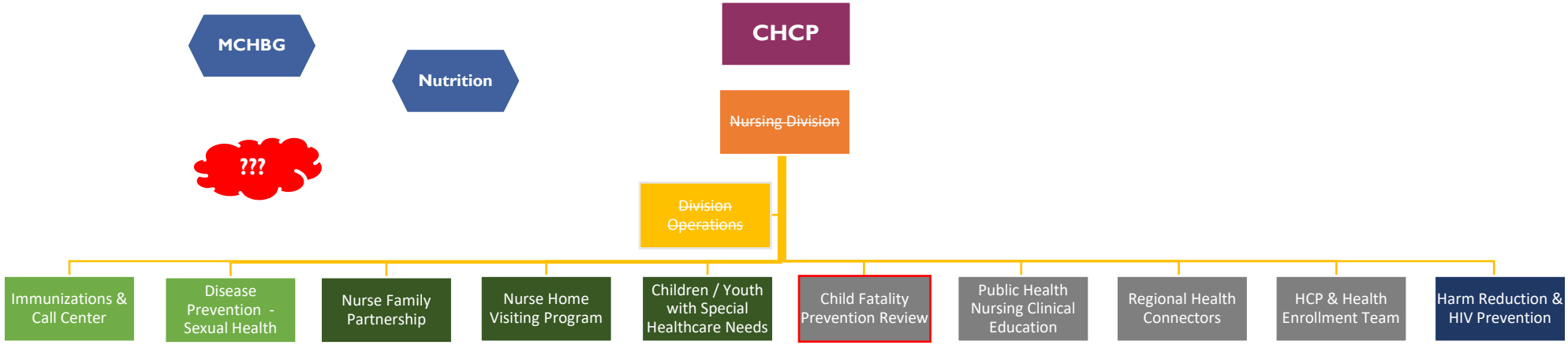
Peak Vista Community Health Centers
(719) 632-5700
www.peakvista.org
Serving El Paso, Adams, Arapahoe, Douglas, Elbert, Kit Carson, Lincoln, Park, and Teller counties

Salud Family Health Centers
(303) 892-6401 / (303) MYSALUD (697-2583)
www.saludclinic.org
Serving Weld, Adams, Boulder, Larimer, Las Animas, Logan, Morgan, Sedgwick, Phillips, Washington, and Yuma counties

Sheridan Health Services
(303) 315-6150
www.sheridanhealthservices.com
Serving Arapahoe, Adams, Denver, and Jefferson counties

STRIDE Community Health Center
Customer Care Center: (303) 360-6276
stridechc.org
Serving Arapahoe, Adams, Jefferson, Douglas and Park counties

April 7, 2021



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IV. Partial Contract with TCHD/CHCP Paired with Partial Contract with Other Service Provider

Hypothetical Example: Immunizations and sexual health services are provided by community partners such as Walgreens, CVS, Walmart, Safeway, King Soopers, Life Health or Mako Medical. (see list below) TCHD or community health care provider delivers all other Nursing Division described services.

Facilities

- Immunizations and sexual health services would be administered at existing partner sites across DC or the vendor could easily assume or resume occupancy of both spaces. No adjustments would be needed to county-provided office and clinic space in Lone Tree and Castle Rock.

IT

- Enter into an agreement(s) and establish billing procedures with 1-5 community partners.
- A CHCP's system would need to be evaluated for expansion capacity and efficacy; however, an established system would already be place and one would not have to be developed.
- Efforts would need to be made to separate DC information in TCHD's system from Arapahoe and Adams Counties.

Budget

- National immunization clinics already provide this service economically. Currently, TCHD requests $22 per uninsured patient so that cost-recovery tool would likely be eliminated, however, the highest participation rates achieved through this program in Douglas County is 2,700. This revenue source is projected to raise $175,000 per the overall 2021 TCHD Adopted Budget, however, the Douglas County portion equates to less than $60,000. Savings would be realized through decreased staffing and Call Center costs.

- Sexual Health services can be provided by CVS Minute Clinic or Walgreens Clinic. A cost estimate would need to be developed. Usage statistics provided by TCHD indicate that in 2019, a total of 324 clients accessed these services. The FY21 budget for the Sexual Health Program is $3,423,688 with $96,000 provided in-kind by the State in STI tests so it's likely that outsourcing this service to a clinic will result in a cost savings for Douglas County.
    - DC could also outsource clinical services to Life Health or Mako and administer services at our TCHD offices.

Considerations

- Continuity of the most specialized TCHD services that need higher levels of care and expertise.
- Possibly more cost-effective.
- More convenient for citizens to have access to numerous providers.
- Less centralized model could decrease the ability of trained public health professionals to identify, educate and address other issues at the time of inoculation.
- Possibly yield limited benefit.
- Disjointed service provision may to cause citizen confusion.

- Walgreens Clinic
    - Immunizations
    - Sexual Health
        - At-Home STI Testing and At-Home Treatment
        - Chlamydia
        - Convenient STI Testing
        - Gonorrhea

        - HIV
        - HPV
        - Sexual Health Care
        - STD Testing
        - STI Screening
        - Syphilis

- CVS - MinuteClinic
    - Immunizations
        - Cholera vaccine
        - COVID-19 vaccine
        - Diphtheria, tetanus, pertussis vaccine
        - Hepatitis A vaccine
        - Hepatitis B vaccine
        - Human papillomavirus (HPV) vaccine
        - Influenza (flu) vaccine
        - Japanese encephalitis vaccine
        - Measles, mumps, rubella (MMR) vaccine
        - Meningococcal (meningitis) vaccine
        - Pneumococcal (pneumonia) vaccine
        - Polio vaccine
        - Rabies vaccine
        - Typhoid vaccine
        - Zoster (shingles) vaccine
        - Varicella (chicken pox) vaccine

    - Sexual Health
        - Birth control care
        - Gonorrhea
        - Herpes Simplex Virus
        - HPV (human papillomavirus)
        - Pelvic Exams
        - Pregnancy evaluation
        - Trichomoniasis
        - Urinary tract & bladder infections
        - Vaginal Discharge
        - Vaginosis
        - Yeast infections

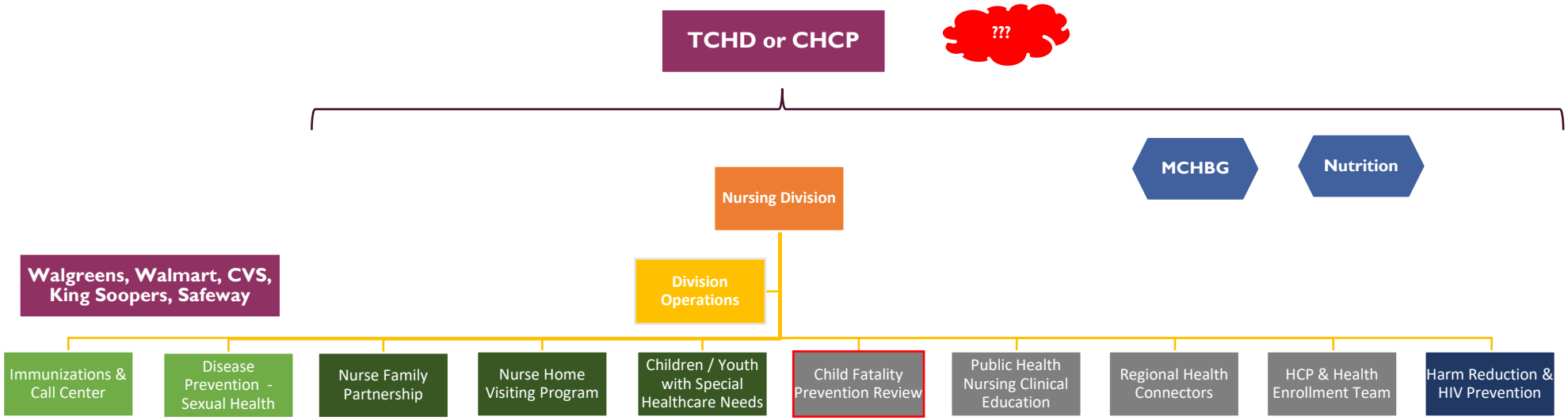
- Walmart
    - Immunizations
    - Health screenings (A1C, cholesterol, glucose)
    - Care Clinic (some locations, not in CO yet)

- King Soopers – The Little Clinic
    - Dieticians
    - Tobacco Cessation
    - Pregnancy Test
    - Physicals
    - Ongoing Health Management
    - Screenings & Other Services
    - Dietitian Services

    - Immunizations
        - DTaP (Diphtheria,Tetanus, Pertussis)
        - Flu Shot
        - HPV (Human Papillomavirus)
        - Hepatitis A
        - Hepatitis A & B
        - Hepatitis A (child)
        - Hepatitis B
        - Hepatitis B (child)
        - Japanese Encephalitis
        - MMR (Measles, Mumps, Rubella)
        - Meningitis
        - Meningitis B
        - Pneumonia (Pneumococcal)
        - Polio
        - Rabies
        - Td (Tetanus and Diphtheria)
        - Tdap (Tetanus, Diphtheria, Pertussis)
        - Travel Vaccinations
        - Typhoid
        - Varicella (Chicken Pox)
        - Shingles (Herpes Zoster)

- Safeway
    - Immunizations
        - Travel
        - Flu
        - Hepatitis A
        - Hepatitis B
        - Human Papillomavirus (HPV)
        - Measles, Mumps & Rubella (MMR)
        - Meningitis
        - Pneumonia
        - Shingles
        - Tetanus (Td)
        - Whooping Cough (Pertussis)

April 7, 2021



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- Mako Medical

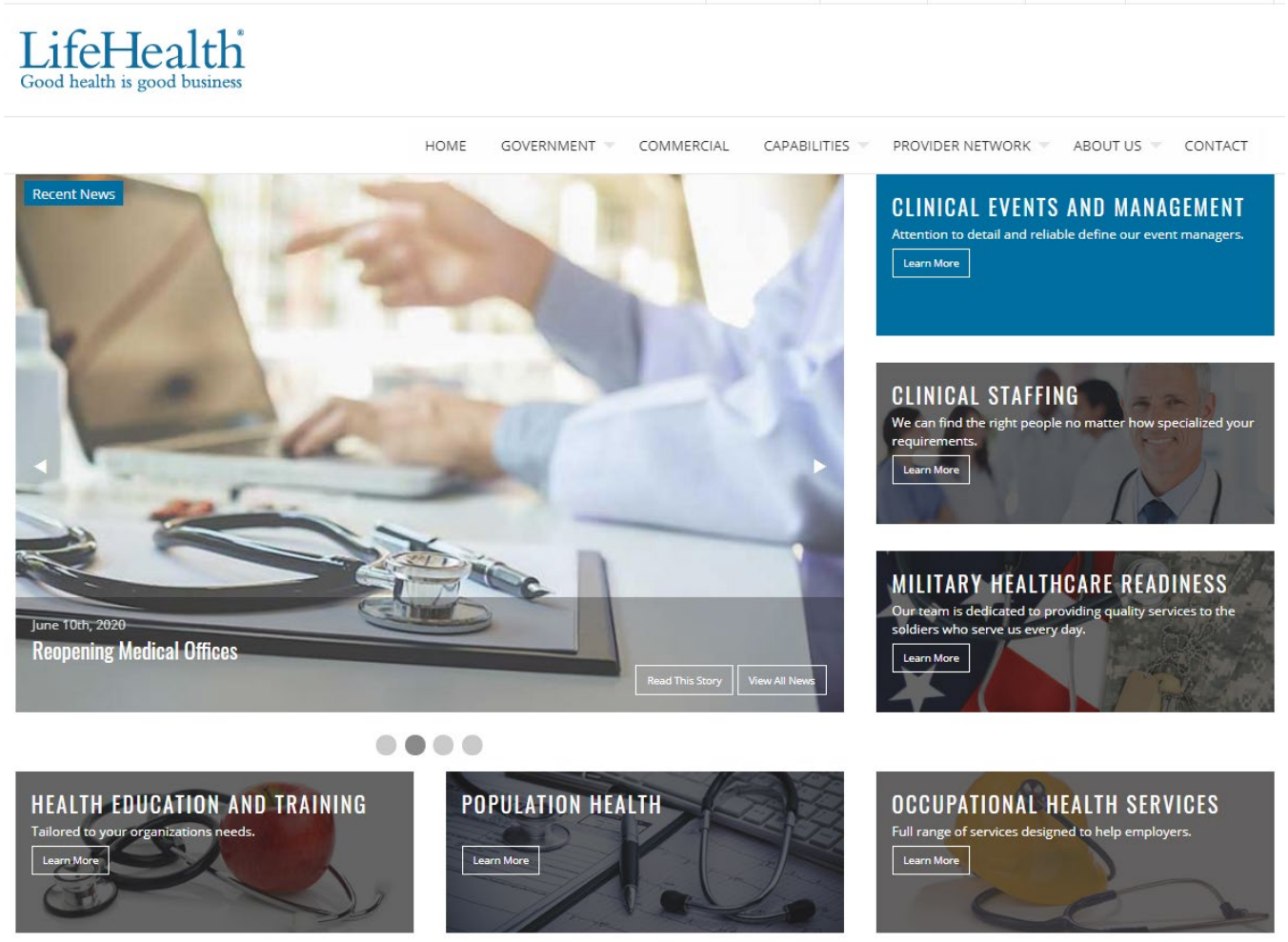
PASSIONATELY DISRUPTING HEALTHCARE

Mako started out to stand out. To serve our clients differently, with attention to timely results, accuracy, innovation, and—most importantly—with integrity. Our aim from the beginning has been to disrupt the status quo with passion and a heartfelt drive to give *more* to our clients.

GIVING MORE TO OUR CLIENTS

- **More time.** Be in charge of your health. Our faster turnaround times ensure you get the quick results you need to make critical medical decisions.
- **More accuracy.** Know you're getting the right results every time. Combining our top talent with the most advanced robotics and technology available, your test results are assured the highest levels of precision and accuracy
- **More innovation.** Get the latest, most advanced solutions at every visit. Our dedication to recruiting the top Ph. Ds, chemists, and scientists along with our investment in state-of-the-art instruments and technology means we're always innovating and moving forward in the medical industry to serve our clients and communities better.
- **More savings.** Get the answers you need without spending an arm and a leg. We're committed to competitive pricing and are in-network with nearly every major insurance company.
- **More focus on you.** Enjoy an easy medical experience designed to make your life better—we're focused on the details to make your experience second to none.

- Life Health



LifeHealth LLC (LifeHealth), is a professional services company specializing in clinical staffing, wellness services and healthcare readiness. What differentiates us from the competition is our 15-years of extensive experience in the commercial world of employers and local governments and in the highly regulated world of the Department of Defense and other national government customers.
All organizations need healthy employees whether to provide the highest level of service to their customers or to meet the military healthcare readiness requirement. LifeHealth is a trusted, reliable partner that has supported the Department of Defense, a variety of federal and civilian government agencies, commercial clients and major insurance companies including Kaiser Permanente, Cigna, Anthem, Blue Cross Blue Shield, and United Health. We understand the issues, reliably and competently deliver services, and comply with all requirements. As your partner, we have the flexibility to respond to ever-evolving customer directives and complex logistical requirements. We have proven reliability through strong past performance, robust staff retention practices, and low attrition of our corporate support staff.
LifeHealth holds the following contract certifications:

- Small Business Administration 8(a) certified
- 100% SBA Woman-Owned Small Business (ED/WOSB) certified
- Veteran Owned Small Business (VOSB-CVE) certified
- NVBDC - National Veteran Business Development Council certified business
- DOT/Disadvantaged Business Enterprise (DBE) certified in Colorado and Texas
- MSEP - Proud member of the Department of Defense Military Spouse Employment Partnership program

Our services include:
Clinical Staffing (short and long term):

- Physicians – General Medicine, Specialty
- Mid-level Providers
- Behavioral Health Specialties
- Licensed Clinical Social Workers, Licensed Marriage and and Family Therapists
- Substance Abuse Professionals (Certified)
- Ancillary Health
- Allied Health
- General Dentists
- Dental Hygienists
- Occupational Health
- Preventative Healthcare
- Academia

Professional Services:

- Biometric screenings and vaccination clinics
- Provider network development
- Independent medical reviews
- Expert medical opinions
- Fitness for duty examinations
- Client data analyses and reporting
- Performance monitoring
- Statistical data modeling
- Healthcare readiness analysis
- Quality assurance
- Clinical events management
- Event organization, implementation and on ground event management
- Client data support-registration for services, customized reporting
- Event equipment-sale or lease
- Logistics coordination
- Customized event design

- Medical / dental staffing customized client registration portals

Occupational Health Services:

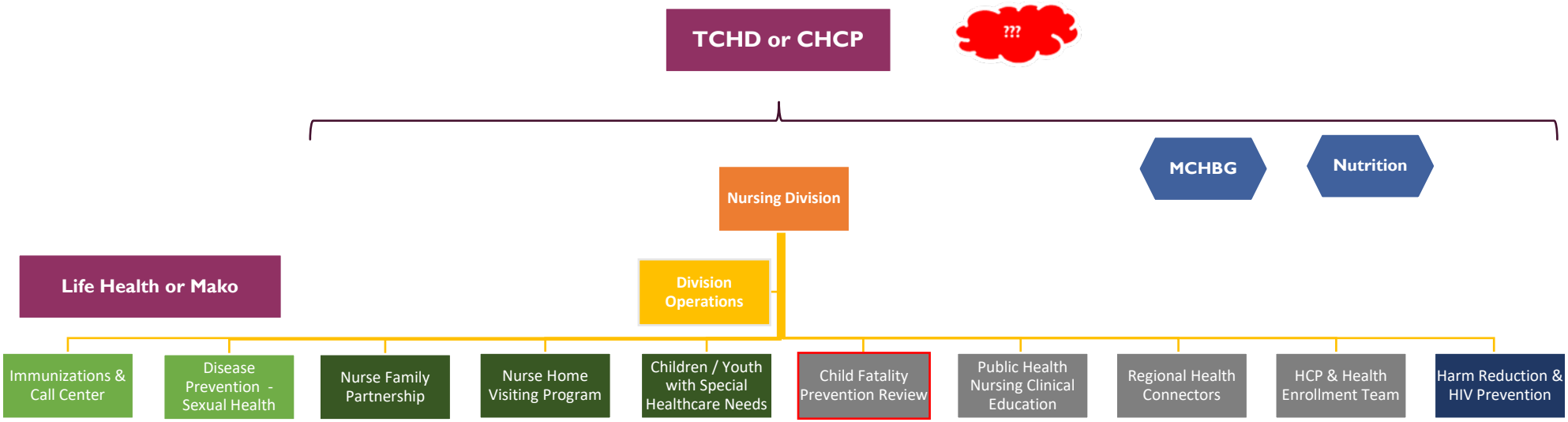
- Drug and Alcohol Testing
- Occupational Physicals and Medical Evaluations
- Return-to-Work and Fitness-for-Duty Evaluations
- Medical Review Officer (MRO)
- More Occupational Health Services
    - Diagnosis of Occupational Injury and/or Illness
    - Evaluation and Management of Chronic Medical Conditions, including:
        - Sleep Disorders
        - Managing Prescription Medications
    - Preventative Screenings
    - Pulmonary Function Testing
    - Surveillance Screenings
    - Workers' Compensation Evaluations

Why LifeHealth?

LifeHealth is the first choice among professional services firms that specialize in healthcare readiness and clinical staffing. Through our strong past performance and successful track record of working alongside customers in the public and private sectors, we have proven our capabilities and reliability. It would be difficult to find a firm that has a stronger commitment to Veterans' health, as one of our founders has served our great country.

We are a low-risk, solutions-driven healthcare readiness partner with a nationwide geographical reach: skilled, responsible, and people-friendly with a personal touch for employers, brokers, providers, active-duty military, our Veterans and their beneficiaries and employees of other organizations. LifeHealth offers competitive market compensation and benefits, as well as employee incentives and recognition, as a means to assure high retention of employees. We look forward to partnering with you for your healthcare readiness needs.

April 7, 2021



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V. Partial Contract with TCHD Paired with Direct Service Provision

Hypothetical Example: One organization to administer non-clinical services and one to provide clinical healthcare services.
(Org A to manage grants, Child Fatality Prevention Review, Nurse Family Partnership program, Regional Health Connectors and Healthy Communities Program and Health Enrollment Team. Org B to manage Call Center screenings and appointment registration, immunization clinics and sexual health program.)

Facilities

- If Douglas County is "Org B", staff could assume occupancy of the existing TCHD offices in Lone Tree and Castle Rock and potentially dedicate space in Human Services for the Call Center. If the opportunity arose to secure a facility or property near the Human Services office, services could be co-located on Castleton Court for increased efficiency and citizen convenience in addition to the Lone Tree location.
- If TCHD is "Org B", then much of the above scenario also applies.

IT

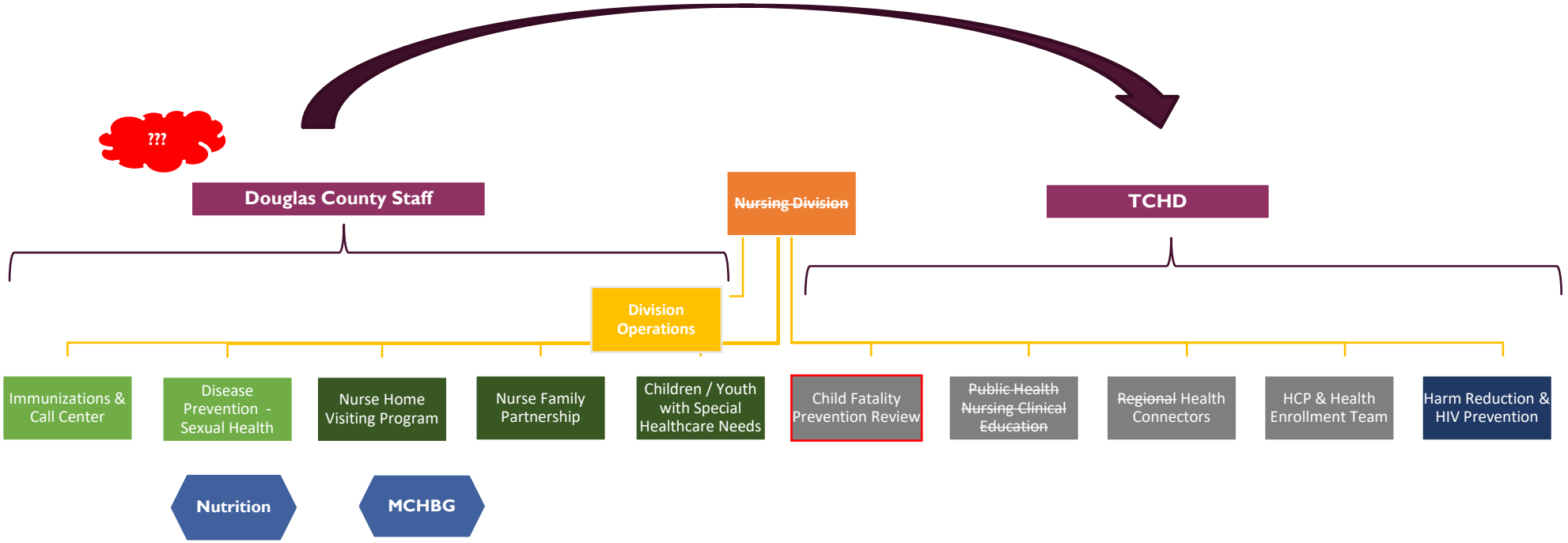
- Potentially significant HIPAA compliant system and network creation and expansion to provide secure storage, management, and access to confidential patient electronic health records.

Budget

- Funding would need to be allocated to initiate the hiring of healthcare professionals and Call Center operators, develop technology infrastructure and possibly augment systems in departments such as Finance, Human Resources and Facilities.

Considerations

April 7, 2021



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VI. Partial Contract with Other Service Provider Paired with Direction Service Provision

Facilities

-

IT

-

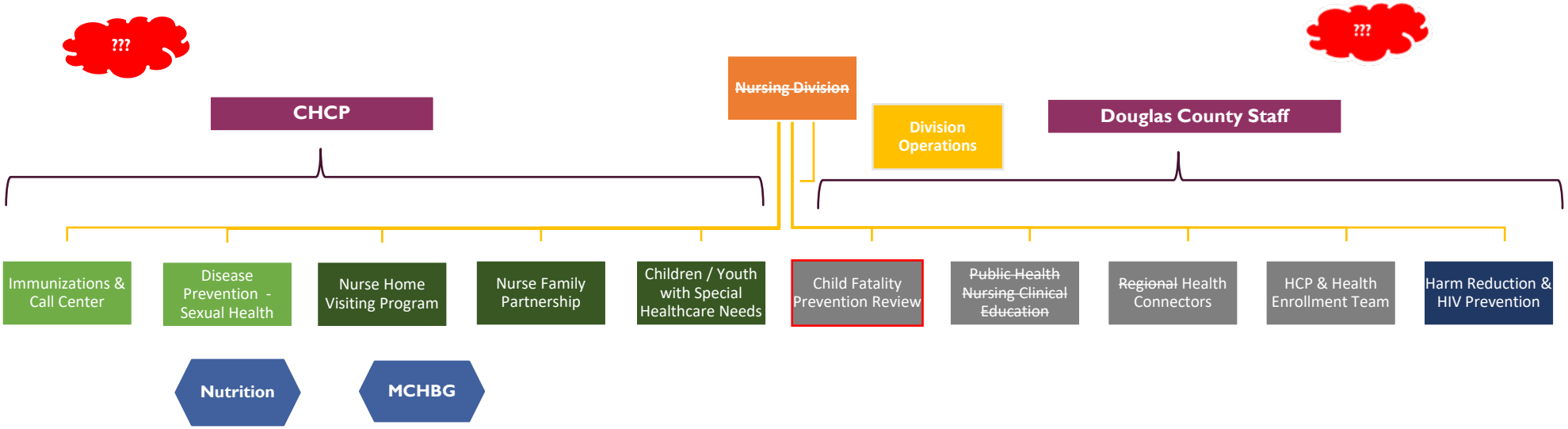
Budget

-

Considerations

-

April 7, 2021



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VII. Full Direct Service Provision

Facilities

-

IT

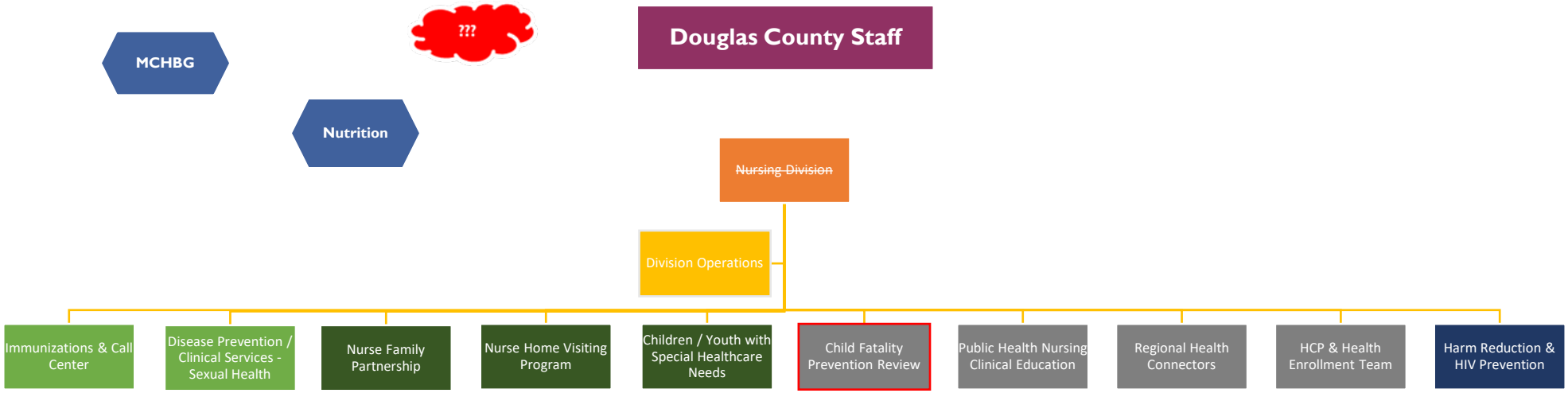
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Budget

-

Considerations

April 7, 2021



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- Any combo as an interim solution to include Jeff Co / El Paso
- Arapahoe County after separation from TCHD
-

Family Planning

Immunizations

Communicable Disease Prevention

Mothers First

WIC

Child Fatality Prevention Review

Health Promotion

- Obesity prevention
- Older adult fall prevention
- HIV/STI/Hepatitis testing
- Chronic disease screenings
- Injury prevention
- Worksite wellness
- Mental health
- Tobacco prevention/cessation
- Substance abuse prevention

Health Services

Our services focus on promoting good health for children and adults through clinical, preventive and health education programs

- ## Children's Health
  - Children's immunizations
  - Medicaid and Child Health Plan Plus (CHP+) benefit questions
  - Health care referrals
  - Resources for children with special healthcare needs
- ## Expectant and New Mothers
  - Referrals to prenatal care and other support services
  - Nurse Family Partnership
  - Breastfeeding education and support
  - Parenting education
  - Medicaid and Child Health Plan Plus benefit questions
- ## Health Care Services
  - Immunizations for uninsured, Medicaid, CHP+, and most private insurance
  - Pregnancy testing
  - Birth control
  - HIV/STI/Hepatitis testing
  - Tuberculosis (TB) screening

Disease Control and Prevention

Tri-County Health Department helps prevent infectious diseases that can be spread from animals, through food/water, and by person-to-person contact

- Chronic and infectious disease surveillance
- Outbreak response
- Infectious disease investigation and control
- Community health data

Castle Rock Services

1. ~~Birth and Death Certificates~~
2. Children with Special Needs Referrals
3. ~~Disease Control / Epidemiology~~
4. ~~Emergency Preparedness and Response~~
5. Environmental Health Services
6. Family Planning / Birth Control/ STI Testing
7. ~~HIV/STI/Hepatitis Testing and Counseling~~
8. Immunizations for Children and Adults
9. Medicaid Assistance and Outreach
10. Nutrition Services / Registered Dietitians
11. ~~Occupational Health / Industrial Hygiene~~
12. ~~Prenatal and Parenting Case Management~~
13. ~~Senior Dental / Arapahoe County, Ages 55+~~
14. WIC Nutrition Services

Lone Tree Services

1. ~~Birth and Death Certificates~~
2. ~~Children with Special Needs Referrals~~
3. ~~Disease Control / Epidemiology~~
4. ~~Emergency Preparedness and Response~~
5. ~~Environmental Health Services~~
6. Family Planning / Birth Control/ STI Testing
7. ~~HIV/STI/Hepatitis Testing and Counseling~~
8. Immunizations for Children and Adults
9. Medicaid Assistance and Outreach
10. Nutrition Services / Registered Dietitians
11. ~~Occupational Health / Industrial Hygiene~~
12. ~~Prenatal and Parenting Case Management~~
13. ~~Senior Dental / Arapahoe County, Ages 55+~~
14. WIC Nutrition Services

- Division Operations
- Immunizations Program
- Call Center
- Disease Prevention and Clinical Services – Sexual Health
- Home Visitation Programs
    - Douglas County Nurse Support Contract Program
- Child Fatality Review (legislatively mandated)

- HCP - A Program for Children and Youth with Special Healthcare Needs
- Public Health Nursing Clinical Education
- Regional Health Connectors
- Healthy Communities and Health Enrollment Team
- Disease Prevention and Clinical Services – Harm Reduction and HIV Prevention Program

Essential Services

- Monitor the health status of the population and the environment and identify community health problems.
- Prevent and control the spread of communicable disease.
- Promote positive health behaviors and environmental practices.
- Mobilize community partnerships to solve identified health problems.
- Enforce laws and regulations that protect the health of the public and the environment.
- Counsel and support high-risk children, youth, and families.
- Assure access and provide linkages to personal health services.
- Provide alcohol and drug treatment services.
- Develop policies that support and protect the health of the community and the environment

Treatment program for trafficked children? Detox?

Birth Control and Family Planning
HIV Care and Prevention
Immunization Clinic
Infectious Disease
Sexual Health Clinic
Travel Clinic
Tuberculosis Clinic

- Outsource until/if Adams County separates then possibly partner with Arap Co for services

Nursing as a category – structure make sense?

Considerations = strengths/weaknesses. Some items are both. Public record – be diplomatic

References back to data/metrics as DC specific utilization – some available and comparable, some are very low or 0 and need more background to analyze and some aren't provided at all. Data lumped into super bucket of all 3 or us and Arapahoe.

In some cases, just because it was available did not mean the measures were particularly useful, but to be fair some of these outcomes are difficult to measure.

In the partial provision of services proposal, it may actually be more cost effective to provide all services, but it's an option that I thought worthy of including. Since I'm not intimately familiar with TCHDs processes it's possible that teasing out services would be more of a hindrance than the cost savings would be a benefit, but that would be revealed in further analysis.

Land Use Plan Review Fees

Effective September 4, 2018

Tri-County Health Department (TCHD) land use plan review fees are based off a fee level structure. Fees may differ depending on if the property is served by a central sewer system or on-site wastewater treatment system (OWTS), more commonly referred to as a septic system. Please refer to the table below. Only one fee per case type applies. If you do not see a case type on the list please contact TCHD at landuse@tchd.org.

Level 1: $55 | Level 2: $110 | Level 3: $245 | Level 4: $600

Case Type	Fee Level	
	Central Sewer System	OWTS
Administrative Amendment (Use by Special Review)	$55	$55
Administrative Exemption	$55	$110
Administrative Horse Boarding	$110	$110
Administrative Variance	$55	$55
Certificate of Designation	$600	$600
Combined Preliminary/Final Plat	$110	$245
Entertainment Event Permit	$55	$55
Final Plat/Replat - Non-Administrative	$55	$110
Location and Extent	$55	$55
Master Plan Amendment	$55	$55
Matter of State Interest (1041) - Review	$55	$55
Matter of State Interest (1041) - Waiver	$55	$55
Minor Development	$55	$110
Planned Development - Administrative Amendment	$55	$110
Planned Development - Major Amendment	$110	$245
Preliminary Plan	$110	$245
Replat/Lot Line Vacation/Ratification - Administrative	$55	$55
Rezoning - Planned Development	$110	$245
Rezoning - All other zone districts	$110	$245
Rezoning - Planned Development	$110	$245
Road Vacation/Plat Vacation	$55	$55
Rural Site Plan	$245	$245
SB 35 Exemption	$55	$110
Seasonal Use permit	$55	$55
Site Improvement Plan	$110	$245
Site Improvement Plan - Major Revision	$110	$245
Site Improvement Plan - Minor Revision	$55	$110
Site Improvement Plan - Modification	$55	$110
Use by Special Review	$245	$245
Variance	$55	$55
Waiver - Subdivision	$55	$55
Waiver - Zoning	$55	$55
Zoning Code Amendment	$55	$55

Frequently Asked Questions
Environmental Health

Introduction

The purpose of this document is to provide answers to questions that a new public health leader might have about providing core environmental health services in a local public health agency in Colorado. The questions are organized topically. In each topic area, the Colorado core public health services and related statutes and regulations are identified that pertain to the questions in that section. If you are unable to find a question in this list of frequently asked questions, contact your environmental health liaison at the Office of Planning and Partnerships, who can assist you in finding answers for your issue from CDPHE staff. In addition, if you have an environmental health lead, they should be connected to the Colorado Directors of Environmental Health (CDEH) network. This is an excellent resource of experienced local environmental health directors from throughout Colorado that share ideas on how to respond to the more complicated environmental health issues. Contact the Environmental Health Liaison for assistance with connecting with the CDEH network.

Many of the FAQ's address various scenarios that could be unique to a local community or neighborhood and come in the form of a complaint lodged with the local public health agency. Local public health staff respond often to residential and business complaints on a variety of issues including sewage, hazardous materials leaks and spills, and illness believed to be caused by food or associated with environmental conditions. Public health directors and their environmental health staff routinely seek voluntary compliance to eliminate public health nuisances but should be trained and prepared to take legal action if necessary to protect the health of the community. Even in uniquely local issues it is important to collaborate with CDPHE and other local public health colleagues for guidance and assistance when needed and to assure that responses are consistent when possible.

Colorado Department of Public Health and Environment

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CORE PUBLIC HEALTH SERVICES
6 CCR 1014-7 Section 4.1 F. Environmental Health

Recognizing that significant responsibility for environmental quality management and oversight lies with state and federal agencies, all agencies are required to participate in the protection and improvement of air, water, land, and food quality by identifying, investigating, and responding to community environmental health concerns, reducing current and emerging environmental health risks, preventing communicable diseases, and sustaining the environment. These activities shall be consistent with applicable laws and regulations, and coordinated with local, state and federal agencies, industry, and the public. Furthermore, agencies are required to:

1. Identify and mitigate vector-borne (e.g. insects, rodents), air-borne, water-borne, foodborne, and other public health threats related to environmental hazards.

2. Take appropriate steps to support the protection of surface water and groundwater, including recreational waters and drinking water sources, and assure appropriate local regulatory oversight of onsite waste-water systems.

3. Implement public health laws, policies and procedures to assure the safety of food provided to the public at retail food establishments.

4. Implement public health laws, policies and procedures to assure the sanitation of institutional facilities (e.g. child care facilities, local correctional facilities and schools).

5. Take appropriate steps to assure the proper storage, collection, treatment, and disposal of garbage, refuse, and solid and hazardous waste.

6. Promote programs to minimize the amount of solid and hazardous waste and maximize the amount of recycling and reuse.

7. Participate in land use planning and sustainable development to encourage decisions that promote positive public health outcomes (e.g. consideration of housing, urban development, recreational facilities and transport), and that protect and improve air quality, water quality and solid waste management.

8. Where appropriate and practicable, enter into contracts or other acceptable agreements with the state's environmental programs in order to perform local assessments, inspections, investigations, and monitoring programs.

Air Quality	4
Apartments/Rentals	5
Biosolids	6
Body Art	6
Camps	7
Childcare	8
Core Services – Environmental Health	2
Disease Prevention	8
Food Protection	9
Hotels/Motels	11
Land Use	11
Marijuana	12
Mass Gatherings	12
Methamphetamine Labs	13
Mobile Home Parks	14
Oil and Gas	15
Onsite Wastewater	16
Private Residences	16
Public Health Pests/ nuisances, lice, bed bugs	18
Schools	19
Solid and Hazardous Waste	19
Swimming Pools	20
Vector Surveillance and Control	20
Water Supplies	21

Air Quality
Core Services Rule – Environmental Health

Where appropriate and practicable, enter into contracts or other acceptable agreements with the state's environmental programs in order to perform local assessments, inspections, investigations, and monitoring programs.

QUESTION: What are some typical air quality complaints and inquiries and where can I find resources and assistance in responding?

- ***Odors*** - Air Quality Control Commission Regulation No. 2 regulates odors in Colorado. Agricultural sources are exempt with the exception of hog farms which are subject to odor standards. Examples of agricultural sources could include manure piles, onion dumps, and feedlots. There are odor standards for residential or industrial sources. The procedure for determining the odor intensity must be done using special equipment by specially trained and certified personnel. For more information contact the Air Pollution Control Division.
- ***Indoor air quality complaints (Mold, etc.)*** – Indoor air quality complaints can be very complex. Refer to CDPHE's Indoor Air Quality webpage for information as well as federal, state and local contacts for assistance.
- ***Open burning*** – Refer to CDPHE's Outdoor Burning webpage for information and state and local contacts for assistance.
- ***Wood/pellet stove burning***- Refer to CDPHE's Indoor Burning webpage for information and state and local contacts for assistance.
- ***Dust complaints*** - Dust or particulate emissions are regulated by the Air Quality Control Commission Regulation No. 1 and enforced by the Air Pollution Control Division. Contact the Air Pollution Control Division for more information.
- ***Asbestos-related demolition and remodeling*** - Refer to the Asbestos and Asbestos-containing Household Wastes web pages for information and state and local contacts.

QUESTION: **How does a local public health agency go about obtaining air quality monitoring data for their area?**

ANSWER: Here are some steps to walk through in order to obtain local air quality data:

1. Start with the Air Pollution Control Division Technical Services Program website.

    a. Click on "Air Quality Report View" for draft hourly data.

    b. Click on "Technical Reports" for the Annual Data Report or Annual Network Plans for information on air monitoring sites.

2. For finalized/validated data or larger datasets or if there are specific areas where you don't see data on the Air Pollution Control Division website, contact the Technical Services Program. They can check if there might be some data from other agencies that is available. This is also true for much of the particulate data, which is filter-based and does not go on to the website.

3. If you are just looking for some basic data, summaries can also be found on EPA's website.

4. If there are requests for additional monitoring, contact the Technical Services Program.

QUESTION: What resources are available for local radon programs?
ANSWER: The Hazardous Materials and Waste Management Division administers the Radon Program. For information, resources and contact information, visit the Radon website.

Apartments/ Rentals – Institutions and Public Accommodations Core Services Rule – Environmental Health

Implement public health laws, policies and procedures to assure the sanitation of institutional facilities (e.g. child care facilities, local correctional facilities and schools).

QUESTION: **How do I handle complaints regarding structural issues (electrical, sagging floors, plumbing, etc.) in rental apartments or houses?**
ANSWER: Complaints regarding structural problems in rental apartments or houses should be referred to local code enforcement for investigation. Most local health departments have very little, if any, authority to address complaints involving apartments or rental properties and, because they involve private residences with little or no impact on neighbors or to the community, they tend to fall outside the scope of "public" health. In most cases, these issues are handled as a civil matter between the tenant and the landlord. Most counties do not have housing codes or other local regulations to apply to these issues. Tenants can be referred to legal aid, municipal housing, building or code enforcement authorities, human services or others depending on the matter.

- Colorado Legal Services – This site provides self-help legal information for civil legal matters, where to find no or low-cost legal help, court information and other referral information.

Biosolids
Core Services Rule - Environmental Health

Take appropriate steps to support the protection of surface water and groundwater, including recreational waters and drinking water sources, and assure appropriate local regulatory oversight of onsite waste-water systems.

QUESTION: **What are biosolids?**
ANSWER: Biosolids are nutrient-rich organic materials resulting from the treatment of domestic sewage in a treatment facility. When treated and processed, these residuals can be recycled and applied as fertilizer to improve and maintain productive soils and stimulate plant growth.

QUESTION: **Who regulates biosolids in Colorado?**
ANSWER: Biosolids are regulated by the Water Quality Control Division, CDPHE. Some counties have local ordinances.

- Beneficial use of water treatment sludge and fees applicable to the beneficial use of sludges Regulations (Water Quality Section).

Body Art – Institutions and Public Accommodations
Core Services Rule – Environmental Health

Implement public health laws, policies and procedures to assure the sanitation of institutional facilities (e.g. child care facilities, local correctional facilities and schools).

QUESTION: **Who inspects body art facilities?**
ANSWER: Regular inspection of body art facilities is optional according to the state regulations. Local boards of health may opt to establish a local body art inspection program. However, local public health agencies have a responsibility to investigate public health complaints. Local boards of health can adopt more stringent regulations, as well as license and inspect artists and body art studios. Some local boards of health have adopted their own regulations to inspect and license artists and studios, while other agencies only respond to complaints. If the local public health agency does not have a program they should make a determination if the complaint warrants an investigation. Information on local programs can be found on CDPHE's Tattoo and Piercing webpage.

QUESTION: **Who investigates complaints on body art facilities?**

ANSWER: Environmental health staff should investigate complaints involving body art facilities. If the local public health agency does not have an inspection program or environmental health staff, the public health director could investigate based on state body art regulations.

QUESTION: **Are there laws that prohibit underage children/youth from getting body art without parental consent?**
ANSWER: Body artists cannot perform body art procedures on a minor without consent from the minor's parent or legal guardian by state law. Body artists who perform such a procedure without parental consent can be fined $250 for each offense, regardless of whether the artist or studio is located in a county with an inspection program.

QUESTION: **Is it legal for people to do body art in their home?**
ANSWER: Unless prohibited by local ordinance, body artists can work out of their homes only if a designated area is used for all procedures and the area and artist meet the requirements found in the State Board of Health Rules and Regulations for Body Art Establishments. A plan review may be required for body art facilities, depending on the county it's located in. Existing local inspection programs can be found on the CDPHE website. Contact the Division of Environmental Health and Sustainability for more information and a list of local public health agencies that have body art programs.

Camps–Institutions and Public Accommodations
Core Services Rule – Environmental Health

Implement public health laws, policies and procedures to assure the sanitation of institutional facilities (e.g. child care facilities, local correctional facilities and schools).

QUESTION: Who can assist me with complaints and issues regarding campgrounds and recreation areas?
ANSWER: The Division of Environmental Health and Sustainability can provide assistance with complaints and issues regarding camps. Information regarding campgrounds and recreation areas can be found in rules for Campgrounds and Recreation Areas . These and all rules adopted by the State Board of Health are located on this CDPHE webpage and listed by Division.

Childcare–Institutions and Public Accommodations
Core Services Rule – Environmental Health

Implement public health laws, policies and procedures to assure the sanitation of institutional facilities (e.g. child care facilities, local correctional facilities and schools).

QUESTION: **How often is my agency required to inspect Child Care Facilities?**
ANSWER: Inspections of child care facilities are required every two years in accordance with Colorado Department of Human Services regulation, but may be conducted more frequently based on an assessment of risk and available resources. The Division of Environmental Health and Sustainability can assist with the implementation of a risked based inspection protocol.

QUESTION: **Who issues the license for a Child Care Facility?**
ANSWER: Childcare facilities are licensed by the Colorado Department of Human Services (CDHS). However, CDPHE and delegated local public health agencies are responsible for inspection and enforcement of the State Board of Health Rules and Regulations Governing the Health and Sanitation of Child Care Facilities in the State of Colorado. For more information regarding the licensing of child care facilities visit the Child Care Centers website for the Division of Child Care at CDHS.

Disease Prevention
Core Services Rule – Communicable Disease Prevention, Investigation and Control - CRS 25-1-509

Take appropriate measures to prevent disease transmission using methods specific to: infected persons (isolation, treatment, contact tracing/notification); contacts to infected persons (quarantine, prophylaxis); and the environment in which the communicable disease occurs (facility closure, disinfection).

Work closely with CDPHE in communicable disease investigation and control, particularly if the investigation crosses county lines or technical assistance is needed.

QUESTION: Who investigates foodborne illness complaints?
ANSWER: Foodborne illness complaints should be investigated in collaboration with local communicable disease and environmental health staff in cooperation with CDPHE, especially when a retail food service establishment is implicated in the investigation.

QUESTION: **What do I do if a citizen reports that their coworkers or family members ate at a restaurant and became ill?**
ANSWER: Encourage the caller to have those affected call the local public health agency themselves. They will need to provide information to verify the complaint, determine whether a communicable disease has been confirmed, and provide other necessary information regarding the suspected establishment. Based on the information received, the complaint should be reported to the indicated food service establishment and an inspection focusing on critical items should be completed. If a communicable disease has been confirmed, a full foodborne illness investigation should be completed by environmental and communicable disease staff in collaboration with CDPHE.

QUESTION: **When should communicable disease staff partner with environmental health staff on a disease investigation?**
ANSWER: Local communicable disease staff should partner with their environmental health colleagues when investigating disease reports involving food service establishments, daycare centers, and schools. Other examples include, but are not limited to, camps, recreational waters and nursing homes. State and local environmental health staff should be consulted when investigating a vector borne disease such as tularemia, plague or West Nile virus. All staff should be notified of significant disease investigations in case there is an unexpected connection.

QUESTION: **When would I recommend that a school close?**
ANSWER: You should rarely recommend that a school close. Consult with CDPHE disease control and Environmental Health and Sustainability staff as they have historical experience with other school closings within the state. Situations that may require a closure recommendation include inadequate hot and cold running water; reasonable heating and air conditioning; contaminated water or other environmental concerns.

Food Protection
Core Services Rule-Environmental Health

Implement public health laws, policies and procedures to assure the safety of food provided to the public at retail food establishments.

QUESTION: **What should I do with information from food, drug and product recall notices?**
ANSWER: It is important for you to keep up to date on recall notices. Recall notices are sent from CDPHE's Office of Communications based on information from the FDA including details

on product information, labels, affected lot numbers, and information on the potential health impacts. These links can be posted on your agency website. Some agencies have email services set-up through which they can send recall and other public health information out to their residents. Also, if there is a recall, environmental health staff may need to follow up with stores to assure recalled items are removed.

You can also access recall information from the following places:

- CDPHE's food, drug and cosmetic recall page
- FDA Recalls, Market Withdrawals, and Safety Alerts - There is a link for signing up to receive alerts directly on this page.

QUESTION: **How is food safety in retail food establishments such as restaurants, grocery stores and bakeries assured by local public health agencies?**
ANSWER: Every local public health agency should have a food safety program as a core public health service. Currently most programs are managed and implemented by local food safety personnel or less commonly by CDPHE staff. Food safety programs are delegated to the local health agency and program functions managed through a contract with CDPHE. A food safety program includes plan review, permitting/licensing, inspections, education and if necessary enforcement.

If inspection records indicate food safety regulations are not being followed, in order to gain compliance, food inspectors may increase the frequency of inspection. In addition, the local public health agency may utilize other locally determined administrative processes such as an informal hearings or educational classes.

If these measures are unsuccessful, a Civil Penalty process may be implemented as established under the Colorado Revised Statutes (C.R.S.) section 25-4-1611. The statute prescribes when a facility will receive a penalty and for what amount.

Actual civil penalties range from $250-$1,000. They can be for violations of law (such as operating without a license) or for violations of the regulations (such as having pests on multiple inspections). For violations of the law, a facility/owner/operator is issued a notification and if the process continues, a civil penalty is assessed.

The Division of Environmental Health and Sustainability of CDPHE manages and assures consistency in the administration of the statewide food safety program. They provide assistance with establishing and managing a local food safety program.

QUESTION: **Where can I find information pertaining to the sale of food out of a private residence?**
ANSWER: The Colorado Cottage Foods Act allows a limited range of foods that may be prepared in a private residence for sale. Information including a fact sheet on the Colorado Cottage Foods Act can be found at the website for The Division of Environmental Health and Sustainability.

Hotels/Motels–Institutions and Public Accommodations
Core Services Rule – Environmental Health

Implement public health laws, policies and procedures to assure the sanitation of institutional facilities (e.g. child care facilities, local correctional facilities and schools).

QUESTION: **Who can assist me with complaints and issues regarding hotels and motels?**
ANSWER: The Division of Environmental Health and Sustainability of CDPHE can provide assistance with complaints and issues regarding hotels and motels. Hotels and motels are regulated in the Sanitary Standards and Regulations for Public Accommodations.

Land Use
Core Services Rule –Environmental Health

Participate in land use planning and sustainable development to encourage decisions that promote positive public health outcomes (e.g. consideration of housing, urban development, recreational facilities and transport), and that protect and improve air quality, water quality and solid waste management.

QUESTION: **What should my role be in land use, planning and zoning?**
ANSWER: Local public health agencies should develop a close working relationship with local land use, planning and zoning authorities at the county and municipal level. Many local public health agencies collaborate with local land use/planning departments review and comment on applications for new and modified land uses in their jurisdictions. This provides the opportunity to proactively address potential public and environmental health impacts that may not be otherwise regulated by state or federal regulations or policies. Some local public health agencies participate in regular new case review meetings as a way to keep informed of changes

in the community and monitor and respond to potential public and environmental health impacts.

QUESTION: **What activities and public health impacts might be addressed in my local land use office or code enforcement?**
ANSWER: Activities and public health impacts that might be addressed by my local land use office or code enforcement generally through local zoning or building ordinances and specifically through site-specific land use permits and conditions. This can include:

- Trash
- Odors
- Noise
- Road dust
- Traffic
- Water quality
- Built environment and its impacts on public health

Marijuana

QUESTION: Where can I find information about medical and retail marijuana?
ANSWER: For help with questions about medical and retail marijuana in Colorado, please refer to the following resources:

- Official State of Colorado Website for Retail Marijuana Information & Resources
- Retail marijuana contacts
- Medical marijuana laws and regulations
- Medical marijuana contacts

Mass Gatherings – Institutions and Public Accommodations
Core Services Rule – Environmental Health

Implement public health laws, policies and procedures to assure the sanitation of institutional facilities (e.g. child care facilities, local correctional facilities and schools)

QUESTION: A concerned citizen calls about dozens of visitors that have gathered in an unincorporated area of the county for several days now. They are complaining about traffic, noise and the lack of facilities. Are there regulations that address situations like this?

ANSWER: Standards and Regulations for Group Gathering Areas are addressed in 6 CCR 1010-10. CDPHE, Colorado Parks and Wildlife, all Departments, Boards of Health or any peace officer is authorized to administer. The Standards and Regulations for Group Gathering Areas can be found on CDPHE's Consumer Concerns and Complaints webpage.

Methamphetamine Labs
Core Services Rule – Environmental Health

Take appropriate steps to assure the proper storage, collection, treatment, and disposal of garbage, refuse, and solid and hazardous waste.

Promote programs to minimize the amount of solid and hazardous waste and maximize the amount of recycling and reuse.

QUESTION: **What government entity has the authority to red-tag a property that has been determined to be a clandestine methamphetamine lab?**
ANSWER: For the most part, the local building department has the authority to red-tag a property. Some local public health agencies may also have ordinances that allow them to red-tag a property. The meth lab cleanup statute (25-18.5-101 et seq.) gives the local governing body authority to enforce the statute and the cleanup regulation (6 CCR 1014-3) through local ordinances or resolutions. This includes preventing entry, requiring cleanup and overseeing cleanup. The statute defines "governing body" as the entity designated by the city council or county commissioners. If one is not designated, the default definition is the public health agency, building department and law enforcement agency with jurisdiction over the property. So it is up to each jurisdiction who they want to be involved. The statute allows the governing body to declare properties not remediated to be public health nuisances, so they can also use state or local nuisance codes as authority.

QUESTION: **Who approves the site-specific cleanup plan that is submitted by the cleanup contractor?**
ANSWER: Local public health agency personnel approve the site-specific cleanup plan. The regulation does not require that a cleanup plan be submitted for approval. This is because there is no requirement for local oversight. However, governing bodies can require that a cleanup plan be submitted for review if feel it is appropriate.

QUESTION: **Who releases the property back to the homeowner after cleanup to the standard has been achieved and confirmed?**

ANSWER: Because the statute doesn't require local oversight, or establish a state oversight program, the regulation only requires certification by an industrial hygienist. The governing body may establish a program to review reports and determine if a property meets the standard.

QUESTION: **Who should my agency work with during the cleanup of meth labs?**
ANSWER: If the governing body chooses to be involved in the oversight of meth lab cleanup, they would work directly with the property owner, industrial hygienist, and cleanup contractor. They may also choose to limit their involvement and only interact with the owner. Even if they choose not to have an oversight program, the statute and regulation require that they receive a copy of the final report documenting cleanup. The Hazardous Materials and Waste Management Division is available to provide technical assistance upon request. Visit their website for more information, regulations and contact information.

Mobile Home Parks – Institutions and Public Accommodations Core Services Rule – Environmental Health

Implement public health laws, policies and procedures to assure the sanitation of institutional facilities (e.g. child care facilities, local correctional facilities and schools).

QUESTION: **Who can assist me with complaints and issues regarding mobile home parks?**
ANSWER: The Division of Environmental Health and Sustainability of CDPHE can provide assistance with complaints and issues regarding mobile home parks. Mobile home parks are regulated in the Mobile Home Parks regulations.

Oil and Gas
Core Services Rule – Environmental Health

Take appropriate steps to support the protection of surface water and groundwater, including recreational waters and drinking water sources, and assure appropriate local regulatory oversight of onsite waste-water systems.

Take appropriate steps to assure the proper storage, collection, treatment, and disposal of garbage, refuse, and solid and hazardous waste.

Participate in land use planning and sustainable development to encourage decisions that promote positive public health outcomes (e.g. consideration of housing, urban development, recreational facilities and transport), and that protect and improve air quality, water quality and solid waste management.

QUESTION: **What do I do if I get a complaint regarding an oil well or oil and gas development issues?**
ANSWER: Oil and gas operations are regulated by the Colorado Oil and Gas Conservation Commission (COGCC) and by CDPHE.

The Colorado Oil and Gas Conservation Commission (COGCC) is authorized by the legislature to foster the responsible development of Colorado's oil and gas natural resources in a manner consistent with the protection of public health, safety and welfare, including the environment and wildlife. Questions about a new or proposed oil and gas permit can be addressed by the Local Government Designee for their county. The current list of county designees is available at the local government link on the Colorado Oil and Gas Conservation Commission webpage. All contact information for COGCC and other regulating entities can also be found on their webpage.

The Colorado Department of Public Health and Environment (CDPHE) has a limited role in regulating oil and gas development. For questions about environmental permits and requirements with regard to air, water or solid waste please refer to CDPHE Oil and Gas webpage. Here also is additional information about oil and gas activities with a focus on health along with details to report possible health concerns. (on the Colorado Health Emergency Line for Public Information (COHELP) Line. The COHELP line can be reached at 1-877-462-2911 or 303-389-1687.)

Onsite Wastewater - Septic Systems
Core Services Rule – Environmental Health

Take appropriate steps to support the protection of surface water and groundwater, including recreational waters and drinking water sources, and assure appropriate local regulatory oversight of onsite waste-water systems.

QUESTION: **Who is responsible for onsite wastewater permitting, inspection and enforcement in my jurisdiction?**

ANSWER: The local public health agency is responsible for permitting, inspection and enforcement of regulations pertaining to onsite wastewater treatment systems with a capacity less than 2,000 gallons per day. Some counties have delegated this responsibility to other local government offices. Onsite waste water treatment systems that have a capacity greater than 2,000 gallons per day are handled by CDPHE, Water Quality Control Division. For more information visit the Clean Water page and click on-site wastewater treatment systems.

Private Residences
Core Services Rule – Environmental Health

Participate in land use planning and sustainable development to encourage decisions that promote positive public health outcomes (e.g. consideration of housing, urban development, recreational facilities and transport), and that protect and improve air quality, water quality and solid waste management.

Take appropriate steps to support the protection of surface water and groundwater, including recreational waters and drinking water sources, and assure appropriate local regulatory oversight of onsite waste-water systems.

Identify and mitigate vector-borne (e.g. insects, rodents), air-borne, water-borne, food-borne, and other public health threats related to environmental hazards.

Take appropriate steps to assure the proper storage, collection, treatment, and disposal of garbage, refuse, and solid and hazardous waste.

QUESTION: **How do I handle complaints regarding private single-family residences?**

ANSWER: Complaints regarding private residences can be complex and multi-faceted. Consultation with the agency's or county attorney and with the Colorado Directors of Environmental Health network may be helpful.

Here are some common scenarios with some suggested responses.

SCENARIO: **A mobile home resident has 20-30 cats**. This home is in terrible condition and the smell is unbearable for neighboring trailers.
RESPONSE: First, identify conditions that have a potential to negatively affect neighbors. Odors are an air quality issue that has an impact on neighbors. Odors that are detectable from outside the property line are regulated by the Colorado Air Quality Control Commission Regulation Number 2. However, even in residential settings, odors can be problematic for neighbors at intensities that are well below the allowed limits.

See the Air Quality Section for more details. The internal condition of the home does not constitute a public health issue. The number of cats or other "animal units" that are allowed on an individual property may be governed by county or municipal ordinances. In this case, an inquiry or referral to the local land use or code enforcement authority should be made. Finally, the public health director or staff should notify the property owner or resident that a complaint was received. If the public health director or staff have concern for the health, safety or welfare of children or aging adult residents, a referral can be made to the county department of human services. Depending on the conditions on the property, a joint investigation from human services and the local public health agency may be appropriate.

SCENARIO: **A garage is being used for living space.** The “tenants” have installed a stove and small space heater. Neighbors are concerned about carbon monoxide poisoning.
RESPONSE: This is usually a building code issue and should be referred to the county or municipal building or code enforcement authority. The public health director or staff should inform the resident of the complaint and provide health education and recommendations for carbon monoxide monitors as appropriate. If the garage is being rented as an "apartment", the public health director should determine if there are adequate drinking water and toilet facilities available in the unit and that they comply with onsite wastewater treatment regulations if applicable.

SCENARIO: **An elderly person lives alone in an old and poorly kept home**. Neighbors say that water from the laundry is pumped outdoors; dishwater is thrown outside, yard smells of urine. There is suspicion that there is no operable plumbing in the home.
RESPONSE: The internal condition of the home does not constitute a public health issue. The public health director or environmental health staff should notify the property owner or

resident that a complaint was received. An inspection of the property should be conducted by environmental health staff to determine if there are indications of a failed onsite wastewater treatment system or dumping of waste water. If these conditions or practices are confirmed, the public health director or staff should work with the residents to assure compliance with the Colorado On-Site Wastewater Treatment System Regulations.

See the On-site wastewater section for more information. If the public health director or staff has concern for the health, safety or welfare of the elderly residents, a referral can be made to the county department of human services. Depending on the conditions on the property, a joint investigation from human services and the local public health agency may be appropriate.

SCENARIO: A neighbor complains about tall weeds, junk cars, lumber, trash and dog droppings in the yard next door.
RESPONSE: These types of complaints should be referred to a local code enforcement or zoning department. However, if there is evidence that these conditions provide a harborage for animal or insect vectors for infectious disease, the public health director may declare that a public health nuisance exists. The Public Health Act directs the county or district board of health to examine all nuisances, sources of filth, and causes of sickness, which, in its opinion, may be injurious to health, and it shall destroy, remove, or prevent the nuisance, source of filth, or cause of sickness, as the case may require. More information can be found in Section 25-1-518 C.R.S.

Public Health Pests/nuisances, lice, bed bugs - Vector Surveillance and Control

Core Services Rule – Environmental Health

Identify and mitigate vector-borne (e.g. insects, rodents), air-borne, water-borne, food-borne, and other public health threats related to environmental hazards.

QUESTION: **What do I do if I get a call regarding public health pests (lice scabies, bed bugs...)**
ANSWER: Contact the manager for the public accommodation or apartment complex and inform them that a complaint was received. Determine and/or recommend that the complex has a pest management plan in place for response as appropriate from a licensed exterminator service. Confer with local zoning and code enforcement authorities to determine if there are local ordinances that may apply and make referral if appropriate. For complaints regarding

non-public accommodations or residences, refer them to licensed pest control services. Here are some resources for more information:

- EPA Bed Bug Website with a link to Bed Bug Information Clearinghouse
- CDC Information about Bed Bugs

Schools - Institutions and Public Accommodations
Core Services Rule – Environmental Health

Implement public health laws, policies and procedures to assure the sanitation of institutional facilities (e.g. child care facilities, local correctional facilities and schools)

QUESTION: **How often are schools inspected?**
ANSWER: Some agencies inspect schools on a routine basis, while others respond to complaints only. See Rules and Regulations Governing Schools in the State of Colorado Rules and Regulations Governing Schools. CDPHE recommends that all schools with laboratories, and/or engaging in industrial arts or hazardous vocational activities should be inspected a minimum of once per year. All other schools should be inspected a minimum of once per three years. School food service inspections shall be conducted at the frequency established in the Colorado Retail Food Establishment Rules and Regulations, 6 CCR § 1010-2.

Solid and Hazardous Waste
Core Services Rule – Environmental Health

Take appropriate steps to assure the proper storage, collection, treatment, and disposal of garbage, refuse, and solid and hazardous waste.

Promote programs to minimize the amount of solid and hazardous waste and maximize the amount of recycling and reuse.

QUESTION: **How can a public health director address calls involving waste management issues including, abandoned barrels, waste tires, onion dumps, roadside dumping, or a neighbor's trash?**
ANSWER: Determine if there are local ordinances or programs in city or county offices to which the complaint can be referred and collaborated. These issues can also be handled as a public

health nuisance which would be the responsibility of the public health director to determine the appropriate next steps.

QUESTION: **What do I do with landfill complaints?**
ANSWER: Refer the complaint to local zoning and code enforcement authorities to determine if they have local permits or ordinances that apply. Landfills are also regulated by the Hazardous Materials and Waste Management Division.

- CDPHE solid waste management webpage

Swimming Pools
Core Services Rule – Environmental Health

Take appropriate steps to support the protection of surface water and groundwater, including recreational waters and drinking water sources, and assure appropriate local regulatory oversight of onsite waste-water systems.

QUESTION: **Are natural swim areas such as beaches and hot springs regulated like swimming pools?**
ANSWER: Yes. They are all regulated under the Regulations for Swimming Pools and Mineral Baths . Natural swimming areas are in Article 4.6 and hot springs are in Article V.

Vector Surveillance and Control
Core Services Rule – Environmental Health

Identify and mitigate vector-borne (e.g. insects, rodents), air-borne, water-borne, food-borne, and other public health threats related to environmental hazards.

QUESTION: **What do I do if I get a call regarding an animal bite?**
ANSWER: Response to animal bites is an important responsibility for local public health agencies for the prevention of rabies and other animal borne diseases. It is important to determine as quickly as possible if an animal that has bitten a human is current on its vaccinations and if the animal should be quarantined or specimens submitted to a public health laboratory for rabies testing; and if the person that is bitten will require prophylaxis. For more information visit CDPHE's Rabies webpage. The Environmental Health and Sustainability

Division are a resource in dealing with animal borne disease response. New public health directors should familiarize themselves with the resources available on the Colorado rabies resource guide page for information on how to obtain a resource guide as well as the following:

- Guidelines for the handling and submission of skunks.
- Management of domestic dogs, cats, and ferrets involved in human bites.
- Algorithm for managing cat, dog, and ferret bites in Colorado.
- Management of domestic pets exposed to wildlife.
- Algorithm for Rabies management of domestic pets exposed to wildlife.
- Hybrid-wolf bite management algorithm.
- Recommendations For hybrid wolves regarding vaccination, bite follow-up and exposure to rabies.
- Compendium of animal Rabies prevention and control.

Water Supplies
Core Services Rule – Environmental Health

Take appropriate steps to support the protection of surface water and groundwater, including recreational waters and drinking water sources, and assure appropriate local regulatory oversight of onsite waste-water systems.

QUESTION: **LPHA's are frequently copied on notices to water treatment facilities from CDPHE. Explain who inspects these facilities and sends out these notices**.
ANSWER: Within the Safe Drinking Water Program in the Water Quality Control Division, there are three sections: Engineering, Field Services, and Compliance Assurance. The Engineering section is who approves designs and any changes or alterations to drinking water systems. Field Services conducts sanitary surveys, and interacts with water providers to physically inspect systems for compliance with the Colorado Primary Drinking Water Regulations. Compliance Assurance assures that these Regulations are being followed by interacting with water systems, issuing compliance advisories, and issuing formal Enforcement Orders for systems out of compliance. If a public health director has questions or comments regarding correspondence to a particular water system, they should contact the person who wrote the letter (the engineer/field inspector/compliance assurance specialist), although the administrative assistant who emailed the letter, should be able to assist as well.

There are a number of people in different programs who work with water systems. It is the Water Quality Control Division's practice to copy local health agencies on certain types of

correspondence, both for their information as the local health agency, and also because they may have additional information that may be helpful to the Water Quality Control Division.

Water Quality Control Division tries to copy the local public health agencies on information requests they send out on "proposed" or "discovered" systems, which are systems that may need to be regulated as public water systems, but the Water Quality Control Division doesn't have enough information about them yet. It may be the case that the local public health agency might have important firsthand knowledge about the system that would assist the Water Quality Control Division in classifying a system.

Aside from the extra information that the Water Quality Control Division can gain from local public health agencies, the correspondence serves to provide information to the local public health agency. Another situation in which the Water Quality Control Division would directly contact a local public health agency would be one involving an acute health situation. Depending on the particular situation, the Water Quality Control Division may contact you just in an advisory capacity, or there have been cases where the Water Quality Control Division asks a local health agency staff member to physically visit a water system. With any acute health case, CDPHE will contact the local agency directly and consult about the actions needed to protect public health.

QUESTION: **When does a public health director need to get involved with issues involving sanitary surveys or corrective action plans (or other processes) and what assistance might they be asked to provide?**

ANSWER: All public water systems are required to have sanitary surveys conducted either by the Water Quality Control Division field services inspectors, or in certain counties, by delegated local health agency inspectors. Depending on the type of customer served, these sanitary surveys are required every three to five years. If deficiencies or violations of the regulations are identified during the survey, the water system must (in most cases) enter a corrective action plan to address the outstanding deficiencies. Sanitary surveys include records review for the system, viewing the system's monitoring plan, some maintenance and responsibility questions for care of the system, plus an inspection of the well, water treatment including disinfection, and water distribution. When violations or deficiencies are noted the local public health agency will follow up to ensure resolution. If corrective action plans are required the case will be turned over to the Water Quality Control Division.

QUESTION: **Who regulates public water supplies?**

ANSWER: CDPHE Water Quality Control Division regulates public water supplies.

QUESTION: **Who regulates the construction of new wells?**

ANSWER: Regulatory and enforcement responsibilities for residential wells lie with Colorado Department of Natural Resources. For more information on well permitting and regulation go to the Colorado Division of Water Resources.

QUESTION: **Who is responsible for inspections at water treatment facilities?**
ANSWER: CDPHE Water Quality Control Division is responsible for inspections at water treatment facilities.

QUESTION: **What are the recommendations and process for testing private wells?**
ANSWER: Ground water wells are the principle source of water for most homeowners in rural areas of Colorado. There are over 200,000 permits for ground water wells currently issued in our state and approximately 4,000 new permits are requested annually. Typical well water tests for most areas should include bacteria, nitrate and fluorides. The Laboratory Services Division of CDPHE provides water testing for a fee. They will ship sample bottles and instructions to the resident. The samples can be shipped or dropped off at the Laboratory Services Division at CDPHE. For more information refer to the Customer Resources page on the CDPHE website. The CDPHE Lab offers several testing packages, including one frequently recommended for new wells or new well owners that would cover a variety of possible contaminants and pollutants. Some local public health agencies can also test for bacteria such as total coliform and *E.coli* and can serve as resources to other agencies. Here are local public health agencies that provide laboratory services:

- Weld County Department of Public Health and Environment
- Northeast Colorado Health Department
- Mesa County Health Department Regional Laboratory
- San Juan Basin Health Department
- Larimer County Health Department
- Pueblo City County Health Department

Environmental Health – Service Provision Alternatives
April 7, 2021 – revised June 1, 2021

TCHD's Environmental Health Division consists of the following primary programs:

- Administration
- Food Protection
- Child Care
- General Environmental Health Services
- Water (wastewater systems and recreational water facilities)
- Land Use
- Solid and Hazardous Waste
- Industrial Hygiene
- *Rocky Mountain Arsenal (not applicable to Douglas County)*
- Vector Surveillance

Key Assumption: While technically some services provided by TCHD could be devolved back to the CDPHE (e.g.: OWTS or Recreational Water Facilities), in practice that would likely have a significantly negative impact on the level of service Douglas County landowners and businesses would receive. Therefore, we have assumed that any future LPHA serving Douglas County would continue to provide those services.

<u>Alternative 1: Full contract with TCHD or other entity</u>

This alternative is certainly feasible for Environmental Health services. Barring an extraordinary finding in a Community Health Assessment for Douglas County that generates the need for new services or programs, TCHD or other LPHAs in the region should be capable of meeting the County's Environmental Health needs. TCHD seems the most obvious choice since it already has staffing and infrastructure to serve Douglas. For another LPHA (Jeffco or El Paso seem most likely candidates) to serve Douglas they would likely need to add staff and also learn the ins and outs of the Douglas County community.

<u>Alternative 2: Partial contract and direct service provision</u>

This alternative is also feasible for Environmental Health services, particularly at the startup of any transition. Programs that require extensive staffing and overhead (particularly the food protection and water programs) that would benefit most from economies of scale would be primary candidates for contracting with another LPHA or, possibly, private contractors in some instances. Private contracting would seem most likely to be an option in the water program, particularly for on-site wastewater systems and recreational water facilities, using private engineering and/or geo-tech firms. Other LPHAs might be more likely to provide at least some services in this scenario since the arrangement could be tailored to take advantages of strengths in their particular organization.

Alternative 3: Full direct service provision

This alternative is least likely to be feasible for Environmental Health services, at least in the short term. The food protection and water programs, in particular, would require staffing, overhead support, and infrastructure that could be difficult to standup in a short timeframe. It seems more likely that full direct services could be achieved by building in-house expertise over time while working with contractors to determine how best to serve Douglas County's particular needs.

Notes

Teller County has spun off the Environmental Health functions from its Department of Public Health and Environment (https://www.co.teller.co.us/PublicHealth/default.aspx) and moved them to its Community Development Services Division (https://www.co.teller.co.us/CDSD/default.aspx), which also encompasses the Planning and Building functions.

Per Megan Datwyler, Pinnacol does a lot of "industrial hygiene" services for its clients. Maybe they could be a partner for us on at least some of the environmental health inspection-related services.

Tri-County Health Department

Environmental Health
Proposed Schedule of Fees
September 1, 2020

Fees set by TCHD Board of Health

Environmental Health Fee Type	Number of Licenses/Activities2019	Current Fee	Unit of Activity	Calculated Fee	Proposed Fee	Authority	Change
Body Art - Number of Active Facilities	80 facilities	$355.00	Annual	$340.53	$345.00	25-1-508	($10.00)
Body Art - Temporary Event Inspection	1 event	$60.00	Per Hour	$59.71	$60.00	25-1-508	No Change
Child Care - Biennial Inspection	581 facilities	$205.00	Biennial	$191.25	$190.00	25-1-508	($15.00)
Child Care - Annual Inspection, Lic. for 5-50 Children	29 facilities	$235.00	Annual	$216.75	$215.00	25-1-508	($20.00)
Child Care - Annual Inspection, Lic. for 51-250 Children	205 facilities	$275.00	Annual	$249.86	$255.00	25-1-508	($20.00)
Child Care - Annual Inspection, Lic. for 251+ Children	10 facilities	$345.00	Annual	$318.75	$320.00	25-1-508	($25.00)
Industrial Hygiene - General Consultation / County Agencies	0 requests	$50.00	Per Hour	$42.69	$50.00	25-1-508	No Change
Industrial Hygiene - Mold Complaints - Sampling	18 complaints	$50.00	Per Hour	$42.69	$50.00	25-1-508	No Change
Industrial Hygiene - Other Government Agencies	0 agencies	$75.00	Per Hour	$64.04	$70.00	25-1-508	($5.00)
Industrial Hygiene - Private Sector	4 requests	$80.00	Per Hour	$68.31	$75.00	25-1-508	($5.00)
Industrial Hygiene - Private Sector / Mutual Aid / Non-Emergency (Outside Tri-County)	0 requests	$95.00	Per Hour	$81.12	$85.00	25-1-508	($10.00)
Land Use Plan Review - Level One	100 plan reviews	$150.00	Per Plan Review	$150.00	$150.00	25-1-508	No Change
Land Use Plan Review - Level Two	70 plan reviews	$210.00	Per Plan Review	$210.00	$210.00	25-1-508	No Change
Land Use Plan Review - Level Three	57 plan reviews	$360.00	Per Plan Review	$360.00	$360.00	25-1-508	No Change
Land Use Plan Review - Level Four	1 plan reviews	$750.00	Per Plan Review	$750.00	$750.00	25-1-508	No Change
Methamphetamine - Number of New Reports of Meth Labs	44 new reports	$320.00	Per Case	$309.95	$310.00	25-1-508	($10.00)
Environmental Assessment File Review (minimum one hour)	227 requests	$60.00	Per Hour	$59.71	$60.00	25-1-508	No Change
Environmental Health Consulting - All Programs Except Industrial Hygiene	Varies	$60.00	Per Hour	$59.71	$60.00	25-1-508	No Change
Plan Review Application - All Facility Types Except Food	32 plan reviews	$120.00	Per Plan Review	$119.41	$120.00	25-1-508	No Change
Site Assessment / Change of Owner - All Programs Except Food	187 inspections	$60.00	Per Hour	$59.71	$60.00	25-1-508	No Change
Retail Food - Special Events License	123 licenses	$160.00	Annual	$159.49	$165.00	25-4-1607	$5.00
Retail Food - Special Event Plan Review Application (2-15 vendors)	40 applications	$100.00	Per Event	NA	$100.00	25-4-1607	No Change
Retail Food- Special Event Plan Review Application (16 + vendors)	1 applications	$200.00	Per Event	NA	$200.00	25-4-1607	No Change
Retail Food - Special Event Plan Review Late Fee	12 late fees	$50.00	Per Late Application	NA	$50.00	25-1-508	No Change
Retail Food - Special Event Inspection (per inspector)	65 inspections	$60.00	Per Hour	$59.71	$60.00	25-1-508	No Change
Retail Food - Education, 2 Hour In-Service Training	21 trainings	$120.00	Per Training	$119.41	$120.00	25-1-508	No Change
Pool / Spa / Spray Pool - Filtration System	520 filtration systems	$185.00	Annual	$171.88	$175.00	25-1-508	($10.00)
On-Site Waste Water - New Permit	297 permits	$1,023.00	Per Permit**	$1,138.10	$1,143.00	25-10-107	$120.00
On-Site Waste Water - Major Repair or Expansion Permit	54 permits	$673.00	Per Permit**	$747.82	$753.00	25-10-107	$80.00
On-Site Waste Water - Minor Repair	159 permits	$373.00	Per Permit**	$413.29	$418.00	25-10-107	$45.00
On-Site Waste Water - Use Permit Application Fee	874 applications	$85.00	Per Permit	$72.92	$80.00	25-10-107	($5.00)
On-Site Waste Water - Variance Request (New/Repair Permit)	3 requests	$65.00	Hourly	$67.96	$70.00	25-10-107	$5.00
On-Site Waste Water - New/Repair Permit Renewal	0 renewals	$50.00	Per Permit	NA	$50.00	25-10-107	No Change
On-Site Waste Water - Re-Inspection	106 re-inspections	$120.00	Per Inspection	$119.41	$120.00	25-10-107	No Change
On-Site Waste Water - Plan Review per additional hour (first hour free)	0 plan reviews	$60.00	Per Plan Review	$59.71	$60.00	25-10-107	No Change
On-Site Waster Water - Installers' & Cleaners' License - New/Renewal	196 total issued	$40.00	Annual	$35.82	$40.00	25-10-109	No Change
GIS - Customized Map (Hourly - 1 hour minimum)	0 custom maps	$75.00	Per Hour	$77.96	$80.00	25-1-508	$5.00

Tri-County Health Department

Environmental Health
Proposed Schedule of Fees
September 1, 2020

Fees set by Colorado State Legislature

Environmental Health Fee Type	Number of Licenses/Activities 2019	Current Fee	Unit of Activity	Calculated Fee	Proposed Fee	Authority	Change
Retail Food - No fee License (K-12 schools, non-profit)	461 licenses	$0.00	Annual	NA	$0.00	25-4-1607	No Change
Retail Food - License, Limited Food Service (convenience, other)	821 licenses	$270.00	Annual	NA	$270.00	25-4-1607	No Change
Retail Food - License, Restaurant, Seating 0-100*	2180 licenses	$385.00	Annual	NA	$385.00	25-4-1607	No Change
Retail Food - License, Restaurant, Seating 101-200*	530 licenses	$430.00	Annual	NA	$430.00	25-4-1607	No Change
Retail Food - License, Restaurant, Seating >200*	295 licenses	$465.00	Annual	NA	$465.00	25-4-1607	No Change
Retail Food - License, Grocery Store (0-15,000 sq.ft.)*	157 licenses	$195.00	Annual	NA	$195.00	25-4-1607	No Change
Retail Food - License, Grocery Store (>15,000 sq.ft.)*	24 licenses	$353.00	Annual	NA	$353.00	25-4-1607	No Change
Retail Food - License, Grocery Store w/ deli (0-15,000 sq.ft.)*	153 licenses	$375.00	Annual	NA	$375.00	25-4-1607	No Change
Retail Food - License, Grocery Store w/ deli (>15,000 sq.ft.)*	131 licenses	$715.00	Annual	NA	$715.00	25-4-1607	No Change
Retail Food - License, Mobile Unit (prepackaged, non-PHF)*	10 licenses	$270.00	Annual	NA	$270.00	25-4-1607	No Change
Retail Food - License, Mobile Unit (full food service)*	133 licenses	$385.00	Annual	NA	$385.00	25-4-1607	No Change
Retail Food - License, Oil and Gas Temporary*	0 licenses	$855.00	Annual	NA	$855.00	25-4-1607	No Change
Retail Food - Change of Ownership or Site Evaluation (Initial Inspection)	419 inspections	$75.00	Per Inspection	NA	$75.00	25-4-1607	No Change
Retail Food - Change of Ownership or Site Evaluation (Additional Inspections)	201 inspections	$60.00	Per Hour	$59.71	$60.00	25-4-1607	No Change
Retail Food - Plan Review Application	459 applications	$100.00	Per Plan Review	NA	$100.00	25-4-1607	No Change
Retail Food - Plan Review and Pre-opening Inspection (Not to exceed $580.00)	625 inspections	$60.00	Per Hour	$59.71	$60.00	25-4-1607	No Change
Retail Food - HACCP Plan, Written (Not to exceed $100.00)	0 plans	$60.00	Per Hour	$59.71	$60.00	25-4-1607	No Change
Retail Food - HACCP Plan, On-site Evaluation (Not to exceed $400.00)	Not tracked	$60.00	Per Hour	$59.71	$60.00	25-4-1607	No Change
Retail Food - Penalty Assessment, Late License Renewal	88 civil penalties	$250 to $1,000	Per Assessment	NA	$250 to $1,000	25-4-1610	No Change
Retail Food - Penalty Assessment, Enforcement	10 penalties assessed	$250 to $1,000	Per Assessment	NA	$250 to $1,000	25-4-1611	No Change
On-Site Waste Water- 0-17 Regulation	Not tracked	$10.00	Per Copy	N/A	$10.00	24-72-205	No Change
Copy Fees: 8.5” by 11” (First 10 Pages Free)	Not tracked	$0.25	Per Page	NA	$0.25	24-72-205	No Change
Copy Fees: 11” by 17”	Not tracked	$0.25	Per Page	NA	$0.25	24-72-205	No Change
Copy Fees: Greater than 11” by 17”	Not tracked	Not to exceed actual cost	Per Page	NA	Not to exceed actual cost	24-72-205	No Change

* $ 43.00 of each retail food license fee collected is sent to the State Treasurer.

** Effective July 1, 2007, section 25-10-107 of the Colorado Revised statutes was amended allowing the Colorado Department of Public Health & Environment (CDPHE) Water Quality Division to assess a fee of $23 for each authorized new and repair on-site waste water permit; $20 is transmitted to CDPHE and $3 retained by the local health department to cover administrative costs.

Community Health Promotion

IT Systems, Applications, Requirements*

*The following is based on available information at this time (June 2021). It is not an extensive review of systems or applications that may support the work of Tri-County Health Department's Community Health Promotion division.

Divisions within Community Health Promotion:

1. Administration
2. Tobacco Education and Prevention
3. Substance Abuse Prevention
4. Mental Health and Behavioral Health promotion and Suicide Prevention Program
5. Maternal and Child Health (MCH) Block Grant
6. Diabetes Education Program
7. Advance Breastfeeding in Colorado
8. Community Nutrition
9. Healthy Beverage Partnership
10. Worksite Wellness
11. Health Equity

1. Administration

a. Assuming some IT requirements for financial oversight, grant and contract management, and strategic plan/priority tracking.
b. Unknown what applications Administration uses to accomplish these tasks.

2. Tobacco Education and Prevention

a. Routine health surveillance datasets: Behavioral Risk Factor Surveillance System (BRFSS); Healthy Kids Colorado Survey (HKCS)
b. BRFSS and HKCS data used to create data dashboards and GIS maps
c. Health Data and Geographic Information System
    i. https://tobacco-tchdgis.opendata.arcgis.com/
d. Tableau

3. Substance Abuse Prevention

a. Routine health surveillance datasets: Behavioral Risk Factor Surveillance System (BRFSS); Healthy Kids Colorado Survey (HKCS)
b. Colorado Hospital Association Data
c. BRFSS and HKCS data used to create data dashboards and GIS maps
d. Health Data and Geographic Information System
    i. https://substanceabuse-tchdgis.opendata.arcgis.com/
    ii. https://opioid-tchdgis.opendata.arcgis.com/
e. Tableau

4. **Mental Health and Behavioral Health promotion and Suicide Prevention Program**
    a. Routine health surveillance datasets: Behavioral Risk Factor Surveillance System (BRFSS); Healthy Kids Colorado Survey (HKCS); National Violent Death Reporting System (NVDRS)
    b. Colorado Hospital Association Data
    c. BRFSS and HKCS data used to create population health GIS maps by zip code.
    d. Health Data and Geographic Information System
        i. https://mentalhealth-tchdgis.opendata.arcgis.com/
    e. Tableau

5. **Maternal and Child Health (MCH) Block Grant**
    a. Routine health surveillance datasets: Pregnancy Risk Assessment Monitoring System (PRAMS)
    b. Systems and applications unknown

6. **Diabetes Education Program**
    a. TCHD is a recognized by the American Diabetes Association as a Diabetes Self-Management Education (DSME) site which allows access to certain benefits including the DSME documentation platform (*IT consideration*).
        i. System: Chronicle Diabetes, a HIPAA and HI-Tech compliant web based system that provides healthcare professionals tools to facilitate diabetes education documentation.
        ii. https://professional.diabetes.org/content/chronicle-diabetes
        iii. DSME and medical nutrition therapy (MNT) may be reimbursable so some type of billing system may be necessary.

7. **Advance Breastfeeding in Colorado**
    a. Cancer, Cardiovascular Disease and Pulmonary Disease (CCPD) grant is ending so this regional collaborative will be determining how to transition their activities to local leaders and statewide entities.
    b. Unsure what, if any, systems or applications are used for this work.

8. **Community Nutrition**
    a. This team uses a centralized event system to manage the high volume of ad hoc requests received by TCHD's main line for participation in health-influencing community events.
    b. TCHD participated in 133 health-supporting community events requested via this pipeline in 2019, and 41 in 2020 due to the COVID-19 pandemic.

9. **Healthy Beverage Partnership**
10. **Worksite Wellness**
11. **Health Equity**

Regarding data sets, it is unknown if TCHD auto-imports data from the Colorado Department of Public Health and Environment (CDPHE) and other sources, if datasets are sent directly or if TCHD staff pulls data from web portals.

Development of data and analytic services across the agency as needed by program staff. This includes but is not limited to:

DATA AND ANALYTIC SERVICES

• Digital data collection tools	• GIS mapping
• Analytics within the following platforms	• Data storage and management solutions
• SAS, GIS, SQL	• Web mapping tools
• Statistical modeling of health outcomes	• Dashboards (Tableau, ESRI)
• Website development for data delivery	• Creating of factsheets, infographics, page layout (Adobe Creative Suite)
	• Data automation

INFRASTRUCTURE ADMINISTRATION AND MAINTENANCE

- ArcGIS Enterprise (On Premise) / ArcGIS Online
- SQL Server
- FME Server
- Tableau Server (On Premise), Tableau Public
- Windows IIS webhosting (https://data.tchd.org)

CORE TECHNICAL SKILLSET OF TEAM

- Advanced statistics
- GIS
- Graphic/Website design
- Coding languages:
  SAS, HTML, Python, SQL, R, Arcade,
- Data automation

Community Health Promotion	Strengths	Opportunities
Administration	• Straightforward function • Provides oversight and support for planning, implementation, performance management and quality improvement of CHP activities and programs. • Additional responsibilities include financial oversight, grants, and contracts management, ensuring adherence to agency policies and processes, administrative support, and advancing prioritized efforts to support the TCHD Strategic Plan and Public Health Improvement Plan.	• TCHD has 2.4 FTE's dedicated to community health promotion. Douglas County would likely need 1 FTE or less to accomplish this work.
Tobacco Education and Prevention	• Advanced tobacco control policy in two Douglas County municipalities – Lone Tree and Castle Pines. • Douglas County Healthy Youth Coalition (DCHYC) exists – focus on youth, which is critically important for cubing adult use, which often begins in adolescence, and reducing the risk of chronic health issues later in life.	• Increase capacity by funding more than one community partner to advance tobacco prevention, cessation, and control (DCHYC focus is youth). • The county is engaged in this work - only city councils and city staff are listed as engaged leaders. • Opportunity to focus initiation prevention efforts among certain age groups, sexual identities, ethnicities, and SE statuses that are unique to Douglas County.
Substance Abuse Prevention	• Established Tri-County Overdose Prevention Partnership (TCOPP). DCHYC also addresses other substance use prevention. • TCHD has been awarded three highly competitive grant awards in the last two years for coalition development for youth substance abuse prevention (all substance use	• Increase frequency of data analysis and thus understanding of the type and scope of issues in Douglas County (only one assessment in DougCo 2016 – 2020). • Increase capacity to tackle substance use by funding

Substance Abuse Prevention (continued)	prevention work is done through partnerships and coalitions). • Multi-pronged approach – safe storage and disposal (prescription drugs), safe use, prevention, treatment – opioid focus.	more than one community coalition (DCHYC focus is youth). • Broaden the scope to include adult substance use prevention, treatment and recovery as well as targeting other substances besides opioids (high binge drinking rate in DougCo and fewer overdose deaths). • Increase partnerships with Douglas County primary care practices/health care settings which play an important role in identification, early intervention and maintaining good overall health.
Mental Health and Behavioral Health promotion and Suicide Prevention Program	• Recently created frameworks for mental health promotion and suicide prevention. • Hired a program FTE for this work.	• The Douglas County Mental Health Initiative (DCMHI), a well-established community asset that shares some similarities in approach as the TCHD framework for mental health promotion + already has a blueprint under implementation. • DCMHI could partner with a LPHD to further implement community-based prevention and mental health promotion activities through community partnerships. • Increase partnerships with Douglas County primary care practices/health care settings which play an important role in identification, early intervention and maintaining good overall health.

Maternal and Child Health (MCH) Block Grant	• Coordinates with divisions across the CHP department. • Diverse programming – age, level of need i.e. prevention, intervention, referral.	• Data is needed to understand the proportion of Douglas County children and families served by this division. Most data is cumulative and shows a focus on Adams and Arapahoe Counties.
Diabetes Education Program	• Free wellness programs in ENG and ESP, in person and virtual. • A robust network of community partners (24), though unclear how many in Douglas County. • TCHD is a Diabetes Self-Management Education (DSME) site (access to DSME documentation platform (*IT consideration*), enhanced marketing opportunities through the American Diabetes Association (ADA), 40% discount on ADA publications and books), and is recognized by CDC for its NDPP program, indicating attainment of all program benchmarks and provision of evidence-based education.	• Policy advocacy to impact the cost of diabetic medication and supplies for the uninsured and underinsured. • Maintain DSME site recognition. • Data analysis to locate the areas in the county with food deserts, populations at risk for diabetes, populations living with diabetes, populations with higher rates of diabetes related complications and target those areas.
Advancing Breastfeeding in Colorado	• Currently part of a Regional Collaborative. • Tri-County resource guide is simple and straightforward. Easily replicable. • Can partner with Nursing to carry on this work if deemed appropriate.	• CCPD grant funding is ending June 31,2021. • ABC will be examining sustainability and determine how to transition their activities to local leaders and statewide entities. • Pivot to upstream policy choices.
Community Nutrition	• Is connected with many other departments within TCHD to accomplish their work.	• Can easily absorb the promotion pieces (healthy beverage partnership and healthy eating active living - HEAL)into the larger Nutrition division.

Healthy Beverage Partnership	• 6 lead agencies and 11 local coalitions. • Sponsored by the CDPHE Cancer Cardiovascular and Pulmonary Disease Grants Program (CCPD) .	• Efforts currently focused in Aurora • Need data to determine if this is a task that a DC LPH department would be interested in continuing.
Worksite Wellness	• Grant initiative program • Work with Chambers to reach business. Chamber provides programs and assistance to businesses. • Employers are interested in this type of program. • Project is based on a peer-mentoring network to safely share ideas and work through organizational milestones.	• Douglas County business community can access these services independently with minor assistance from a public health department. • Douglas County has a solid wellness program that can serve as a guide and/or absorb some of this work.
Health Equity	• Identified as a priority in the 19-24 Public Health Improvement Plan • A health equity workgroup meets to share learnings and champion efforts to integrate equity best practices.	• This work is woven through numerous departments under TCHD.

Department Structure Opportunity: Create a Behavioral Health Department distinct from, or alongside, Community Health Promotion. A Behavioral Health Department would include tobacco prevention and education, substance abuse prevention, mental and behavioral health promotion, and suicide prevention. This would not limit any inter-departmental collaboration, as behavioral health (mental health, substance abuse) would also support efforts in Maternal and Child Health, Diabetes Education, Worksite Wellness and potentially Nutrition. This adjustment in structure would be a symbolic gesture demonstrating Douglas County's commitment to mental and emotional well-being, while also drawing attention to the connection between physical and mental health.

Emergency Preparedness & Response:

- Protect against and respond to Public Health threats, natural or human caused. Enhance ambient community and organizational resilience. Assist in subsequent recovery efforts.
- Develop and maintain; various plans and protocols, to include: The Public Health Emergency Operations Plan (PHEOP) and Continuity of Operations Plan (COOP).
- Maintain situational awareness relating to Emergency Support Function #8, Health and Medical. Lead and coordinate ESF # 8 functions for relevant Emergency Operations Center(s).
- Develop or maintain coordination of cross-jurisdictional and cross discipline, preparedness, response and recovery partners and/or coalitions.
- Address Project Public Health Readiness (PPHR) components, addressing All Hazards preparedness planning, workforce capacity development. Validating efforts and proficiency through training, exercise and real-life events.

Public Health Incident Management Team (PHIMT)

- Using the Incident Command System (ICS), EPR leads the Public Health Incident Management Team. This allows structured response to incidents of all magnitude and duration.

Health Alert Network (HAN)

- The Health Alert Network provides a venue for actively sharing accurate and timely information with local partners.

Cities Ready Initiative (CRI)

- CDC Program to enhance readiness in major metropolitan areas, of which the North Central Region (NCR) is acknowledged as being one. Focus areas include The Strategic National Stockpile (SNS). CRI's focus is comprehensive and utilizes an All Hazards Approach.

Communicable Disease Surveillance Program (EPI)

- EPI works to protect the public by preventing the spread of infectious diseases.
- EPI conducts ongoing epidemiologic surveillance to identify new and emerging infectious disease trends and outbreaks.
- Epi works to identify cause(s) of disease and identify those at risk.

- EPI provides input as to how to prevent and/or mitigate disease and outbreaks.
- Epi conducts routine investigation of vaccine preventable diseases.
- Epi also investigates zoonotic disease, such as rabies and plague.
- EPI has many rapid response duties and functions, wherein time is of the essence.

Syndromic Surveillance Program*

- This is an extra function that TCHD is involved in. They serve as a data collection and storage point for State-wide Syndromic Surveillance data. It is doubtful that there is merit in recreating this aspect of TCHS's operation. TCHD is committed to this service and will continue to serve the state with this service.

Implications of Preparedness and Response Core Competencies for Public Health

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Public health care practitioners and organizations are a part of community readiness for, response to, and recovery from emergencies and disasters of all kinds. Although response to health threats, particularly communicable disease outbreaks, have long been a part of public health practice, 2 advancements in preparedness, including the integration of public health into the broader community emergency response system and the clarification of exactly what knowledge, skills, and attitudes a public health professional brings to the response, have been made since 2001. This article presents the newly affirmed core competencies to be attained and maintained by the majority of the public health workforce and discusses some of the many ways in which these competencies influence practice, research, and education.

KEY WORDS: competency-based education, public health management and practice, public health preparedness, workforce training

The Public Health Preparedness and Response Core Competency Model[1] (Preparedness Model) (Figure) is the result of a national project undertaken by the Association of Schools of Public Health (ASPH) at the request of the Centers for Disease Control and Prevention (CDC) in response to the Pandemic and All-Hazards Preparedness Act of December 2006, also known as PAHPA.[2] The specific aim of the project was to develop a model of public health preparedness and emergency response competencies for the public health workforce. The PAHPA legislation, as the primary policy driver for the competency development project, was explicit in the requirement for a competency-based training program that is responsive to the needs of state, local, and tribal public health organizations and emphasizes public health security capabilities. Thus, the project kept a focus on the National Response Framework[3] and Target Capabilities List,[4] which recommend an all-hazards approach to emergencies that includes terrorist attacks, natural disasters, emerging infectious disease, health emergencies, environmental threats, and/or other major events such as chemical, biological, radiological, nuclear, high-yield explosives (CBRNE), and food and agriculture events. Within all of these, the National Health Security Strategy, required by PAHPA and Homeland Security Presidential Directive 21,[5] makes it very clear that the nation requires a sufficiently large workforce proficient in emergency preparedness, response, and recovery skills.

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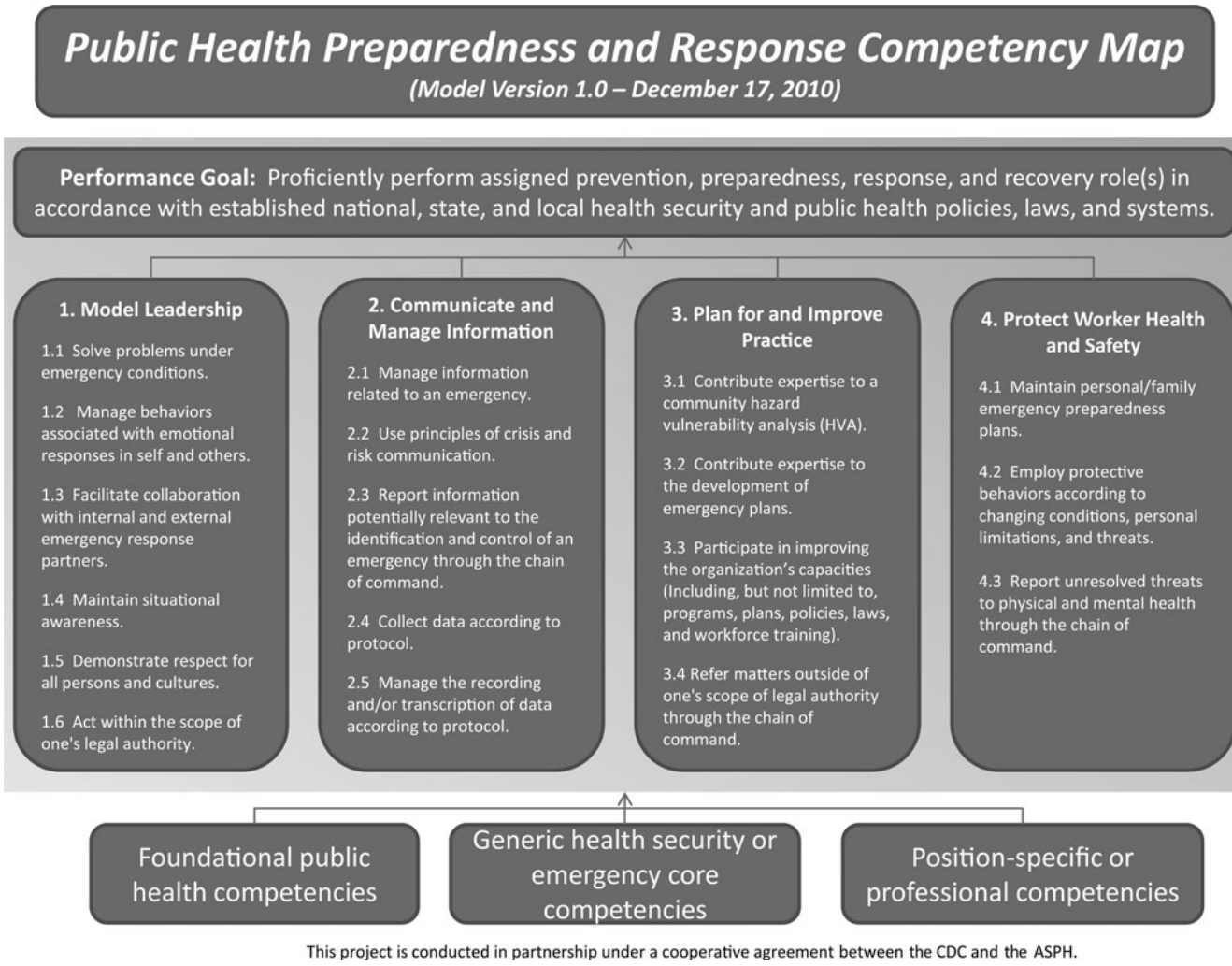
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FIGURE ● **Public Health Preparedness and Response Core Competency Map (Model Version 1.0, December 17, 2010**



The substantial federal investment in public health workforce development for over a decade has included the establishment of training programs covering emergency preparedness and response. However, a careful study of published research on emergency preparedness education[6] has identified a lack of solid evidence on the impact of the training on individuals or public health systems, requiring a substantial research strategy to fill the gap. The CDC Preparedness and Emergency Response Learning Centers, formerly the Centers for Public Health Preparedness, represent a network of accredited, graduate schools of public health uniquely focused on emergency preparedness and response training for the public health workforce, and they are expected to be the major users of the Preparedness Model. ASPH staff made it a particular point to deliver the model directly to the Preparedness and Emergency Response Learning Centers, after having included them in the model development and vetting process. In addition, the model is being disseminated through the ASPH Web site, through regular dialogue with the various public health emergency preparedness organizations, through presentations at professional meetings, and via the peer-reviewed literature.

It is expected as well that the ASPH and others would recommend that public health agencies apply the model both to improve protection of the nation's health and to strengthen accountability for training dollars provided by federal agencies to public health organizations and educational institutions. Application of the model in public health practice will require attention by policy makers, human resources professionals, and individual workers, as well as trainers and evaluators. The use of the Preparedness Model should be evaluated as part of ongoing research to differentiate effective training methods and frameworks from those that do not produce the desired results.

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Core competency–based training (such as that called for by PAHPA) requires a valid, agreed-upon set of competencies. A review of the existing competency literature in circulation at the time of this project was conducted to collect competencies or competency-like statements for consideration as "candidate competencies" in the model development process. This review revealed that nearly 60 public health preparedness and response competency frameworks, models, journal articles, government reports, Web portals, public health practice and academic association training products, as well as slide presentations are available and in use.[7] Of these, some are based on research, some on organizational decisions, and some presented by individual trainers. No universally accepted set of competencies for public health preparedness and response was identified, and many of the competencies did not reflect current federal plans, policies, or capabilities.

The Preparedness Model project was organized as a broad dialogue within the public health community, led by an 18-member group of experts from academia and the practice community.[8] The interactive method by which the competencies were developed is summarized in the Box and detailed by E. Ablah, PhD, et al (unpublished data, 2012). Nearly 400 individuals from a wide range of public health settings participated. The iterative process spanned 21 months and was based on a continuous dialogue among experts and practitioners in the multiple aspects of emergency preparedness, emergency response, and recovery from emergencies. In-person and virtual meetings, coupled with 3 electronic surveys, were used to solicit feedback on draft domains and competencies.[8] The questions continually addressed were whether any one candidate competency was properly stated as a competency and whether it was truly core for all public health workers in the designated target population.

BOX ● Core Competency Development Method Key Steps

Phase I: Initiation (3 mo)
Leadership group drawn from practice and academia
Comprehensive literature and resource review undertaken
Phase II: Delphi-type surveys (13 mo)
Round 1: Selection of domains for inclusion
Between rounds: Expert panel identification of candidate competencies
Round 2: Specification of candidate competencies
Between rounds: Review of data and development of final round
Round 3: Selection of final competencies
Phase III: Compilation of model (4 mo)
Analysis of response data and final statement of competencies
Development of graphics and accompanying explanatory materials
Phase IV: Publication of model (1 mo)

Defining the target population for the core competencies was the essential first step, given the wide range of skills, responsibilities, and experience of the entire public health workforce of more than 500 000 people, from the beginning worker with no prior public health experience to someone such as the senior epidemiologist with 25 years of work experience following the receipt of a doctoral degree. The decision was to identify competencies that are essential for all mid-level public health workers, defined by education and experience as individuals with either 5 years of work experience and an MPH equivalent or higher degree *in public health* or 10 years of experience with a high school diploma, bachelors, or *non–public health* graduate degree.[8] This definition includes a substantial portion of the known public health workforce, providing the backbone of service delivery in any public health program, or responsible for program support, coordination, development, implementation, management, or evaluation; supervision; community relations; or policy analysis. Examples include the following:

- Administrators, such as payroll supervisors, purchasing managers, and human resources staff.
- Chief clerks of vital records.
- Public health nurses who run well-child clinics, immunization programs, and sexually transmitted disease testing, and may assist with epidemiologic tasks.
- Public health sanitarians who perform routine food, water, pool, and/or restaurant inspections, conduct food worker training, and may assist with epidemiologic tasks.
- Senior laboratory technicians who support laboratory scientists and others in organizing, conducting, and reporting laboratory tests.[1]

Those at an entry level (eg, workers new to public health or those with less than a high school education) and at a more advanced level (eg, very experienced workers or those in high-level leadership positions) will need to be competent as well, but to differing degrees or in other areas than these mid-level workers. Using this mid-level core set as a starting place, organizations and educational institutions can more quickly identify what is needed by these other groups.

In the process of specifying the competencies needed by individuals, it was also important to separate them from the emergency capacity that must be developed by any organization. The following example may help illustrate this point: a worker who is *competent* to develop a computer-based record-keeping system is unable to function if the organization does not have computer *capacity*, and it would be an error to describe the provision of computers as an individual core competency. Providing computers during an emergency

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is a logistical task that can be anticipated, should be included in staff assignments, and may require (depending on the organization) some specialized competency in the persons given the assignment, but it is not a core competency.

The Competency Model

As released in December 2010, the Preparedness Model[1] states that the overall goal is to have mid-level public health workers prepared to perform proficiently their assigned prevention, preparedness, response, and recovery role(s) in accordance with established national, state, and local health security and public health policies, laws, and systems. As illustrated in the Figure, the competencies are organized into 4 domains that are critical to build and sustain the capacity to fulfill the worker's responsibilities: model leadership (6 competencies); communicate and manage information (5 competencies); plan for and improve practice (4 competencies); and protect worker health and safety (3 competencies). An important point, however, is that the ability of any one worker to meet the emergency preparedness performance goal for his or her position is closely tied to competencies described in other models and acquired elsewhere. Three other sources are particularly relevant:

1. *Foundational public health competencies*, such as the Council on Linkages Between Academia and Public Health Practice Core Competencies for Public Health Professionals[9] and the ASPH master's degree in Public Health Core Competency Model[10] for those in the target group with specific training in public health.
2. *Generic health security or emergency core competencies*, such as those that may stem from National Incident Management System courses or the new core competencies for disaster medicine and public health recommended for all health professionals.[11]
3. *Position-specific or professional competencies*, such as those developed for public health nursing, environmental health, health education, public health law, applied epidemiology, administrative support, and informatics, depending on the individual's background or assignment.

A key feature of the model is the expectation that those who fit the definition and gain these competencies will maintain proficiency in them as a unified set. Although competencies once learned and never practiced might be relearned quite quickly, responding to an emergency situation does not provide adequate time for extensive refresher training to take place before the response occurs. As stated, these competencies are generic, but they are always carried out by the worker within a specific position and organization. Therefore, each mid-level public health worker requires regular opportunities to practice the competencies in realistic situations in order to maintain the required proficiency in all of these core competencies. When that is the case, the "just in time" training specific to an event (eg, geographic features of the affected area, update on management of an infectious organism, or abilities of newly arriving volunteers) can contribute to effective performance.

Discussion

This model of core competencies is a foundation for many activities associated with ensuring that public health fulfills its necessary role in community preparedness for emergencies, actions to reduce the likelihood of emergencies or the degree of impact when one occurs, effective response when emergencies occur, and both immediate and long-term recovery actions. Among those who should consider use of the model are policy makers, planners, employers, academic faculty and professional trainers, individual workers, evaluators, accrediting bodies, and researchers. Sketches of actions that might be taken by these potential stakeholder groups are provided later. This is not an exhaustive list of either stakeholders or actions but is intended to stimulate thinking about ways in which the model can serve as a positive influence on practice.

Policy makers

Policy makers at every level should consider the requirements in place for programs under their control, whether for training of individual public health workers, for facilitating coordination between training requirements and support for training programs, or for ensuring that system capacity is addressed at the same time workers are becoming better prepared for the jobs they must perform. This extends to policy makers in the general emergency preparedness area as well as those specific to public health. Congress, by passing PHAPA, has shown that it considers public health competency-based preparedness training a key component of ensuring effective use of resources. It is impossible to answer definitively the perpetual question "Are we prepared yet?" The policy commitment to preparedness at a national level entails an understanding that this must be an ongoing quality improvement process, with the competencies providing assistance to policy makers as they identify benchmarks for appropriate resource allocation.

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Planners

The world of emergency preparedness also includes many *planners*: those developing individual organizations' emergency preparedness plans and annual exercise plans and those planning for interagency or jurisdiction-wide emergency capacity. All of these planners, whether full or part time, should become familiar with this new Preparedness Model and should consider how to ensure that workers fitting this mid-level description are provided adequate training prior to participation in either exercises or actual emergencies. Planners are also critical for identifying where and when the performance of an individual role requires expertise beyond this core and for making plans to ensure that time and resources for additional development will be available as needed.

Employers

Every public health *employer* should ensure that the currently employed workers in the defined mid-level range develop and maintain the competencies. Even while providing for the education of the existing mid-level workforce, it will be important to develop a combination of new employee orientation, continuous on-the-job learning, and regular exercises and drills with interwoven quality improvement loops, all designed to bring the target audience to proficiency and maintain expertise over time. It will be important to increase the likelihood that employees moving across the somewhat arbitrary 5-year or 10-year experience line of the definition have already become at least novices in these competencies and thus are ready to develop and maintain proficiency without beginning anew. Having a workforce with the core competencies also opens the door to developing the abilities of entry-level employees, those assigned into preformed teams for specialized duties, those moving into senior leadership roles, and those requiring expertise in interagency response. Even if an agency has a commitment to employee development as a part of continuous quality and performance improvement, resources are needed. Employers planning for development need to allocate a reasonable share of those resources to ensure that employees achieve and maintain core emergency preparedness competencies.

In larger organizations, the human resources/personnel/civil service systems also have the opportunity to update position requirements and general personnel information to reflect the expectation of proficiency in these competencies. Career counseling available to employees should include information on ways to achieve and maintain these emergency preparedness competencies in anticipation of future roles that will be assumed by employees during the course of a career in public health. The human resource offices may be able to ensure continued proficiency by requiring continuing education, refresher courses, or documentation of currency as part of each employee's annual performance appraisal. Some human resource departments are also in a position to facilitate access to continuing education training, either directly or through compensation. The personnel office can also help communicate to employees how the abilities exhibited during an emergency situation are related to the basic job for which they were hired. This means that in a state of emergency, public health nurses remain nurses, sanitarians remain sanitarians, and administrative assistants continue to be administrative assistants, although they may be applying the core competencies and their skills in a different setting or under the direction of an unfamiliar leader. For those employees who discover that they wish to engage more extensively in emergency situations, the human resource office can become a source of information on how to join a Medical Reserve Corps unit, Community Emergency Response Team, the National Disaster Medical System, or an international relief team. Employees participating in such activities do need to keep their employers informed and be aware that they cannot respond to any one emergency through more than 1 resource agency.

Academic faculty and professional trainers

Academics in accredited, graduate schools and programs of public health as well as *trainers* in public health organizations and independent training firms are already presenting a variety of emergency preparedness and response programs, some developed specifically for public health, some based primarily on knowledge transfer rather than competency development, and some extremely specialized. All existing training approaches that target mid-level public health workers should be examined against the expectations of these competencies, with the goal of ensuring that any course on emergency preparedness, response, or recovery to be taken by a mid-level public health worker is consistent with the expectations of these competencies. For each competency, expert educators and trainers must identify the subcompetencies, and specific knowledge, skills, and attitudes to be translated into learning objectives and learning activities. With CDC support, the ASPH and the Preparedness and Emergency Response Learning Centers have already begun the task of operationalizing the model.[12] This work and related implementation efforts, supported by evaluations from training sessions that enhance training and education, are expected to assist faculty in improving the model for sustaining readiness in the US public health workforce.

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As a further reminder to trainers, there are at least 3 other groups of public health workers to be considered: the entering workers without the requisite years of experience to fit this model; senior leaders; and those workers who will be representing public health in interagency planning, Incident Command Centers, and community-wide recovery efforts. These groups all need competency-based training specific to the expectations of their roles, and although this core competency model provides general guidance, much additional work is needed to ensure that these groups receive the specific preparation for their roles as well.

Individual workers

Individual workers have a responsibility to their employers and colleagues to maintain their expected knowledge, skills, and attitudes, and this is perhaps more important in emergency situations than at any other time. For example, a worker who does not know how to share important continuity issues for his or her programs with the risk assessment team, does not develop and maintain a personal preparedness plan, cannot differentiate reliable information from rumor, and loses all ability to remain culturally sensitive during times of crisis, will not only be at personal risk of a bad outcome but also puts colleagues and the community at risk. Taking advantage of every training opportunity and participating in drills and exercises are essential. Part of this preparation process is one of self-assessment that can increase understanding of one's own tolerance for stress and adaptability, in anticipation of the need for these characteristics during implementation of an emergency plan.

Evaluators

Evaluators of both educational programs and public health organizations now have this competency set as a framework for critical questions about performance of individuals and organizations. When a disaster drill, a community exercise, or a response to an emergency event does not go well, a key question to ask is whether the involved mid-level public health responders had acquired the core competencies that would have allowed them to perform well. Related questions are whether there were expectations of a specialized response (eg, establishing a new epidemiology protocol or conducting just-in-time training for emergency volunteers) that should have been anticipated with separate training provided. The model can also assist an evaluator to tease out the differences between what was done (or not done) because of the competence of individual workers and what was accomplished (or not accomplished) because system capacity had not been developed or deployed. For example, if the jurisdiction has not developed public health legal preparedness and outlined in accessible places what needs to be done to authorize changes in agency regulations under emergency conditions, then expectations of employee performance "within legal scope" may be unrealistic.

Accrediting bodies

The *Public Health Accreditation Board* has begun implementing standards for public health organizations. Just as The Joint Commission has included very specific expectations for emergency preparedness and response within the standards for accredited hospitals,[13] the Public Health Accreditation Board (and the similar bodies at the state level) should consider how these core competencies might be used to measure the performance of a health department. The National Association of County and City Health Officials' Project Public Health Ready, also known as PPHR,[14] has successfully assisted many local health departments to receive recognition for emergency preparedness and has grown to include regional and statewide systems. While PPHR criteria does not require agencies to utilize any specific set of competencies, it recommends that the competencies draw from "nationally recognized" work and, thus, the guidelines now include reference to this new model. Given the wide range of organizations that practice public health, there may be other accrediting or recognition bodies useful to nongovernmental public health practice that should also consider how to take advantage of the standard set by this core competency model to strengthen the workforce within participating member organizations.

Researchers

Finally, *researchers* studying public health education and public health systems are a critical group to begin incorporating this Preparedness Model into programs of research. Although the competencies have been developed through a well-designed research method, the implementation of training programs and the long-term impact on public health practice need to be studied. The relationship of these competencies to other emergency preparedness sets already in existence or under development needs to be explored. Another major issue is the frequency of refresher training, drills, and exercises essential to maintain proficiency. In other health-related areas, such as surgery, it has become clear that there is a level of repeat performance that makes a significantly positive difference in outcome; public health leaders must determine the level of repeat performance of these competencies that increases the likelihood that mid-level public health workers will act as desired when an emergency occurs.

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Conclusion

This discussion has provided a preliminary overview of the expected and potential impact of having a well-founded model of core competencies for public health workers, particularly those at the mid-level of practice. The model moves the field a significant step forward from prior competency sets in at least 2 ways: the model benefits from the breadth of input from both academia and practice, and the field of public health practice has advanced on the basis of the prior decade of experience with a stronger overall national emergency preparedness program.

The full impact, however, will only be realized when public health organizations have fully incorporated an expectation of emergency preparedness competency appropriate to the worker's job, years of experience, and expected emergency roles into agency policy, planning, and practice. And it cannot be done by public health alone: adequate planning to minimize the likelihood of emergencies, to strengthen the response when an emergency arises, to move smoothly into a community recovery process, and to support overall community resilience is an essential function of public health that can only be accomplished through meaningful collaboration with emergency response and other agencies at all levels of government.

Having a workforce that maintains proficiency in these core competencies brings public health to the community table prepared to assume its responsibilities as a team member. Yet, that same workforce is expected to maintain competency in many areas, some of them specific to a programmatic area; some to a population group; and some in a specific analytic or intervention skill. Given that many public health organizations seldom are called into full emergency response mode, the expectation of proficiency in even this small number of core competencies may sound like an extreme response to a current popular issue rather than an essential part of practice. The developers of the competencies understood the need for parsimony in a core competency model, and the reactions of public health workers to more specialized candidate competencies were helpful in narrowing down the candidate list to the core set. The worker proficient in these core competencies will be better able to handle other situations as well, such as those involving heightened tension, communication gaps or failures, and suddenly rearranged communication patterns. With a better-prepared workforce, the public health sector will become more competent in fulfilling community and partner organization expectations for the benefit of all. The dialogue should continue, and this newly developed core competency model should be subject to reconsideration and improvement over time.

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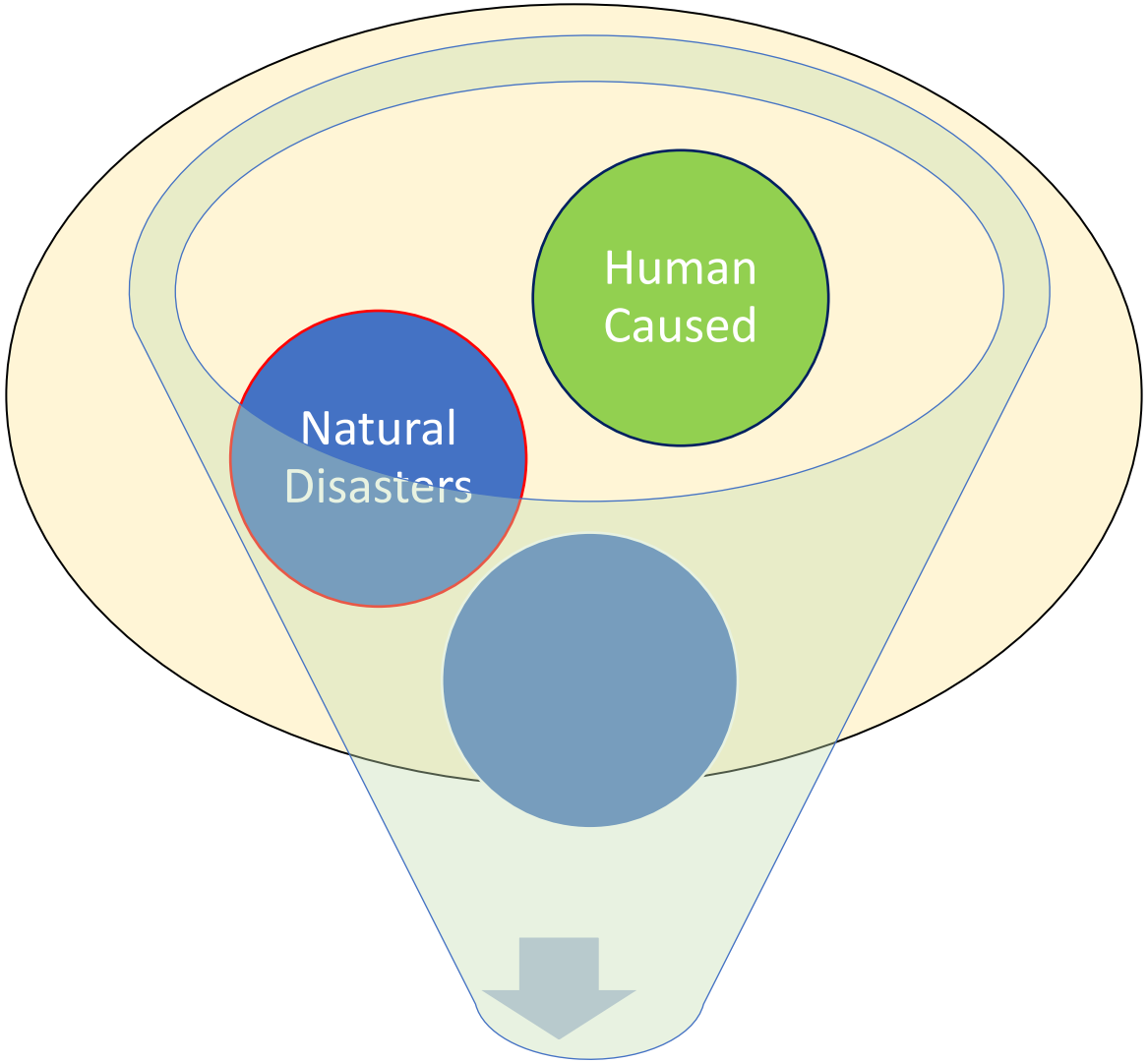
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Public Health Structure; Setting the table

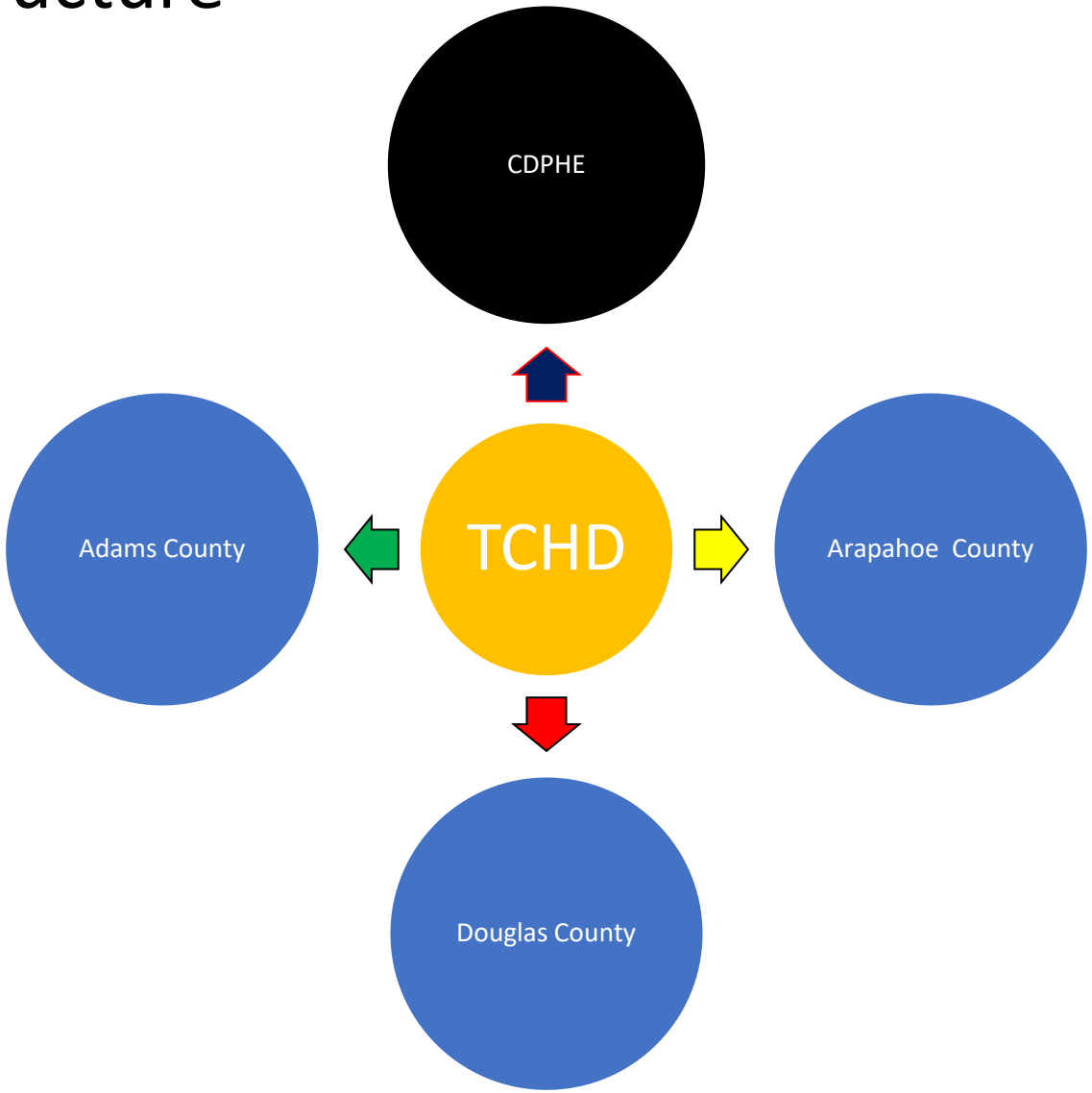
Emergency Preparedness & Response

All incidents and events either have or if they last long enough will have a Public Health relationship…

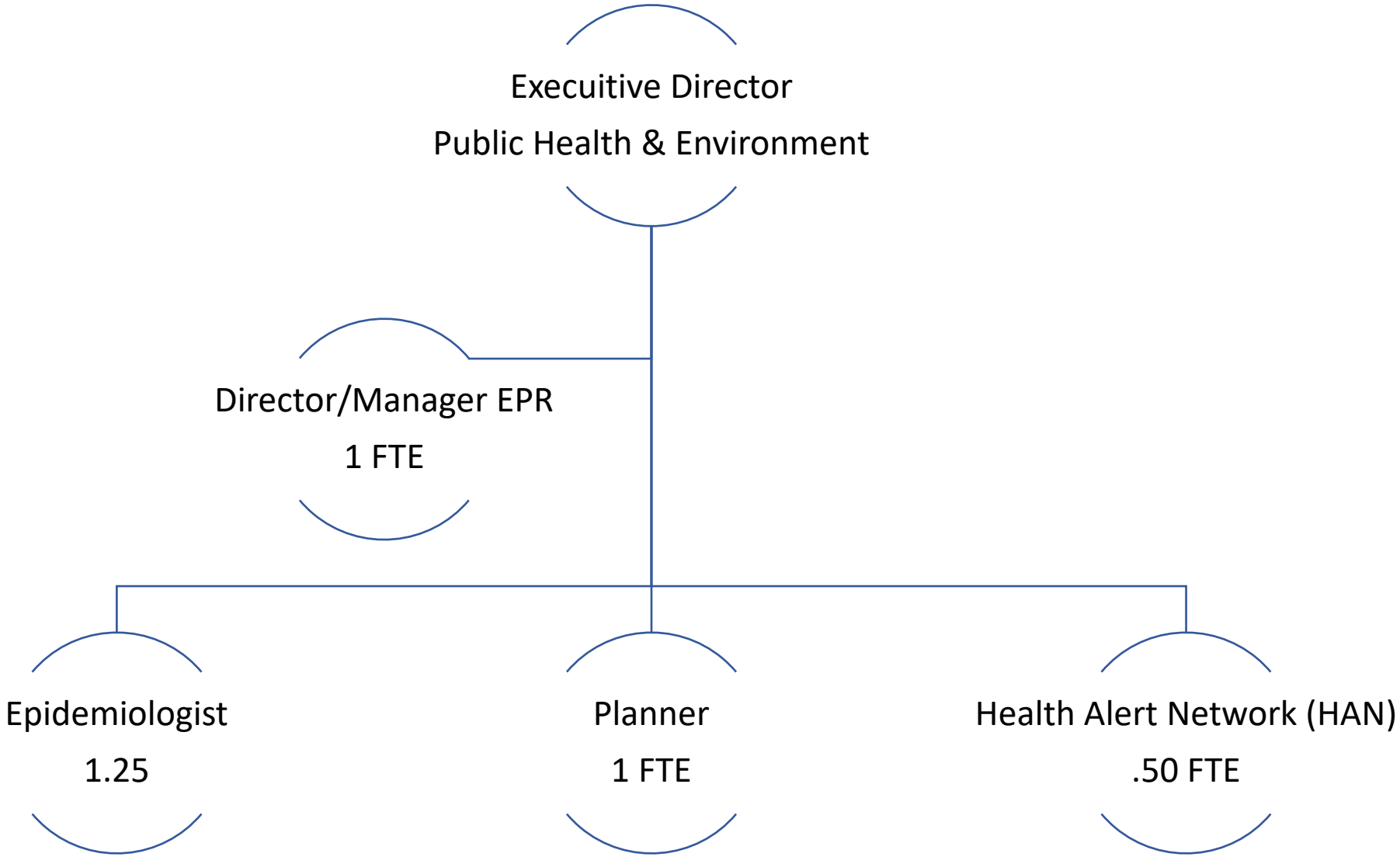


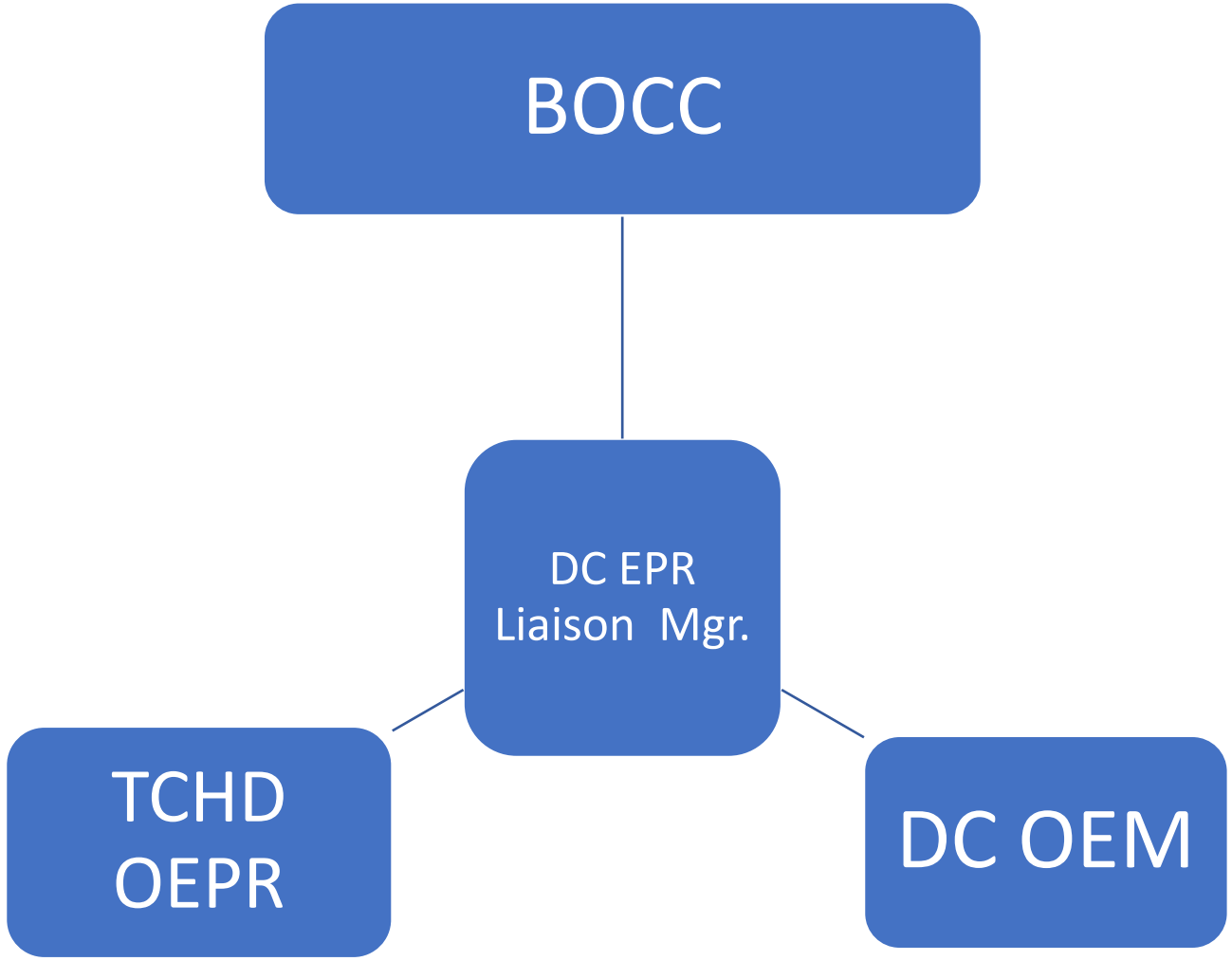
Require Elements of Public Health & Environment Action and/or Response

Current EPR structure




Douglas County EPR Program Manager
Contractor
EPI
Planning
HAN


Executive Director
Public Health & Environment
Director/Manager EPR
1 FTE
Epidemiologist
1.25
Planner
1 FTE
Health Alert Network (HAN)
.50 FTE


BOCC
DC EPR
Liaison Mgr.
TCHD
OEPR
DC OEM

2019-2024 Public Health Improvement Plan

Tri-County Health Department

Adams | Arapahoe | Douglas
Colorado



Released February 2019

Table of Contents

2 Table of Contents
3 Letter from the Executive Director
4 Executive Summary
5 Background and Introduction
6-13 Planning Process and Phases
15-34 Priorities, Goals, and Objectives
15-19 Priority Area 1: Access to Mental and Physical Health Care Services
20-24 Priority Area 2: Mental Health
25-29 Priority Area 3: Health and Food
30-34 Priority Area 4: Health and Housing (Developmental)
35 Appendix A: Community Characteristics
36 Appendix B: Asset Mapping
37 Appendix C: Goal Alignment with State & National Objectives
38 Appendix D: Outcome Measures
39 Appendix E: Acknowledgements

January 2019

Dear Residents, Partners, and Staff:

The mission of Tri-County Health Department (TCHD) is to *promote, protect and improve the lifelong health of individuals and communities in Adams, Arapahoe, and Douglas Counties through the effective use of data, evidence-based prevention strategies, leadership, advocacy, partnerships, and the promotion of health equity*. In line with our mission, the Centers for Disease Control and Prevention's Essential Public Health Services, and Colorado's Public Health Improvement Act of 2008, following our Community Health Assessment, TCHD and our community partners periodically work together create a Public Health Improvement Plan (PHIP). The purpose of the plan is to organize and coordinate a systematic effort to address the top health issues identified in the Community Health Assessment and prioritized by our partners, our community members, and our staff. While the Public Health Improvement Act requires that Local Public Health Agencies, such as TCHD, update their PHIPs every five years, the Colorado Department of Public Health and the Environment allowed us to slightly modify this timeframe and instead design a six-year plan with a review and update after three years. This timeframe allows us the flexibility to align our work with that of a key segment of our community partners – our not-for-profit hospitals – who develop Community Benefit Plans every three years.

Our 2019-2024 Public Health Improvement Plan includes three primary Priority Areas and one developmental Priority Area. These include: Access to Mental and Physical Health Care Services, Mental Health, Health and Food, and, the developmental Priority Area, Health and Housing. These four Priority Areas will influence our own work at TCHD and it is our hope that we can better support and align with our partners' work in these areas as well as influence their priorities and activities.

As encouraged by the visionary document on public health in the 21st century, Public Health 3.0, TCHD strives to play an effective role as a Chief Health Strategist for our communities, mobilizing efforts to form and strengthen strategic partnerships. We hope that by naming these issues Priority Areas, we call attention to the connection between seemingly disparate systems and population health, and that our goals and strategies are such that over the next six years we, as a community, will find that substantial progress has been made in each Priority Area. Believing that "Public Health is what we do together as a society to ensure the conditions in which everyone can be healthy,"[i] we look forward to working together with our partners and our community members on this, our 2019-2024 Public Health Improvement Plan.

Sincerely,



John M. Douglas, Jr., MD
Executive Director

[i] Public Health 3.0: A Call to Action to Create a 21st Century Public Health Infrastructure. (2016) Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services. Accessed November 16, 2016 at https://www.healthypeople.gov/sites/default/files/Public-Health-3.0-White-Paper.pdf

Executive Summary

We are excited to share the 2019-2024 Tri-County Health Department (TCHD) Public Health Improvement Plan (PHIP) for Adams, Arapahoe, and Douglas Counties. In 2018, TCHD completed a Community Health Assessment (CHA) that was the starting point for our PHIP process. The CHA highlighted twelve health issues that were identified by our partners, our community members, and TCHD staff. The CHA and the ensuing health improvement planning process led to the creation of the PHIP.

With the input of numerous community members, stakeholders, and partner organizations, TCHD staff prioritized four areas that will be the focus of our community plan over the course of the next six years. The Priority Areas are:



Priority Area 1: Access to Mental and Physical Health Care Services

Goal 1 Improve access to care through advocacy, policy development and implementation, and alignment of quality and/or performance measures

Goal 2 Improve access to care through health insurance enrollment support and health care system navigation

Goal 3 Decrease barriers to care



Priority Area 2: Mental Health

Goal 1 Improve mental and behavioral health through advocacy, policy development and implementation, and shared performance measures

Goal 2 Reduce poor health outcomes related to mental health



Priority Area 3: Health and Food

Goal 1 Increase access to safe, nutritious, affordable and culturally relevant food, especially in communities with limited resources and communities of color

Goal 2 Promote food security and healthy eating habits through messaging, education, advocacy, and policy development



Priority Area 4: Health and Housing (Developmental)

Goal 1 Improve quality of housing for TCHD population, especially for those most vulnerable in our communities.*

Goal 2 Improve access to attainable housing for TCHD population, especially for those most vulnerable in our communities.

Goal 3 Prevent displacement of TCHD populations, especially for those most vulnerable in our communities.

*The most vulnerable in our communities often include people of color, immigrants and refugees, and people with insufficient income.

This plan describes community characteristics, public health priority areas—including goals and objectives—and describes the process used to create the plan and identify these goals and objectives. Also included is a description of the next phases: implementation and evaluation. This plan will be used to encourage collaboration and alignment with partners to build healthier communities across Adams, Arapahoe, and Douglas Counties.

To the community members, community partners, and TCHD staff for their contributions to the plan and dedication to Building Healthy Communities across our jurisdiction: thank you.

Background and Introduction

In 2008, Colorado's Public Health Act was signed into law (C.R.S. 25-1-505). The purpose of the Act is to assure that core public health services are available to every person in Colorado, regardless of where they live, with a consistent standard of quality.

One of the requirements of the Act is that every five years the Colorado Department of Public Health and the Environment (CDPHE) develop a statewide Public Health Improvement Plan (PHIP). Following completion of the statewide plan, the statute directs each local health department to assess community health and local public health capacity, and use the results of the assessments to develop a five-year, local Public Health Improvement Plan that engages community partners in improving the health of their communities.

To guide the development of local plans, CDPHE created the Colorado Health Assessment and Planning System (CHAPS). CHAPS provides a standard mechanism for assisting local health departments in meeting the assessment and planning requirements of the Public Health Act of 2008 and the national Public Health Accreditation Board. CHAPS includes an eight-phase, collaborative community health assessment and public health improvement planning process, which all local health departments must complete. The phases are:

1. Plan the Process
2. Identify and Engage Stakeholders
3. Conduct a Community Health Assessment
4. Conduct a System-wide Capacity Assessment
5. Prioritize Issues
6. Develop a Local Public Health Improvement Plan
7. Implement, Promote and Monitor the Plan
8. Inform and Participate in Statewide Public Health Improvement Planning

This document discusses Tri-County Health Department's efforts in all eight Phases of the CHAPS process for the jurisdiction comprised of Adams, Arapahoe and Douglas Counties.

Jurisdiction

Tri-County Health Department (TCHD) serves over 1.5 million people in Adams, Arapahoe, and Douglas Counties, comprising 26% of Colorado's population, and offers over 60 programs and services. The region covers more than 3,000 square miles, and includes 26 municipalities, 12 hospitals, and 15 school districts. The three counties cover a wide range of geographies: urban, suburban and rural. Appendix A includes a more detailed summary of key characteristics of our communities



Colorado Health Assessment and Planning System (CHAPS) Process

The steps taken to complete the planning phases for the TCHD 2019-2024 Public Health Improvement Plan are described below. The steps outlined follow the process recommended for CDPHE's CHAPS process.

Phase 1: Plan the Process

In this phase, TCHD developed an internal planning team and designated a coordinator to lead the Public Health Improvement Planning process. The planning team created a work plan and timeline to guide subsequent phases.

Phase 2: Community Stakeholder Engagement

In Phase 2, TCHD strategically engaged community stakeholders and partners that represented diverse sectors and populations and asked them to participate in the planning process. The purpose of this phase was to identify key stakeholders and key TCHD staff, and define both of their roles in the plan as well as identify ongoing community efforts to which with this process could link and/or align. Additional community engagement methods and strategies are shared in the Phase 3-6 sections of this document.

Phase 3: Community Health Assessment

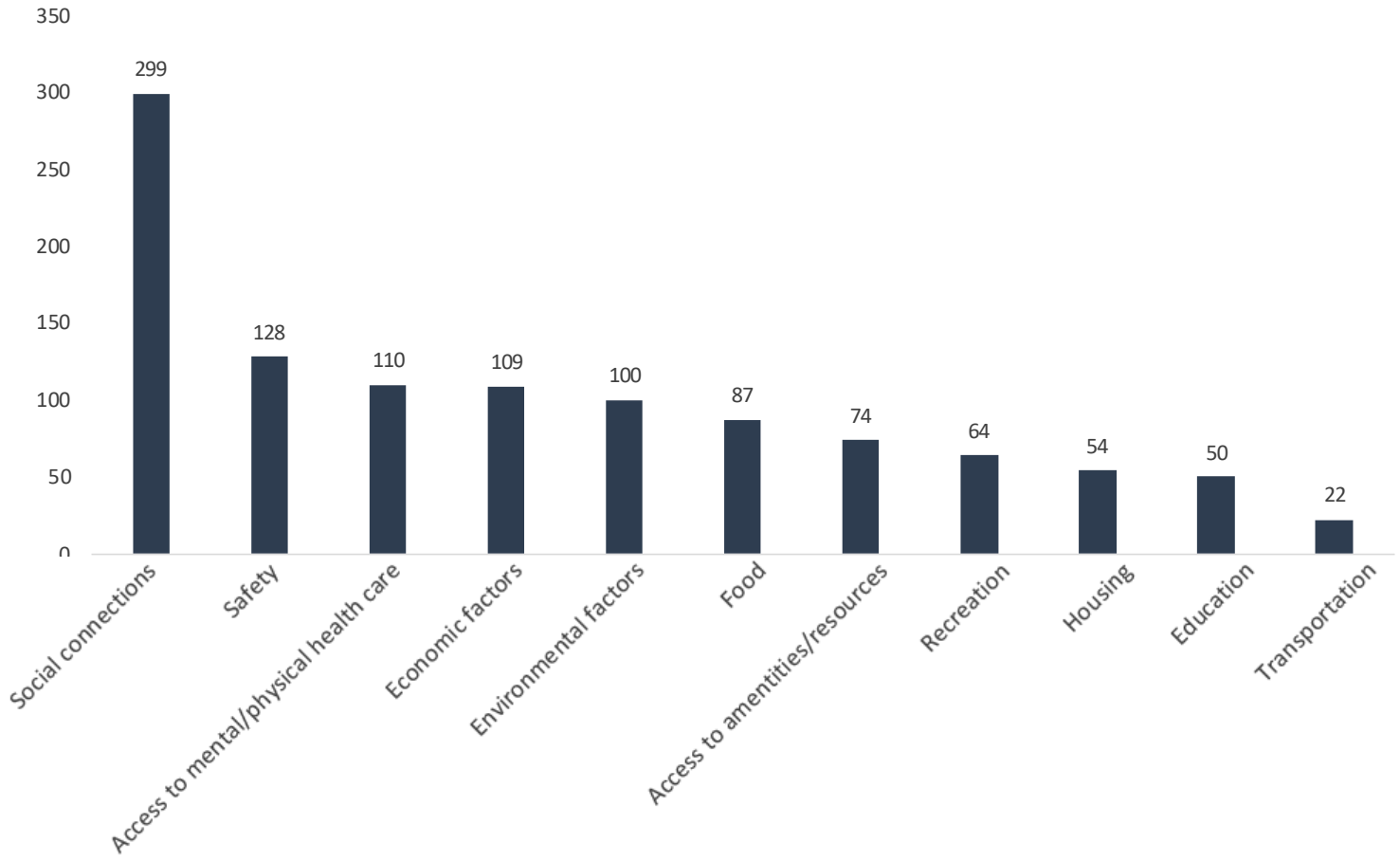
To complete the third phase, in 2018 TCHD led the development of the 2018 Community Health Assessment (CHA). The purpose of the CHA was to learn about the community: the health of the population, contributing factors to higher health risks or poorer health outcomes of identified populations, and community assets and resources that could be mobilized to improve population health.

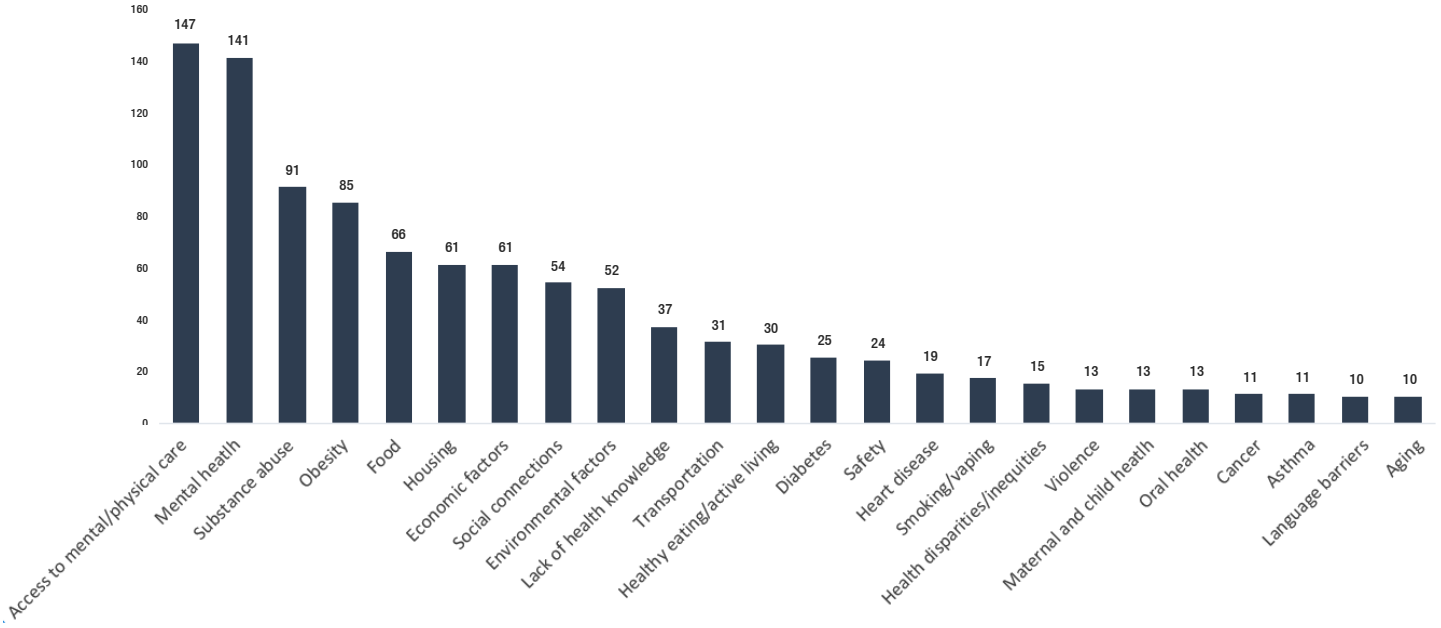
CHA PROCESS

Step 1. Previous health assessments conducted by TCHD in the recent past were reviewed in order to identify significant findings from previous years and to investigate significant changes or trends. Health needs assessments conducted by other organizations in the community were also reviewed to supplement the assessment, prevent duplication of effort, and help determine which additional community-specific data or information were needed. Colorado's Statewide Health Assessment and State Public Health Improvement Plan were also reviewed to ensure alignment with state priorities.

Step 2. In considering the scope of the assessment, the CHA team gathered input from the community as an initial step. In February 2018, 70 community members and 139 partners and stakeholders provided input into the assessment by responding to a survey which asked them to name the three most important characteristics of a happy, healthy, and thriving community (Figure 1) and the three most important health problems in their communities (Figure 2). Community members were invited to participate in the survey through an advertisement on the TCHD website, Facebook Site, Twitter, and through links disseminated by partner organizations and the Public Information Officers at Adams, Arapahoe, and Douglas Counties. In addition, nearly 200 TCHD staff also gave input by responding to the survey, for a total of 399 respondents.

Figure 1: What are the three most important characteristics of a happy, healthy, and thriving community? (N=399)

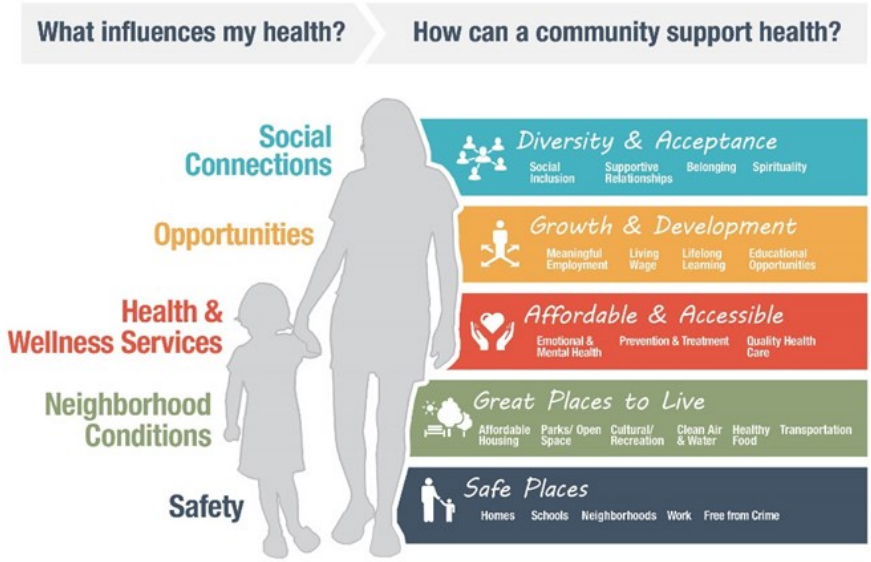




Source: Tri-County Health Department Community Input Survey, All Respondents, All Counties, 2018

Planning Process: Phase 3

Based on community input, the diagram below was developed to depict the five key components of a healthy community. The CHA was designed to reflect the status of TCHD's communities in light of this image of a healthy community. The CHA was organized into 12 chapters (listed below the diagram) and designed to provide context and data reflecting the health status of the areas covered by each.



1. Social Connections and Health
2. Health and Economic Security
3. Health and Housing
4. Health and Education
5. Health and Food
6. Health and Safety
7. Health & the Environment
8. Health Behaviors and Outcome
9. Mental Health
10. Substance Use and Health
11. Sexual & Reproductive Health
12. Access to Mental & Physical Health Care Services

Step 3. In selecting the indicators included in the assessment for each chapter, a wide range of measures were considered from a variety of sources including:

- Healthy People 2020
- The Center for Disease Control and Prevention's Winnable Battles
- America's Health Rankings
- County Health Rankings and Roadmaps
- Indicators of Health Inequalities
- Colorado Health and Environmental Assessment 2013
- Colorado Health Indicator Set
- Public Health Assessments by other local public health departments
- Other local assessments
- Citizen's Surveys from each county in TCHD's jurisdiction

Community priorities; repeated key national, state, and local indicators; and TCHD's epidemiologic analysis of key health problems facing our communities resulted in in the final list of indicators included in this report.

Primary data sources included our community and staff input surveys as well as a Youth Photo Voice Project. High school youth participating in Substance Abuse Prevention Coalitions in each of our three counties were encouraged to consider their own health and the health of their families and contributing factors, and their school, home, and community environments, and to express those thoughts through photos, original art work, poems or quotes. Their voices were used to illustrate the assessment. Secondary data sources from a range of national, state, and local surveillance systems and databases were also used. Appendix A outlines key demographic characteristics of our counties.

The Community Health Assessment included a description of the demographics of the population of the jurisdiction served by TCHD, a description of the health issues of the population and their distribution, including the existence and extent of health disparities between and among specific populations. The assessment also included a discussion of the contributing causes of the health challenges and community factors that contribute to higher health risks and poorer health outcomes of specific populations.

Step 4. After the CHA was drafted, community members and partners were asked to provide input into the preliminary findings. The draft report was posted on Tri-County's website and the link was mailed to partners and community members who had participated in the initial input survey. Over 400 people responded to the survey, and over half of these were community members (224 community residents; 64 organizational partners; 119 TCHD staff members). Based on this feedback, indicators related to older adult health and oral health were added to the assessment. The final CHA can be found here.

Phase 4: Capacity Assessment

TCHD conducted capacity assessments at several points throughout the CHAPS process. In completing the CHA (Phase 3), we inventoried assets in a range of sectors across our communities addressing the five key components of a healthy community; this inventory is included in Appendix B.

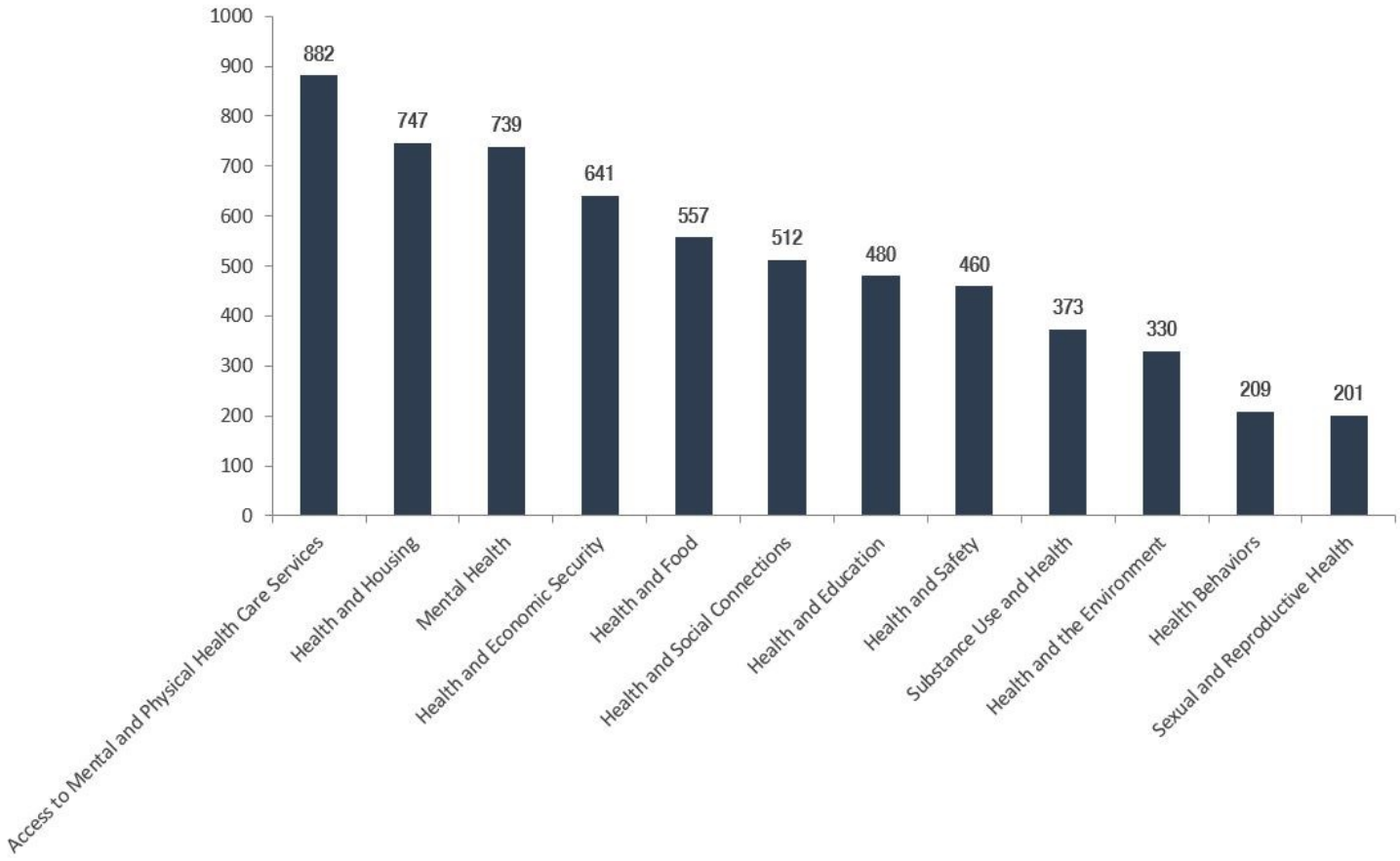
In addition, once we completed the prioritization process, we worked with key partners not only to develop goals and objectives for the priority areas of the PHIP (Phase 6), but also to identify capacity that they had to support the goals and objectives. Stakeholders were asked to provide guidance on the direction of work, role clarity, and resource gaps to gauge collective capacity in these areas. During this phase, TCHD staff collected partner feedback using a questionnaire, the process used is described in more detail in Phase 6 of this document (page 12). Thus, assessment of capacity in both phases helped to inform prioritization of issues as well as to identify resources to support the plan implementation.

Phase 5: Prioritization Process and Results

The purpose of the prioritization process and results phase was to further prioritize the 12 top issues that arose during the assessment to determine a few focus areas for the PHIP.

As noted in the Community Health Assessment (Phase 3), we started with 12 health topic areas. In June of 2018, 224 community members, 64 community partners and stakeholders, and 119 TCHD staff members provided input by responding to a survey asking them to rank in order of importance the top 5 most important health problems in their community. Total votes are presented as weighted totals: 5 points for #1, 4 points for #2, and so on (Figure 3). Community members and stakeholders were invited to participate in the survey through an advertisement on the TCHD website, Facebook Site, Twitter, and through links disseminated by partner organizations and the Public Information Officers at Adams, Arapahoe and Douglas Counties.

Figure 3: Rank the top 5 most important health problems in your community (N=420)

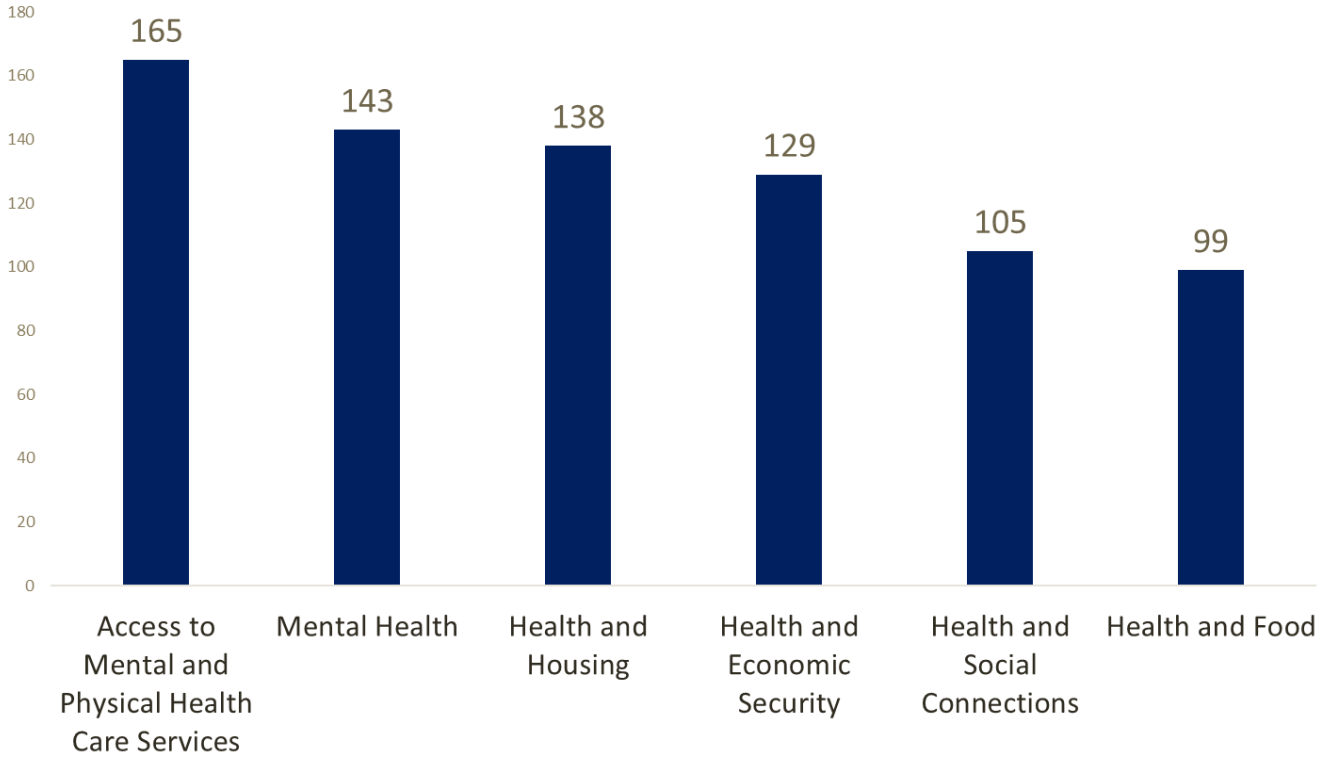


With the results of the survey tabulated, we narrowed the prioritization to the top six health topic areas of:

- Access to Mental & Physical Health Care Services
- Health and Housing
- Mental Health
- Health and Economic Security
- Health and Food
- Health and Social Connections

After the top six areas were chosen, we facilitated focused discussions with community members, partners, elected officials and TCHD staff to gather more feedback and input on the six areas. We held three community-focused discussions made up of seven community members, 21 partners, and 11 elected officials. In addition, we held a focused discussion with the Human Services staff from Adams, Arapahoe, and Douglas Counties and, lastly, we held two focused discussions with TCHD staff to help prioritize the health topic areas for the plan. At the end of each discussion, we asked participants to consider all of the information presented and discussed, and to rank the health topic areas in order of importance. The results were tabulated and the ranked order of topics is shown in Figure 4.

Figure 4: Ranked health topics in order of importance



Source: Tri-County Health Department Community Prioritization Survey, All Respondents, All Counties, 2018

Considering the results of the health topic rankings, the data from the Community Health Assessment, and the assessment of the capacity of the community and TCHD staff, TCHD decided to focus on three Priority Areas: Access to Mental and Physical Health Care Services, Mental Health, and Health and Food. TCHD recognizes the importance of Health and Housing for our communities, and although we have less experience in addressing this topic, decided to include it as a fourth "Developmental" Priority Area. During the first two years of development, TCHD will take time to review literature around affordable housing best practices, research the roles that public health agencies around the country are taking in working on affordable and healthy housing efforts, and develop relationships with community and partner organizations also working in this arena. After working with our community stakeholders and conducting internal research, we will reevaluate this Priority Area to determine whether Health and Housing will continue to stay in our plan as a more fully designated Priority Area. While economic security and social connections were recognized as priorities, we felt that we had relatively less capacity to address them as part of this plan.

Phase 6: Develop the Public Health Improvement Plan

Based on the prioritization results, TCHD and community stakeholders developed a PHIP for Adams, Arapahoe, and Douglas Counties focusing on the four Priority Areas noted above: (1) Access to Mental and Physical Health Care Services, (2) Mental Health, (3) Health and Food, and (4) Health and Housing (Developmental). Priority Area vision, goals, and objectives were created based on feedback collected from community members, community partners and stakeholders, and TCHD staff during the prioritization process. Community partners and stakeholders provided guidance on the direction of the work, role clarity, resource gaps, missing partners and work, and overall capacity (Figure 5). This feedback was collected by TCHD staff using a questionnaire that was administered in a variety of ways including: in person meetings, phone calls, email, and coalition settings. Thirty-one community partners and stakeholders were contacted through this process and their valuable feedback shaped the final goals and objectives that are included in the PHIP. A more detailed implementation plan for each Priority Area will be developed in the first half of 2019.

Figure 5: Organizational Partners Contacted during PHIP Phases 1-6, Partner Priority Areas

Organizational Partner	Access to Mental and Physical Health Care Services	Mental Health	Health and Food	Health and Housing
Adams County Human Services	X	X	X	X
Adams County	X		X	X
Aurora Health Alliance	X			
Aurora Housing Authority	X	X		
Aurora Mental Health		X		
Center for Health Progress	X	X	X	X
Colorado Department of Public Health and Environment	X	X	X	X
Clinica Family Services		X		
Colorado Access	X	X		
Colorado Children's Hospital	X	X	X	X
Colorado Department of Health Care Policy and Financing	X			
Community Reach Center	X	X		
Colorado Hospital Alliance	X	X	X	
Doctor's Care	X	X	X	
Douglas County Health Alliance	X	X		
Douglas County Housing Partnership				X
Douglas County Human Services	X			
Douglas County Schools		X		
Denver Regional Council of Governments	X	X	X	X
Early Childhood of Adams County	X	X	X	X
Enterprise Community Partners				X
Growing Home			X	
Hunger Free Colorado			X	
Innovative Housing Concepts	X	X		X
Kids First Health Care	X	X	X	
Littleton Public Schools		X		
National Alliance on Mental Illness, Arapahoe & Douglas Counties		X		
Random Acts of Kindness		X		
South Metro Housing Options		X		X
Unison Housing Partners				X
University of Colorado Department of Pediatrics	X	X	X	X

Planning Process: Phases 7-8

Phase 7: Implementation & Evaluation

Critical components of the PHIP include oversight of the plan's implementation and evaluation of its progress. The group responsible for ensuring full implementation of the PHIP is the TCHD PHIP Coordination Team. This team is comprised of one lead staff member and other key staff working in each priority area, and members of the Executive Management Team. The Coordination Team is supported by the Planning Initiatives Coordinator and two additional health planning and data staff. The Coordination Team meets once per month to review progress, share information, and problem-solve. Each priority area also has a dedicated internal work group comprised of staff at all levels of the organization (including two executive sponsors) responsible for various strategies in the plan. These work groups meet as needed.

The lead staff member for each priority area will continue to coordinate internal and external engagement to ensure plan implementation. Coordination can take different forms depending on the priority area. For instance, there is already a very strong lead agency working on Food and Health – Hunger Free Colorado – and TCHD plays a supportive role in this work. In other priority areas, such as Access to Physical and Mental Health Care Services, TCHD staff play both lead and participatory roles in convening and attending local health alliance meetings, which include a multitude of partners working in the access to mental and physical health care spaces.

A Community Advisory Group will be convened to provide continued input during plan implementation. The group will be coordinated and supported by the Planning Initiatives Coordinator and will be comprised of experts from each of the priority areas as well as community residents from our jurisdiction; the Group will meet a minimum of twice annually.

The Planning Initiatives Coordinator will provide TCHD's Executive Team and Board of Health with regular updates on the progress of the plan and will call special study sessions in the event that work groups encounter challenges, identify a resource need, or new opportunities lead to a reassessment of the goals and objectives in the plan.

Monitoring and evaluation of the plan will be accomplished through time-specific reporting of progress on the performance metrics of the plan. A public-facing performance management dashboard will be developed to display progress. The Coordination Team will review progress at each monthly meeting, address issues as they arise, and engage in performance improvement processes, as appropriate. Because the dashboard will be public facing, partners will also be able to assess progress.

TCHD has developed a target-setting method for population health outcomes that uses the past performance of the indicator (where data are available) to establish a six-year goal that will be statistically significantly different from baseline, if met. Progress will be assessed annually against the target. If the indicator is moving in the wrong direction, or at a slower pace than anticipated, study will be undertaken to explore environmental conditions as well as current activity of both TCHD and partners that may explain the indicator's behavior. Strategies can be adapted or changed in response. TCHD's lead evaluator will support program evaluation. Quality improvement activities will be implemented, as needed. TCHD's Performance Management Coordinator will support the dashboard and quality improvement work.

Phase 8: Inform and participate in the comprehensive Statewide Public Health Improvement Plan

The objective of Phase 8 is to include local perspective in statewide public health improvement planning and implementation. TCHD staff will continue to participate on the Colorado Assessment and Planning Advisory Council as well as in other opportunities, as they become available. Tri-County will submit this PHIP Report to the Colorado Department of Public Health and Environment to help inform the statewide planning efforts.

2019-2024 Public Health Improvement Plan

Tri-County Health Department



Priority Area 1: Access to Mental and Physical Health Care Services



In a healthy community, all people across the life course, regardless of their income or other circumstances, can access high quality physical health, mental health, and substance use services.

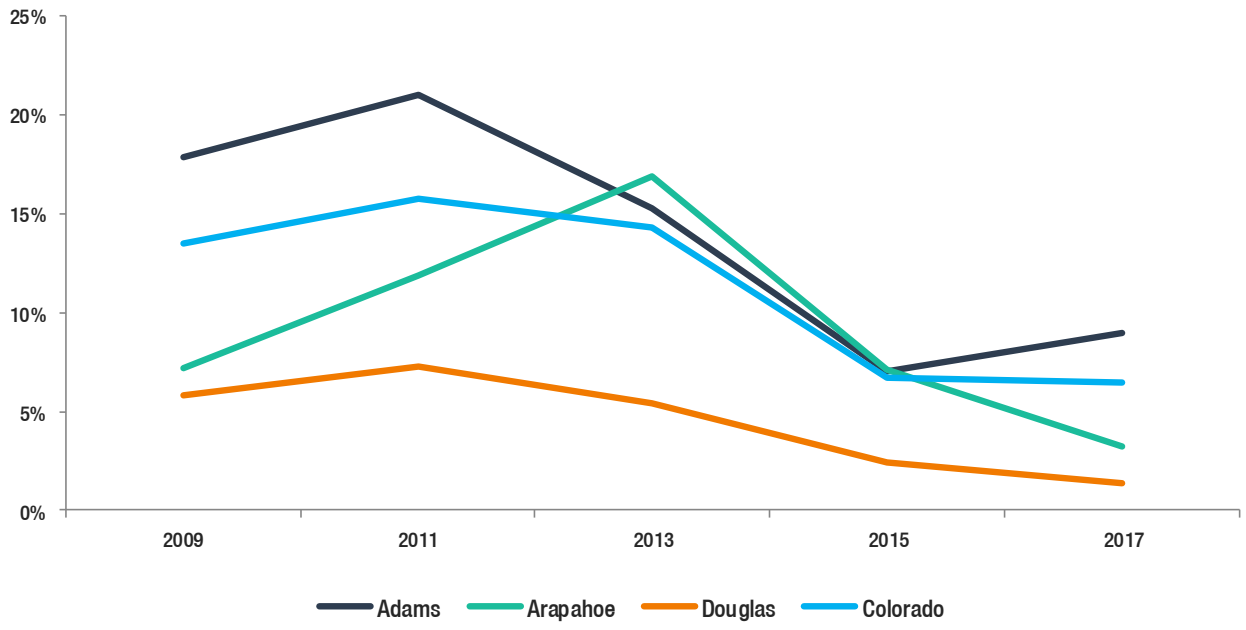
Priority Area 1: Access to Mental & Physical Health Care Services





Being able to afford the mental and physical health services needed to be healthy is one of the most important health problems identified by our community members. Lack of specialists and mental health care providers, transportation limitations, and knowledge of how to navigate the health care system are also barriers to good health. Although many factors influence health, people need access to services for prevention, management, and treatment of various health conditions and diseases in different settings. Having health insurance is the main way people pay for health services. The percentage of people without insurance in our three counties started declining after the implementation of the Affordable Care Act in 2012. However, since people without insurance tend to be sicker and die earlier than those who are insured, lack of insurance access remains an important health issue for up to 9% of our counties' residents (see Figure 1).

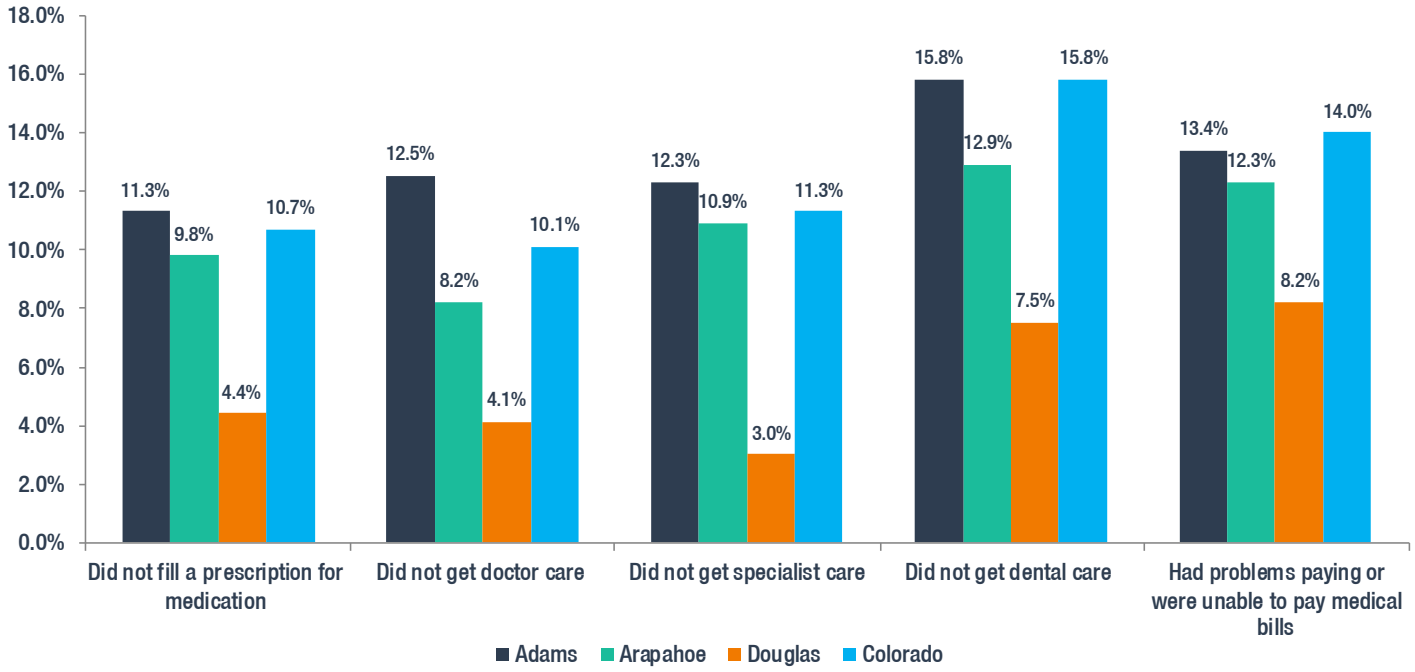
Figure 1: Percent of residents with no health insurance, 2009-2017



Source: Colorado Health Access Survey, Colorado Health Institute

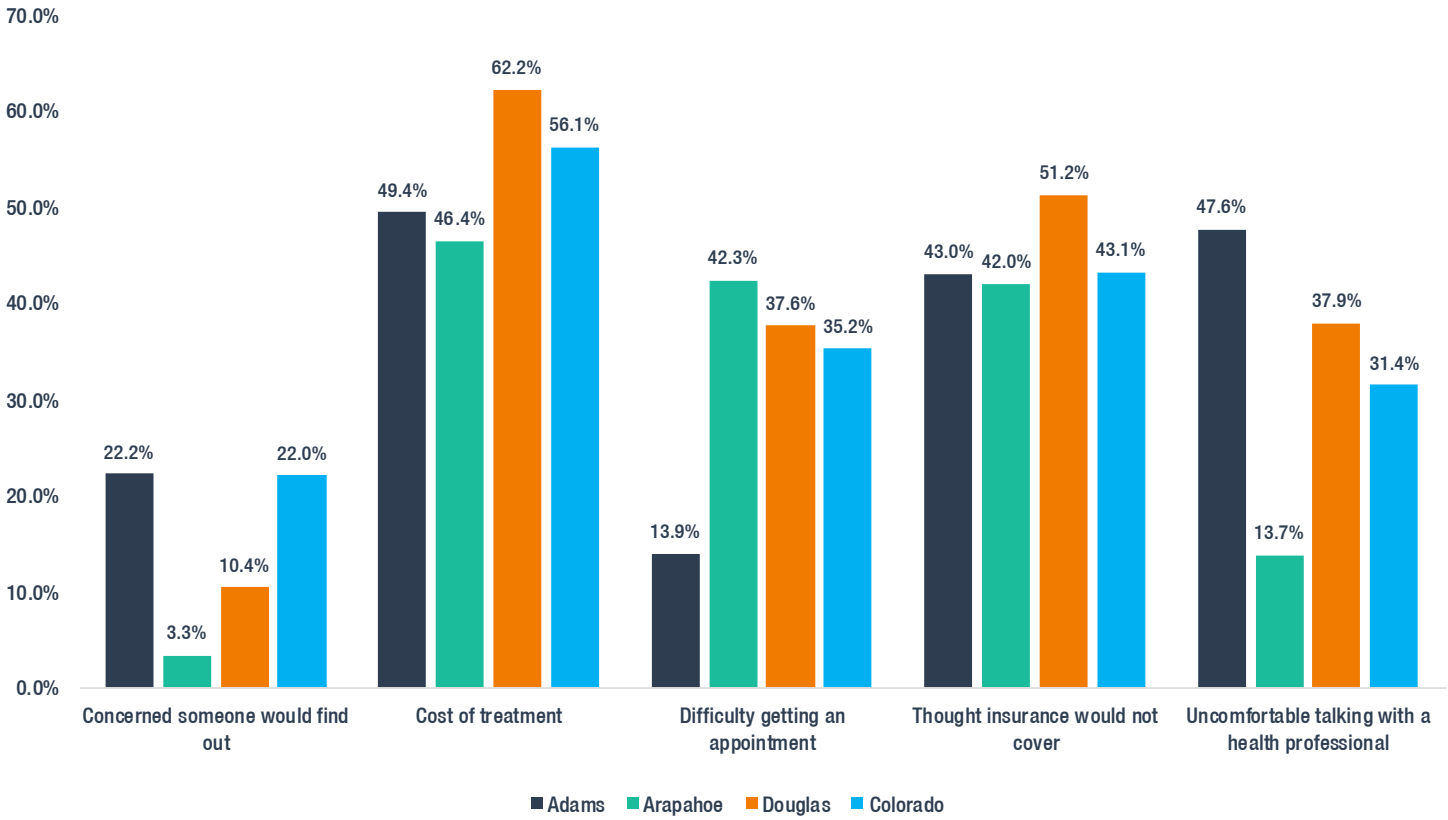
Even those with insurance coverage can struggle to pay for services. Insurance varies in the types of services included in each plan as well as in how much of those services it will cover. People may be required to purchase supplemental coverage for services, such as dentistry and vision care. In addition to the premiums (the regular payment people make to pay for their coverage), deductibles and co-pays can lead to additional, high out-of-pocket costs, which can force some people to choose between services, medications, or other basic necessities. Figure 2 represents the proportion of all people who were unable to obtain certain types of care due to cost, regardless of insurance status.

Figure 2. Percent of people unable to obtain certain types of care due to cost, regardless of insurance, 2017



Source: Colorado Health Access Survey, Colorado Health Institute

Figure 3. Reasons for not getting mental health care, ages 5+, 2017



Source: Colorado Health Access Survey, Colorado Health Institute

Priority Area 1: Access to Mental & Physical Health Care Services

People with a usual source of care – such as one health care clinic where someone goes or one provider that someone sees most regularly – have been shown to receive more preventive services and have better control of some chronic medical conditions. The vast majority of residents in our three counties report having a usual source of care (Adams 83%, Arapahoe 90%, Douglas 92%); however, many residents still do not get the care they need.[1] Access to mental health care remains a particular concern. The main reasons that people in our counties did not get the mental health they needed are related to the cost of services (even with insurance), not having insurance, and thinking one's insurance would not cover mental health services (Figure 3). This same survey found that approximately 67,000 Colorado adults also went without needed substance use disorder treatment in the past 12 months.[1]

Access to affordable, high quality mental and physical health care services is necessary to prevent, manage, and treat various health conditions. Preventive health care provides protection to those at risk, treats people who may not have symptoms but have unhealthy conditions detected through screening, and promotes positive health behaviors to keep people from developing illness, such as diabetes or heart disease (Healthy People 2020). Most mental health disorders and substance use disorders can benefit from preventive care, treatment, and support services. Affordable services help ensure that all people in our communities have the mental and physical energy, vitality, and resilience to obtain optimal health.

To improve access to care, we can work to ensure that all people in our three counties are insured with appropriate, affordable coverage; have a regular primary care provider who provides culturally competent services; are able to quickly connect to needed mental health, physical health, and substance use services; and know how to access and navigate the health care system to meet their needs.

Below are some examples of recommendations for addressing access to mental and physical health care. These recommendations, along with additional sources, were considered and explored during our planning process, and some of them are included in our priority area objectives.

Recommendations from Healthy People 2020:[2]

- Increasing and measuring insurance coverage and access to the entire care continuum (from clinical preventive services to oral health care to long-term and palliative care)
- Addressing disparities that affect access to health care (e.g., race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location)
- Assessing the capacity of the health care system to provide services for newly insured individuals
- Determining changes in health care workforce needs as new models for the delivery of primary care become more prevalent, such as the patient-centered medical home and team-based care
- Monitoring the increasing use of telehealth as an emerging method of delivering health care

[1] Colorado Health Access Survey (CHAPS), Colorado Health Institute
[2] https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

Priority Area 1: Access to Mental & Physical Health Care Services

VISION: In a healthy community, all people across the life course, regardless of their income or other circumstances, can access high quality physical health, mental health, and substance use services.

Goal 1 Improve access to care through advocacy, policy development and implementation, and alignment of quality and/or performance measures

Objective 1 Develop materials and mobilize community action for 3-5 policy and/or advocacy initiatives, annually

Objective 2 By the end of 2020, align quality and/or performance measures, and related efforts, across health systems, including the community, to increase the uptake of at least two shared and prioritized population health preventative services (e.g., well-child checks).

Goal 2 Improve access to care through health insurance enrollment support (or assistance) and health care system navigation

Objective 1 By 2020, conduct environmental scan of community and organizational communication strategies, materials, and research of health literacy.

Objective 2 By 2020, implement two, data-driven strategies to increase understanding and improve consumer navigation of the health care system.

Objective 3 By 2021, help implement a sustainable community network to provide consumer assistance that resolves consumer barriers to health insurance enrollment.

Goal 3 Decrease barriers to care

Objective 1 By 2020, help two communities establish integrated and/or co-located models offering services such as WIC, transportation assistance, insurance enrollment, mental health, and others.

Objective 2 By 2021, decrease identified barriers to care in priority populations.

Objective 3 By 2024, implement two community-based initiatives that increase screening and referral for Social Determinants of Health (SDOH).

OUTCOME MEASURES*

- Maintain or increase proportion of persons who are insured
- Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines due to cost
- Increase the proportion of people seeing their regular doctor for routine, preventative care
- Increase the proportion of children receiving well-child checks
- Increase the proportion of adults with mental health disorders who receive treatment

*Data sources are listed in Appendix D

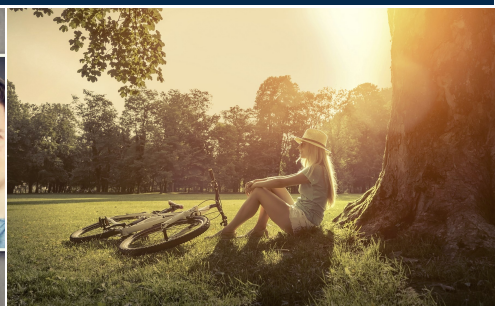
Priority Area 2: Mental Health



In a healthy community, positive mental health and social connections allow people to have the mental and physical energy, vitality, and resilience to live joyfully and cope with the stresses of life, work productively, and make meaningful contributions to their communities.

Priority Area 2: Mental Health

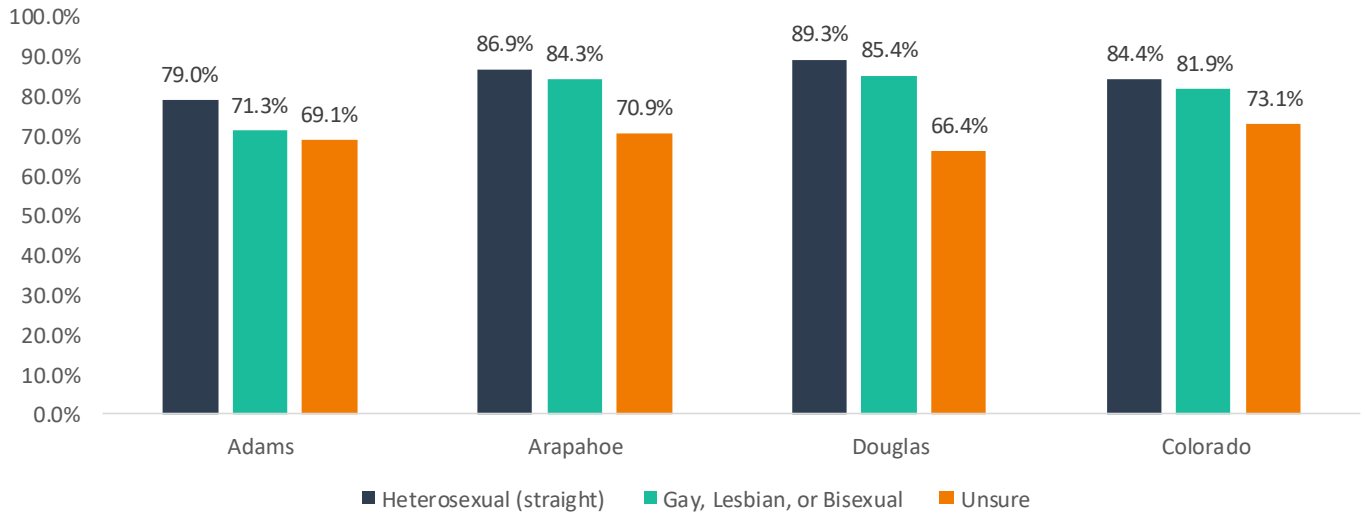




Mental health includes our emotional, psychological, and social well-being. Mental health is important at every stage of life: from infancy, childhood, adolescence, and through adulthood. It affects how we think, feel, and act. Mental health also helps determine how we handle stress, relate to others, and make choices. Good mental health is important for personal well-being, familial and other relationships, and the ability to contribute to community or society.

Good mental health is supported by positive social connection: "People who feel more connected to others have lower levels of anxiety and depression. Moreover, studies show they also have higher self-esteem, greater empathy for others, are more trusting and cooperative and, as a consequence, others are more open to trusting and cooperating with them."[1] Social connection has long been recognized as a factor that can reduce the chance that people will engage in less-healthy behaviors, such as heavy drinking, substance use, and overeating or eating unhealthy foods. Connection also reduces the risk of suicide attempt.[2] The majority of high school students in our three counties report that they do have someone to talk to when they are distressed (Figure 1); however, fewer gay, lesbian, bisexual or those unsure of their sexual orientation report having someone to talk to compared to their heterosexual peers.

Figure 1. Percentage of students who have someone to talk to when feeling sad, empty, hopeless, angry, or anxious, by sexual orientation, by county and Colorado, 2017

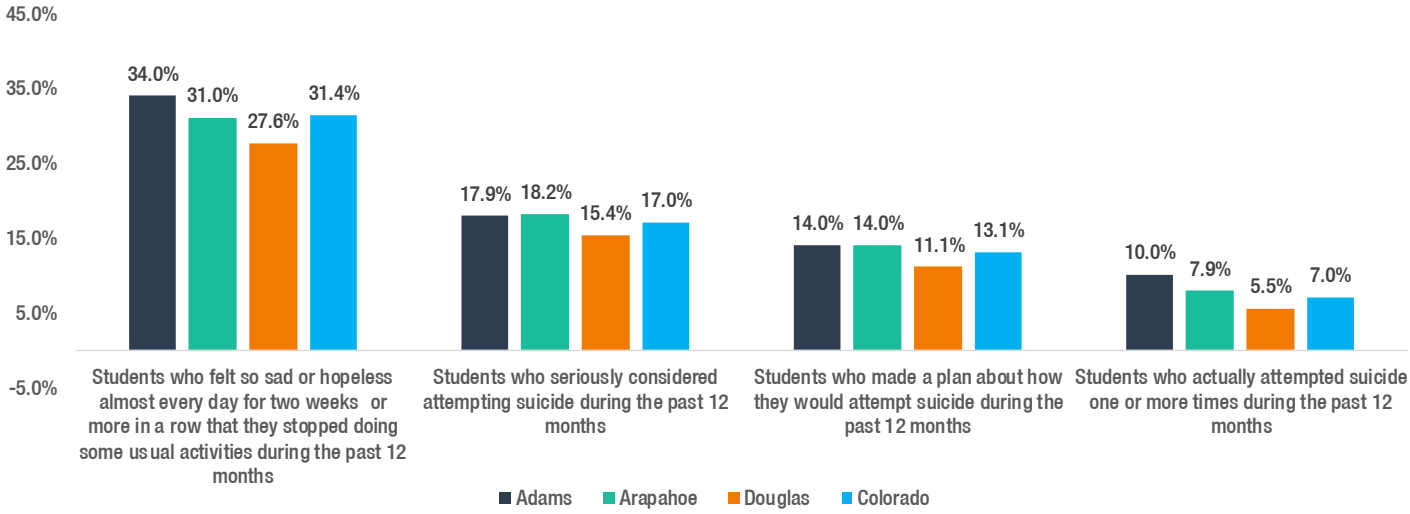


Source: Healthy Kids Colorado Survey, Colorado Department of Public Health and Environment

Mental health and social connection is important across the life course. In infancy and childhood, positive attachment to caregivers and the building of resiliency is critical for children to reach developmental and emotional milestones and learn healthy coping and social skills. Children who experience consistent stress that is not buffered by positive support from a caregiver are at higher risk for experiencing toxic stress – prolonged or permanent abnormal physiologic response to a stressor with risk of end-organ dysfunction. It is estimated that as many as 1 in 5 children in the U.S. experience a mental health disorder in a given year. In our counties, the estimated prevalence in children ages 1-14 of

social and emotional difficulties related to emotions, concentration, behavior, or getting along with others is over 10% (Adams 11.0%, Arapahoe 14.4%, and Douglas 11.8%).[3] Among high school youth, nearly one-third report being so sad or hopeless every day for two weeks that they stopped doing some of their usual activities (Figure 2). Social connection and its influence on mental health is also notable in the adult and elderly populations, although local data demonstrating these connections are limited.

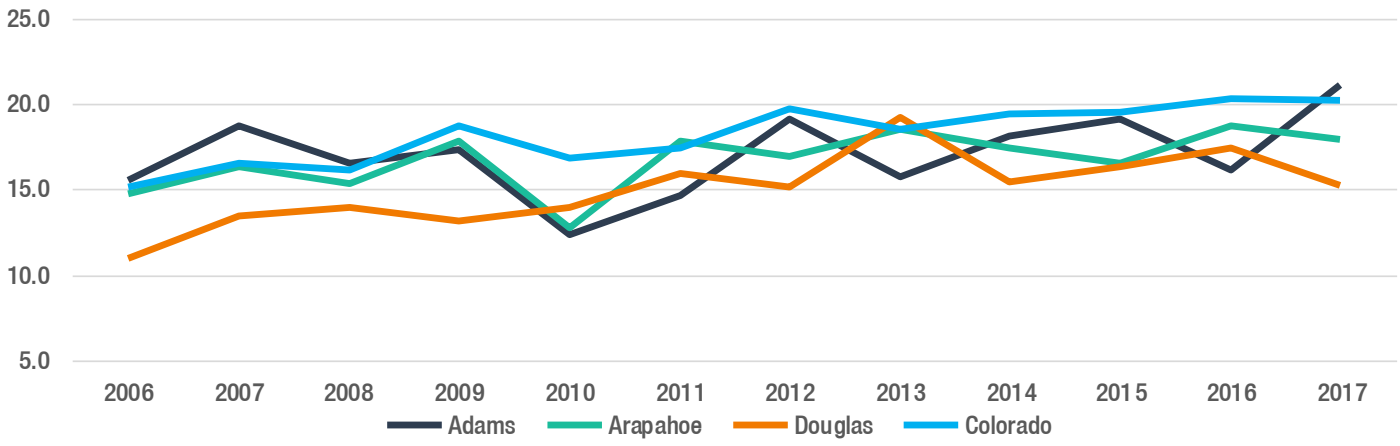
Figure 2: Mental health indicators among high school students, 2017



Source: Healthy Kids Colorado Survey, Colorado Department of Public Health and Environment

Many people experience mental health disorders: health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. According to the National Survey on Drug Use and Health, in 2016, approximately one in six U.S. adults was living with a mental disorder. Disorders can range from mild to moderate to severe and can affect anyone regardless of age, race, sex, or income. Approximately 15% of adults in the Tri-County region have an anxiety disorder. Around 7% of adults in Colorado reported current depressive symptoms as did 10% of adults in Adams County, 19% in Arapahoe County, and 2% in Douglas County.[4]

Figure 3: Suicide death rates,* 2006-2017



*Death rates are per 100,000 population and age-adjusted to the US 2000 standard population
Source: Vital Records Unit, Colorado Department of Public Health and Environment

Priority Area 2: Mental Health

Suicide is one of the most tragic consequences of untreated mental health problems. The suicide rate has increased in all three counties and Colorado over time (Figure 3). The increase has been the smallest in Adams County and the sharpest in Douglas County. Males are much more likely to die by suicide than females. Differences are also seen by race and ethnicity, with suicide rates being higher among whites than for any other racial or ethnic group. Suicide rates by age group are highest among those who are 45-64 years of age in Arapahoe County and in Colorado as a whole. They are highest among 15-24-year-olds in Adams County, and among those aged 65 and over in Douglas County. In 2016, approximately half of all suicide deaths involved a firearm.

Mental health and substance use disorders often co-occur. According to the National Institute on Drug Abuse, about half of those who experience a mental illness during their lives will also experience a substance use disorder.[5] One reason for the co-occurrence of mental health and substance abuse disorder is that they share common risk factors, including genetic vulnerability and early exposure to stress or trauma.[5]

Mental and emotional well-being and connection are essential to overall health. Positive mental health and social connection allow people to realize their full potential, cope with the stresses of life, work productively, and make meaningful contributions to their communities. Early childhood experiences have lasting, measurable consequences later in life; therefore, fostering emotional well-being and social support from the earliest stages of life helps build a foundation for overall health and well-being.

Below are some examples of recommendations for promoting good mental health. These recommendations, along with additional sources, were considered and explored during our planning process, and some of them are included in our priority area objectives.

Recommendations from the National Prevention Strategy:[6]

- Promote positive early childhood development, including positive parenting and violence-free homes.
- Facilitate social connectedness and community engagement across the lifespan.
- Provide individuals and families with the support necessary to maintain positive mental well-being.
- Promote early identification of mental health needs and access to quality services.
- Support state, tribal, local, and territorial implementation and enforcement of alcohol control policies.
- Create environments that empower young people not to drink or use other drugs.
- Identify alcohol and other drug abuse disorders early and provide brief intervention, referral, and treatment
- Reduce inappropriate access to and use of prescription drugs.

[1] http://ccare.stanford.edu/uncategorized/connectedness-health-the-science-of-social-connection-infographic/

[5] Milner, Allison, et al. "Social Connections and Suicidal Behaviour in Young Australian Adults: Evidence from a Case–Control Study of Persons Aged 18–34 Years in NSW, Australia." SSM - Population Health, vol. 1, 2015, pp. 1–7., doi:10.1016/j.ssmph.2015.09.001

[3] Child Health Survey, Colorado Department of Public Health and Environment, 2016

[4] Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment, 2014-2016

[5] https://www.drugabuse.gov/publications/research-reports/common-physical-mental-health-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness

[6] https://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf

Priority Area 2: Mental Health

VISION: In a healthy community, positive mental health and social connections allow people to have the mental and physical energy, vitality, and resilience to live joyfully and cope with the stresses of life, work productively, and make meaningful contributions to their communities. Mental health includes emotional, psychological, and social well-being, and is important at every stage of life.

Goal 1 Improve mental and behavioral health through advocacy, policy development and implementation, and shared performance measures

Objective 1 By 2020, strengths and gaps in current mental health promotion resources and initiatives will be confirmed and/or identified through the completion, analysis, and dissemination of an environmental asset scan.

Objective 2 By 2020, develop, disseminate, and evaluate appropriate and consistent framing and language for mental health promotion in areas such as stigma reduction, adverse childhood experiences (ACEs), risk and protective factors, assets, and trauma-informed care.

Objective 3 Annually, 20 schools will implement restorative justice policies and practices (such as policies that offer alternatives to school expulsions) annually through 2024.

Objective 4 Annually, policies for assessing and referring children with social-emotional needs for appropriate care will be adopted by a minimum of five early childhood centers.

Goal 2 Reduce poor health outcomes related to mental health

Objective 1 By 2019, depression and anxiety data at the census tract level will be mapped, analyzed, and shared using data from the Colorado Health Observation Data Service (CHORDS).

Objective 2 By 2022, implement a community-wide suicide prevention framework based upon evidence-based and evidence-informed strategies across the lifespan.

Objective 3 Public and private partners will continue to collaborate quarterly to reduce prescription drug misuse and overdose deaths in 2024 by 2%.

OUTCOME MEASURES*

- Increase the proportion of adolescents who report having an adult in their lives with whom they can talk about serious problems
- Increase the proportion of adolescents who report participating in extracurricular and/or out-of-school activities
- Increase the proportion of adults who report having good or better mental health
- Increase the proportion of middle and high schools that prohibit harassment based on a student's sexual orientation or gender identity
- Decrease the proportion of suicide attempts by high school students
- Decrease the adult death rate from suicide
- Decrease expulsions from kindergarten through 12th grade

*Data sources are listed in Appendix D

Priority Area 3: Health and Food



In a healthy community, all residents can access safe, nutritious, affordable and culturally relevant food and are able to practice healthy eating habits.

Priority Area 3: Health and Food

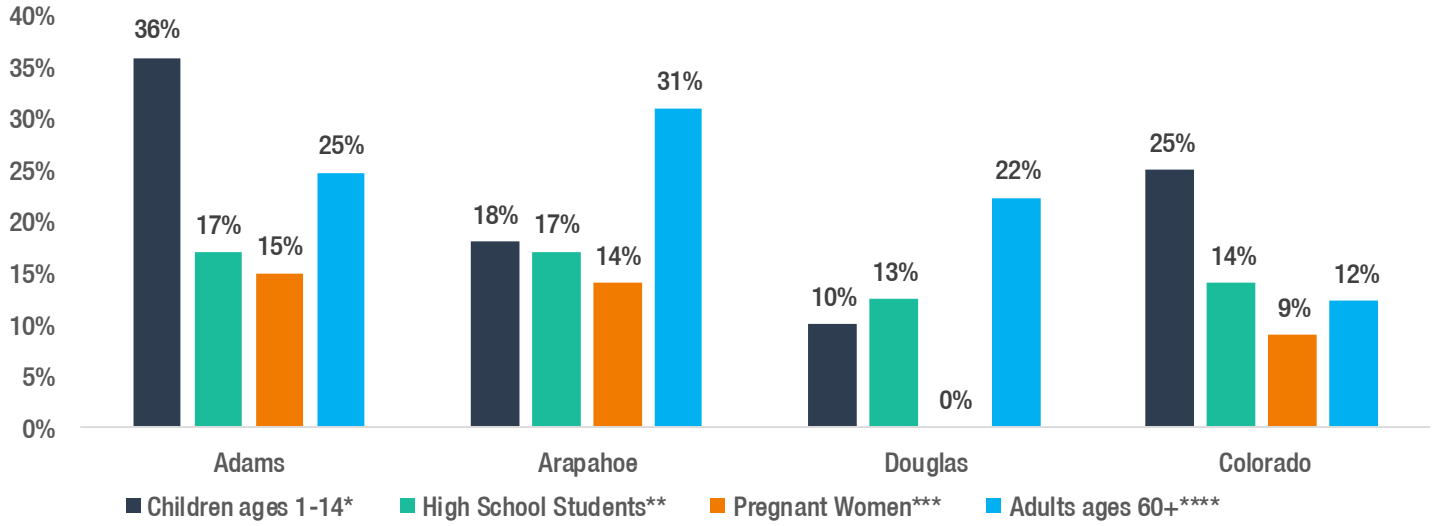




The health benefits of a nutritious diet are clear. Good nutrition helps reduce risk for many health conditions, and maintaining a healthy weight through diet and exercise can help prevent chronic diseases like diabetes, heart disease, and some cancers. A key factor in healthy eating is access to affordable, nutritious food. Food deserts are areas lacking access to fresh fruit, vegetables, and other healthy whole foods; they are often found in low-income communities due to a lack of grocery stores, farmers' markets, and healthy food providers. These areas tend to have local corner stores or gas stations that provide processed foods high in sugar and fat and very few, if any, fresh fruits and vegetables.

Food insecurity – the limited or uncertain availability of nutritionally adequate and safe foods – has been associated with poor pregnancy outcomes, including low-birth weight and gestational diabetes, as well as stress, anxiety, and depression in pregnant women.[1] Among children of all ages, food insecurity is linked with lower cognitive indicators, dysregulated behavior, and emotional distress.[2] Adults aged 60 years and older face a number of unique medical and mobility challenges that put them at a greater risk of hunger, and a range of health-related conditions. As the baby boomer generation ages, there will be an increasing number of seniors in our communities, many of whom will struggle with food insecurity. Figure 1 shows the proportion of children, adolescents, pregnant women, and older adults experiencing food insecurity in recent years.

Figure 1: Food insecurity among different groups, by county, varied years



Source: Colorado Department of Public Health and Environment

*Child Health Survey, 2016-2017 Percentage of parents of children ages 1-14 who sometimes or often relied on only a few kinds of low-cost food to feed their child because they were running out of money to buy food in the past 12 months
**Healthy Kids Colorado Survey. Arapahoe, Douglas, and Colorado 2017, Adams 2015, Percentage of 9-12 grade students who went hungry in the last 30 days sometimes/most of the time/always because of lack of food at home
***Pregnancy Risk Assessment Monitoring System, 2016, Percentage of postpartum women who ever ate less than they felt they should because there wasn't enough money to buy food during the 12 months before their new baby was born
****Behavioral Risk Factor Surveillance System, 2015, Percent who were sometimes, usually, or always worried or stressed about having enough money to buy nutritious meals

Priority Area 3: Health and Food

Two nutrition programs funded by the federal government, the Supplemental Nutrition Assistance Program (SNAP or "Food Stamps") and the Women, Infants, and Children (WIC) Supplemental Nutrition Program, provide assistance to low-income families and their children to purchase healthy foods. Unfortunately, not all those who are eligible for these benefits are enrolled in these programs. Increasing SNAP and WIC enrollment would generate local economic activity from grocery store sales and result in a high return on investment in improved health outcomes and reduced health care costs. The figures below show the percent of people enrolled in these programs out of those who are eligible.

Figure 2: SNAP enrollment, 2014-2106

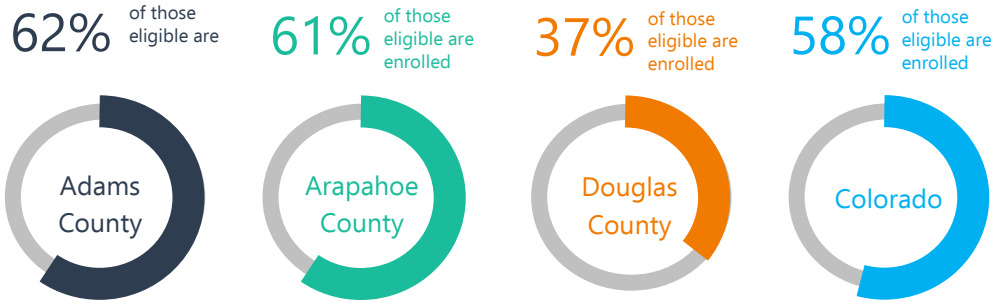
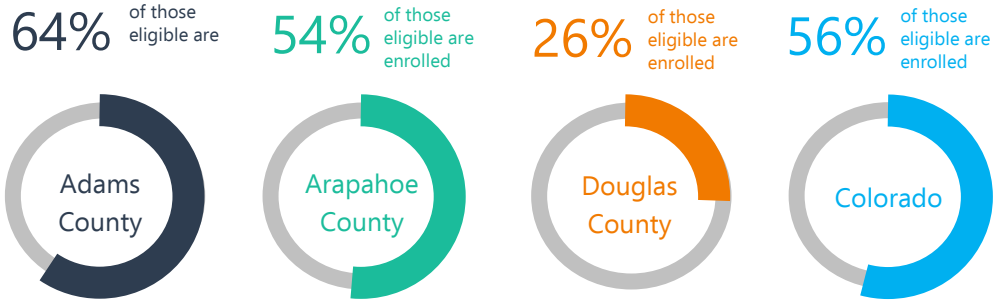


Figure 3: WIC enrollment, 2014-2106



Source: Human Services Gap Map http://gapmap.org/

Other community supports for food insecurity include the DoubleUP™ Food Bucks program, which expands the ability to purchase fruits and vegetables for SNAP participants, and food pantries. The faith community also makes meals available, and offers food pantries, in certain neighborhoods.

Healthy, abundant food is critical for the growth and development of children and the maintenance of health for those of all ages. Good nutrition helps prevent the development of chronic diseases. Increasing access to affordable, high quality, culturally appropriate food is a critical factor in building healthy communities.

Priority Area 3: Health and Food

Below are some examples of recommendations and goals for increasing access to healthy food. These recommendations, along with additional sources, were considered and explored during our planning process, and some of them are included in our priority area objectives.

Recommendations from the National Prevention Strategy:[3]

- Ensure that foods served or sold in government facilities and government-funded programs and institutions (e.g., schools, prisons, juvenile correctional facilities) meet nutrition standards consistent with the Dietary Guidelines for Americans.
- Strengthen licensing standards for early learning centers to include nutritional requirements for foods and beverages served.
- Work with hospitals, early learning centers, health care providers, and community-based organizations to implement breastfeeding policies and programs.
- Use grants, zoning regulations, and other incentives to attract full-service grocery stores, supermarkets, and farmers' markets to underserved neighborhoods, and use zoning codes and disincentives to discourage a disproportionately high availability of unhealthy foods, especially around schools.

Goals from the Colorado Blueprint to End Hunger:[4]

1. Increase public understanding and awareness that solving hunger is vital to the health and well-being of all individuals and families, the Colorado economy and every local community.
2. Increase the number of Coloradans who can access affordable, nutritious food in their communities.
3. Increase the number of Coloradans who can access food assistance and nutritious food through community-based organizations.
4. Maximize SNAP and WIC enrollment to propel Colorado to become a leading state for enrollment in these health and nutrition benefit programs.
5. Maximize participation in federal child nutrition programs, making Colorado a national leader in delivering these vital programs.



1 Ivers, L. C., & Cullen, K. A. (2011). Food insecurity: special considerations for women. The American Journal of Clinical Nutrition, 94(6), 1740S–1744S. http://doi.org/10.3945/ajcn.111.012617

2 FRAC and APP. (2017, February). Addressing Food Insecurity: A Toolkit for Pediatricians. Retrieved from Food Research and Action Center: http://frac.org/aaptoolkit

3 https://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf

4 https://www.endhungerco.org/

Priority Area 3: Health and Food

VISION: In a healthy community, all residents can access safe, nutritious, affordable and culturally relevant food and are able to practice healthy eating habits.

Goal 1 Increase access to safe, nutritious, affordable and culturally relevant food, especially in communities with limited resources and communities of color

Objective 1 By the end of 2019, and annually thereafter, develop a strategy map reflecting interrelated systems-level work, including food, housing, transportation, and employment, which identifies gaps and areas for collaboration with partners and community organizations.

Objective 2 By the end of 2020, establish criteria for complete neighborhood food environments with two neighborhoods within the Tri-County jurisdiction.

Objective 3 By the end of 2021, increase the number of medical providers and community organizations that screen for food insecurity and refer to federal nutrition programs and community-based nutrition programs by 20 medical/community organizations in the Tri-County jurisdiction.

Objective 4 Increase SNAP and WIC participation (enrollment and retention) by 3% by December 31, 2020 and 8% by December 31, 2025.

Objective 5 By the end of 2021, increase Child and Adult Care Food Program (CACFP) and Summer Meals Program (SMP) participation by 5%.

Objective 6 By the end of 2021, increase the number of food retailers that are eligible and accept SNAP and WIC benefits by 10 retailers in the Tri-County jurisdiction.

Goal 2 Promote food security and healthy eating habits through messaging, education, advocacy, and policy development

Objective 1 By the end of 2019, develop a web-based story map site to highlight data related to food insecurity, food safety and related health outcomes.

Objective 2 By the end of 2019 and annually thereafter, compile policy scans to identify state and regional opportunities for reducing food insecurity and promoting development of complete food environments.

Objective 3 By the end of 2020, develop appropriate framing and language for food access, food security, and healthy eating habits with system partners and community members.

Objective 4 By July of 2020, catalogue educational opportunities to increase healthy eating behaviors for residents focused on food skills, nutrition, and food safety.

Objective 5 By the end of 2021, establish 20 new organizational (e.g., schools, worksites) and municipal policies to promote healthy food consumption.

OUTCOMES MEASURES*

- Decrease the proportion of priority populations reporting food insecurity (Pregnant women, children ages 1-14, high school students, adults over 60)
- Decrease the proportion of those eligible but not enrolled in WIC and SNAP
- Decrease the proportion of priority populations who are overweight or obese (children ages 5-14, high school students, adults)

*Data Sources are listed in Appendix D

Priority Area 4: Health and Housing (Developmental)



In a healthy community, quality, attainable housing is available and people have the tools and resources to stay in their communities and feel connected to their neighborhood.

Tri-County Health Department | Public Health Improvement Plan

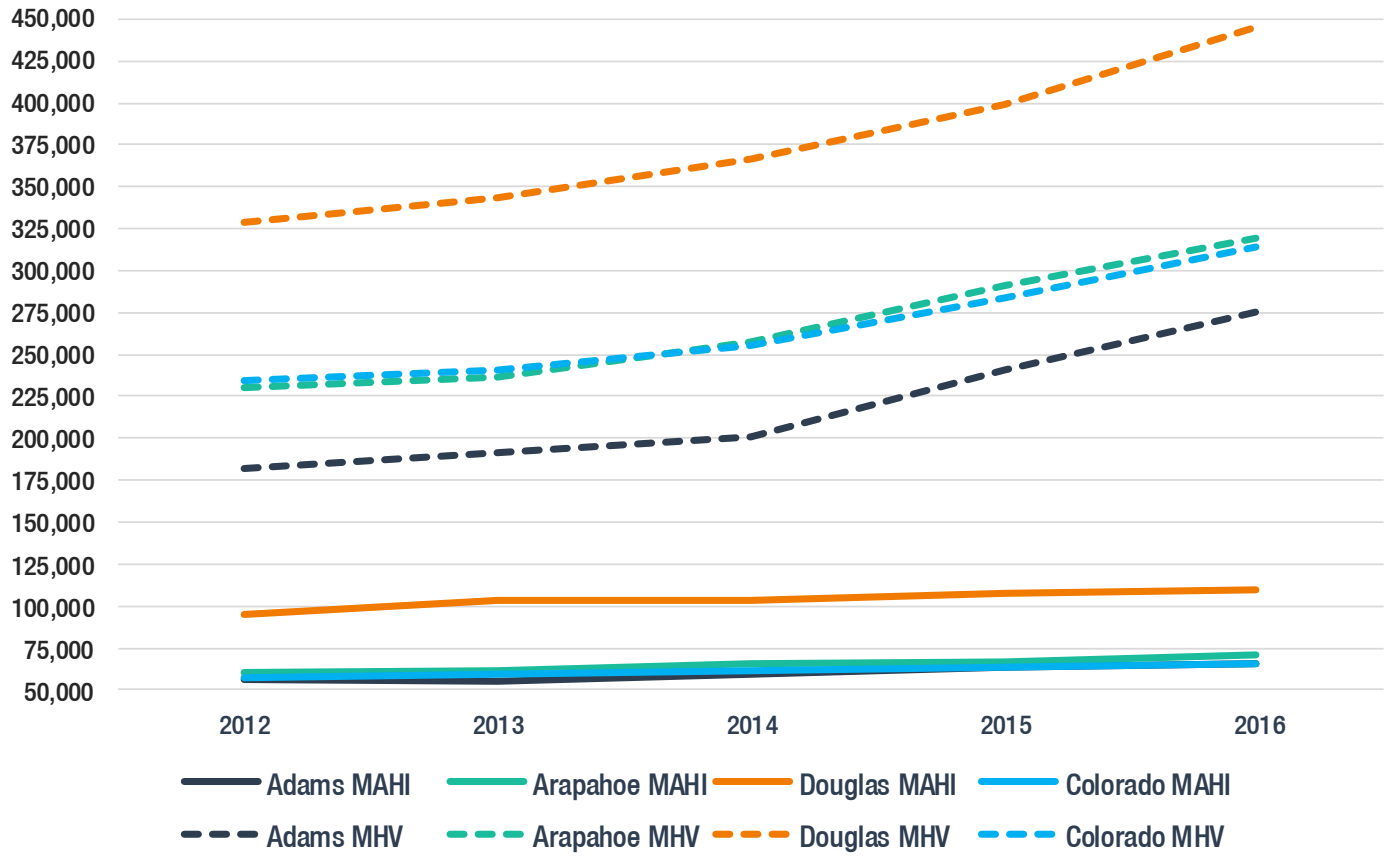
Priority Area 4: Health and Housing (Developmental)





Finding affordable housing of good quality is a significant problem facing our communities. The Denver Metro region's population has grown and wages have stagnated, resulting in a significant shortage of affordable housing. The cost of housing is outpacing the increase in wages. Between 2012 and 2016, while the median monthly household income for residents in Adams, Arapahoe, and Douglas Counties increased by 15% to 18%, the median monthly rent increased by 26% to 30% and the median home value increased between 35% and 51% (Figure 1). A standard first promoted by the United States National Housing Act of 1937, and still in use today, is that households should not spend more than 30% of their income on rent or a mortgage so enough money remains to cover non-housing-related needs. Because of high cost of living, renters in Adams, Arapahoe, and Douglas Counties are having to spend up to or more than half of their monthly income on rent.

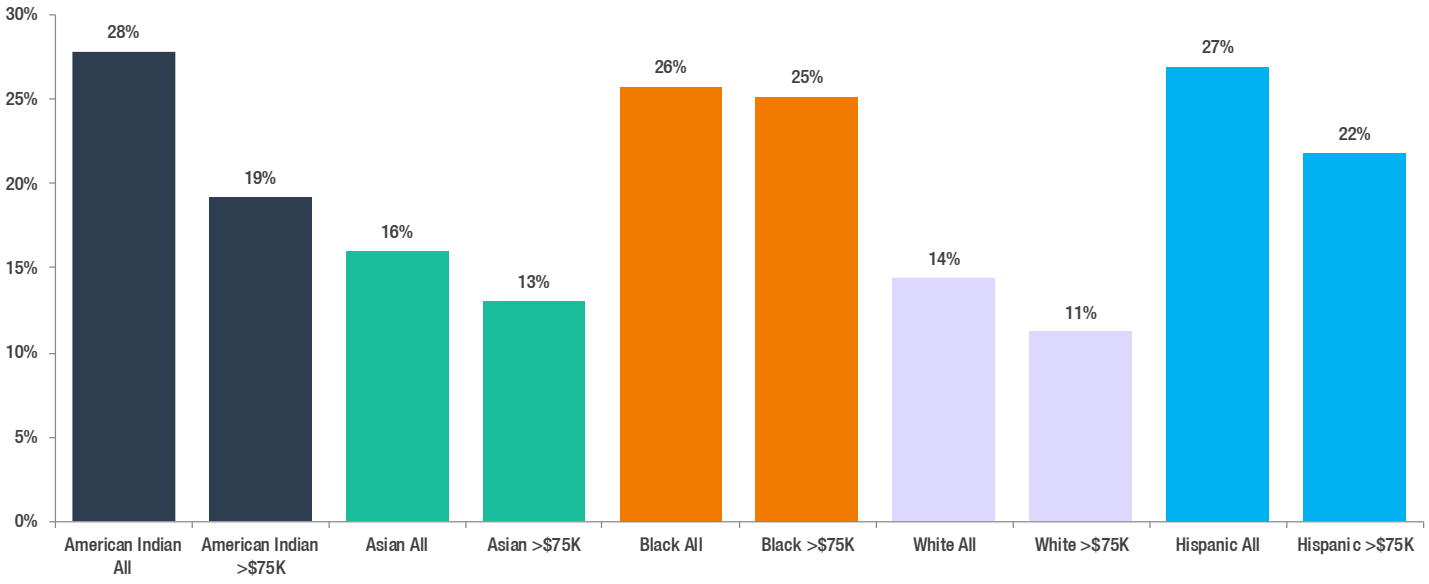
Figure 1. Trends in median home value (MHV) and median annual household income (MAHI), 2012-2016



Source: Healthy Kids Colorado Survey, Colorado Department of Public Health and Environment

These trends make it more difficult for residents both to rent as well as to buy their own homes and build equity. This can be especially true for low-income residents and communities of color who also experience a higher prevalence of substandard housing. In urban areas, this can be a result of redlining (a practice where banks refused to grant home loans in certain neighborhoods based on racial or ethnic composition) which was allowed by the Federal Housing Administration until the 1960's. Neighborhoods of color were systematically denied access to government-backed home mortgages. This and other policies affecting economic and educational opportunity had generational impacts on economic prosperity, which continue to this day (see Figure 2). Compounding this problem, in times of economic growth, these neighborhoods tend to be more vulnerable to displacement, as they have higher proportions of renters and lower net-worth, making them prime areas for redevelopment.

Figure 2. Percent of home loan applications denied by race, ethnicity, and income, Colorado, 2004-2013



Source: Colorado Department of Local Affairs, 2015-2019 State of Colorado Final Report Analysis of Impediments to Fair Housing Choice

Poor housing conditions are associated with a wide range of health conditions, including respiratory infections, asthma, lead poisoning, injuries, and poor mental health. The quality of housing includes structural soundness, handicap accessibility, and indoor air quality, among other characteristics. Housing can be a source of exposure to various carcinogenic air pollutants. Radon, a colorless, odorless radioactive gas that forms naturally in soil, is the second leading cause of lung cancer in the United States. In our counties, 54-55% of homes tested for radon between 2011 and 2015 had radon levels about the recommended limit. Radon mitigation is available, although often expensive, and programs to assist low-income persons are underutilized.

Where we live is directly connected to our health and safety. Without adequate housing, people cannot manage their daily lives. For most people, housing is their greatest monthly expense. Quality, affordable housing is central to individual and community well-being. We can reduce the burden of housing costs by working with municipalities and local governments to prioritize mixed-income housing units. In addition to housing policy, multiplicities can also take steps to ensure inclusionary zoning policies and the creation of auxiliary dwelling units, help ensure that all people earn

a livable wage, and reduce the costs of other basic needs, such as utility costs and high quality food. Improving affordable housing availability and quality housing conditions can improve the health of people in our communities.

Below are some examples of recommendations for increasing quality, affordable housing. These recommendations, along with additional sources, were considered and explored during our planning process, and some of them are included in our priority area objectives.

Recommendations from the Robert Wood Johnson Foundation:[1]

- Sustaining and expanding Healthy Homes initiatives at the federal, state and local levels, including public-private collaborative programs.
- Providing support for high utilities costs through the Low Income Home Energy Assistance Program and similar programs that assist households with unaffordable heating, cooling, and electricity bills.
- Strengthening enforcement of fair housing laws, including the Fair Housing Act and other state and local regulations prohibiting racial discrimination in housing markets.
- Exploring private initiatives, such as Habitat for Humanity, to create affordable, healthy housing.
- Continuing federal involvement in lending and fairness standards for banking and loan institutions, and improving banking and lending procedures to create equal opportunities for credit.

[1] https://www.rwjf.org/en/library/research/2011/05/housing-and-health.html





Priority Area 4: Health and Housing (Developmental)

VISION: In a healthy community, quality, attainable housing is available and people have the tools and resources to stay in their communities and feel connected to their neighborhood.

Goal 1 Improve quality of housing for TCHD population, especially for those most vulnerable in our communities (people of color, immigrants and refugees, and people with low income).

Objective 1 By the end of 2019, conduct an internal scan of current activities related to healthy housing at TCHD.

Objective 2 By the end of 2020, perform an external scan of best practices for improving healthy/quality housing.

Objective 3 By the end of 2020, conduct an external scan of partner activities around healthy housing.

Objective 4 By the end of 2020, provide recommendations on TCHD capacity and alignment of resources to implement healthy housing work and opportunities.

Goal 2 Improve access to attainable housing for TCHD population, especially for those most vulnerable in our communities.

Objective 1 By the end of 2020, engage homeless initiative and affordable housing partners to understand their goals around housing issues to determine TCHD's role.

Objective 2 By the end of 2020, conduct an internal scan of current activities related to affordable housing at TCHD and consult partners to understand framing and language around housing.

Goal 3 Prevent displacement of TCHD population, especially for those most vulnerable in our communities.

Objective 1 By the end of 2020, conduct an internal scan of current activities related to population displacement at TCHD.

Objective 2 By the end of 2020, determine TCHD's role to support current efforts to prevent displacement.

Objective 3 By the end of 2020, develop a strategy map reflecting the intersection of system level work including food, housing, transportation, and employment that identifies areas for collaboration and gaps.

Objective 4 By the end of 2020, catalogue local and state policy changes that could impact displacement and be able to articulate health impacts of policy changes and what, if any, partners are working on them.

OUTCOMES MEASURES*

- Decrease the proportion of households with severe problems (households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities)
- Decrease the proportion of all households (owner and renter) that spend more than 30% of income on housing; decrease disparity by race/ethnicity
- Decrease the proportion of all renter households under 200% of poverty that spend more than 30% of income on housing
- Decrease the number of homeless people
- Decrease the racial and ethnic disparities in the proportion of home application loans denied

*Data sources are listed in Appendix D

Community Characteristics

The demographic characteristics of the population are important in understanding the health risks and challenges as well as the strengths and opportunities of the community. Characteristics such as age, income, education, and household composition are likewise associated with health risk and protective factors and, therefore, health outcomes.

Community Characteristics

	Colorado	Adams	Arapahoe	Douglas
Population				
Population 2017 Estimate	5,609,445	503,375	643,257	335,635
Projected Population 2030	6,892,192	658,864	779,282	413,161
Race/Ethnicity				
White Non-Hispanic	68%	50%	60%	82%
Hispanic	22%	40%	19%	9%
African-American	4%	3%	11%	1%
Asian	3%	4%	6%	5%
Age				
0-17	23%	27%	24%	27%
18-64	64%	63%	64%	62%
65+	14%	10%	13%	11%
Income				
Median Household Income	$69,117	$66,517	$75,357	$111,482
Individuals Living at or Below Poverty	10%	10%	8%	4%
Children Living at or Below Poverty	12%	14%	8%	3%
Unemployment	4%	4%	4%	3%
Households				
Single Parent Households	27%	31%	28%	17%
Residents Age 65 or Older Living Alone (of households with one member 65+)	37%	30%	35%	28%
Educational Attainment				
Less than High School	8%	16%	8%	2%
High School (Diploma or Equivalent)	21%	30%	21%	12%
Bachelor's Degree or Higher	41%	23%	44%	59%

Sources: US Census, American Community Survey 5-Year Estimates 2018, Colorado Dept. of Local Affairs, July 2017 Estimates, 2030 Population Forecast

Appendix B

Asset Inventory

An asset is a useful or valuable thing, person or quality. Assets improve quality of life. Individuals, communities and institutions all have assets that contribute to quality of life. In keeping with the feedback we received from community members, partners, and TCHD staff regarding the components of a healthy community, these assets are similarly organized. This is not an exhaustive list, but provided a starting point for understanding the strengths of our communities.

Social Connections

- Arts organizations
- Boys and Girls Clubs
- Citizen's Advisory Boards
- Community gardens
- Community markets
- Community newsletters/newspapers
- Community parks and public spaces
- Counseling and support programs
- County fair grounds
- Family Resource Centers
- Farmers Markets
- Girls on the Run and other after school clubs
- GLBT Community Center of Colorado
- Indoor/outdoor malls and public spaces
- Leadership groups
- Libraries
- Local "Meet up" events
- Local community events and festivals
- Neighbors and Next Door
- Places of worship
- Recreation centers, including yoga and meditation centers
- School playgrounds
- Social & Resource Centers

Opportunities

Economic Resources

- AmeriCorps/VISTA/Service Corp programs
- Chambers of Commerce
- City Governments
- County Human Services
- Economic development organizations
- Faith-based organizations
- Legal Assistance
- Low-income Energy Assistance Program (LEAP)
- Major employers

Educational Resources

- Adult education classes
- CERT Programs
- Colleges and Universities
- Colorado Child Care Assistance Program (CCAP)
- Community Colleges
- Community-centered boards
- Early Childhood Councils
- English as a second language classes
- Graduate Equivalency Diploma programs
- Head Start

Health and Wellness Services

- 12-Step Organizations (AA, NA, etc.)
- Ambulatory Surgical Centers
- Colorado Access
- Colorado Crisis Services
- Colorado Quit Line
- Community Health Centers
- Community Mental Health Centers
- Community Recreation Centers
- Community-based safety-net clinics
- Counselors and therapists
- Dialysis Centers
- Domestic violence organizations and shelters
- Health Clubs
- Hospitals
- Kids In Need of Dentistry (KIND)
- Local health alliances
- Parks and hiking trails

Neighborhood Conditions

- 211
- City Planning Departments
- Community gardens
- Community recreation centers
- Community-based organizations
- Denver Regional Council of Governments (DRCOG)
- Emergency housing organizations
- Foodbanks and food pantries
- Habitat for Humanity
- Housing Authorities
- Local businesses
- Local non-profit organizations
- Meals on Wheels/Congregate Meals Program
- OneHome
- Parks and Recreations Departments, open spaces and trails
- Regional Transportation District (RTD)
- Resettlement agencies and refugee/

Safety

- 911
- Colorado State Patrol
- County Sheriff's Departments
- Emergency Management
- Fire Rescue Services
- Health Department Emergency Preparedness and Response
- Local Police Departments
- Medical Reserve Corps
- Neighborhood Watch Programs

Appendix C

Goal Alignment with State & National Objectives

A review of Colorado Department of Public Health and Environment and Healthy People 2020 objectives identified areas of alignment in the following areas.

Tri-County Health Department Goals	State of Colorado Goals	Healthy People 2020 National Goals
Improve **access to care** through advocacy, policy development and implementation, and alignment of quality and/or performance measures. Improve **access to care** through health insurance enrollment and health care system navigation. Decrease **barriers to care.**	Align state and local public health with health care reform efforts to **increase access to and utilization of health care** and related services for all Coloradans.	Improve **access to comprehensive, quality health care services.**
Improve **mental and behavioral health** through advocacy, policy development and implementation, and shared performance measures Reduce poor health outcomes related to **mental health.**	Advance policy and community approaches to improve the **social and emotional health** of mothers, fathers, caregivers and children.	Improve **mental health** through prevention and by ensuring access to appropriate, quality mental health services.
Increase **access to safe, nutritious, affordable and culturally relevant food**, especially in communities with limited resources and communities of color. **Promote food security and healthy eating habits** through messaging, education, advocacy, and policy development.	Reverse the upward obesity trend by aligning and intensifying efforts to develop a culture of health and **creating conditions for Coloradans to achieve healthy weight** across the lifespan.	Promote health and reduce chronic disease risk through the **consumption of healthful diets** and achievement and maintenance of healthy body weights.
Improve quality of housing for TCHD population, especially for those most vulnerable in our communities. Improve access to **attainable housing** for TCHD population, especially for those most vulnerable in our communities. **Prevent displacement** of TCHD population, especially for those most vulnerable in our communities.		Create **social and physical environments** that promote good health for all.

Sources: Healthy People 2020 National Goals, https://www.healthypeople.gov/2020/topics-objectives
Colorado's Plan for Improving Public Health and the Environment, https://www.colorado.gov/pacific/sites/default/files/OPP_2015-CO-State-Plan.pdf

Appendix D

Outcome Measures

The table below outlines the population health outcome measures that will be used to track Priority Area progress, as discussed in the Implementation and Evaluation section.

OUTCOME MEASURES	DATA SOURCE
Access to Mental and Physical Health Care Services	
Maintain or increase proportion of persons who are insured	Colorado Health Access Survey, Colorado Health Institute
Reduce the proportion of persons who are unable to obtain or delay necessary medical care, dental care, or prescription medicines due to cost	Colorado Health Access Survey, Colorado Health Institute
Increase the proportion of people seeing their regular doctor for routine, preventative care	Colorado Health Access Survey, Colorado Health Institute
Increase the proportion of children receiving well-child checks	Child Health Survey, Colorado Dept. of Public Health and Environment (CDPHE)
Increase the proportion of adults with mental health disorders who receive treatment	Behavioral Risk Factor Surveillance System (BRFSS), CDPHE
Mental Health	
Increase the proportion of adolescents who report having an adult in their lives with whom they can talk about serious problems	Healthy Kids Colorado Survey, CDPHE
Increase the proportion of adolescents who report participating in extracurricular and/or out-of-school activities	Healthy Kids Colorado Survey, CDPHE
Increase the proportion of adults who report having good or better mental health	BRFSS, CDPHE
Increase the proportion of middle and high schools that prohibit harassment based on a student's sexual orientation or gender identity	TCHD Program Data
Decrease the proportion of suicide attempts by high school students	Healthy Kids Colorado Survey, CDPHE
Decrease the adult death rate from suicide	Vital Statistics Program, CDPHE
Decrease prescription drug misuse and drug overdose deaths	Vital Statistics Program, CDPHE, Colorado Hospital Association
Decrease expulsions from kindergarten through 12th grade	Colorado Dept. of Education
Health and Food	
Decrease the proportion of priority populations reporting food Insecurity (Pregnant women, children ages 1-14, high school students, adults over 60)	Pregnancy Risk Assessment Monitoring System; Child Health Survey; Healthy Kids Colorado Survey; BRFSS, CDPHE
Decrease the proportion of those eligible but not enrolled in WIC and SNAP	Human Services Gap Map
Decrease the proportion of priority populations who are overweight or obese (children ages 5-14, high school students, adults)	Child Health Survey; Healthy Kids Colorado Survey; BRFSS, CDPHE
Health and Housing	
Decrease the proportion of households with severe problems (households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities)	American Community Survey, US Census Bureau
Decrease the proportion of all households (owner and renter) that spend more than 30% of income on housing; decrease disparity by race/ethnicity	American Community Survey, US Census Bureau
Decrease the proportion of all renter households under 200% of poverty that spend more than 30% of income on housing	American Community Survey, US Census Bureau
Decrease the number of homeless people	Point in Time Survey, Metropolitan Denver Homeless Initiative
Decrease the racial and ethnic disparities in the proportion of home application loans denied	2015-2019 State of Colorado analysis of impediments to fair housing choice, Colorado Dept. of Local Affairs

Appendix E

Acknowledgements

The development of Tri-County Health Department's Public Health Improvement Plan was a collaborative effort. We would like to thank the nearly 300 residents of Adams, Arapahoe and Douglas Counties for their input into the 2019-2024 Public Health Improvement Plan. We would also like to thank the following community partners for their contributions to the plan and dedication to Building Healthy Communities:

Adams 12 Five Star Schools
Adams County Criminal Justice Coordinating Council
Adams County
Adams County Human Services
Amazing Grace Community Church
Arapahoe County Sheriff
Aurora Health Access
Aurora Health Alliance
Aurora Housing Authority
Aurora Mental Health Center
Aurora Public Schools
Byers School District 32J
Castle Rock Fire Dept.
Central Colorado Area Health Education Center
Center for Health Progress
Centura Health
Cherry Creek Schools
Children's Hospital Colorado
City of Aurora
City of Centennial
City of Federal Heights
City of Greenwood Village
City of Littleton
City of Lone Tree
City of Northglenn
City of Sheridan
City of Thornton
City of Westminster
Clinica Family Services
Colorado Access
Colorado Advisory Council for People with Disabilities
Colorado Children's Immunization Coalition
Colorado Department of Health Care Policy and Financing
Colorado Department of Public Health and Environment
Colorado Hospital Alliance
Community Reach Center
Denver Regional Council of Governments
Developmental Pathways
Doctor's Care
Douglas County
Douglas County Early Childhood Council
Douglas County Health Alliance
Douglas County Housing Partnership
Douglas County Human Services
Douglas County Schools
Early Childhood Partnership of Adams County
Enterprise Community Partners
Hunger Free Colorado
Integrated Nutrition Education Program
Innovative Housing Concepts
Kids First Health Care
Littleton Public Schools
LiveWell Colorado
Mapleton Public Schools
Mental Health Colorado
Metro Community Provider Network
National Alliance on Mental Illness
Random Acts of Kindness
Regis University
Rising Star Early Learning Center
Romantix, Inc.
SCL Health
South Metro Fire Rescue
South Metro Housing Options
Telligen
Unison Housing Partners
University of Colorado at Denver
University of Colorado Dept. of Pediatrics
University of Colorado School of Medicine
University of Northern Colorado
YMCA


Tri-County
Health Department
Adams, Arapahoe and Douglas Counties, Colorado

Dear Board of Health and TCHD staff:

The vision of Tri-County Health Department (TCHD) is optimal health across the lifespan for the populations we serve. Our mission is to promote, protect and improve the lifelong health of individuals and communities in Adams, Arapahoe, and Douglas Counties through the effective use of data, evidence-based prevention strategies, leadership, advocacy, partnerships, and the promotion of health equity. This Strategic Plan has been developed to ensure we are better able to achieve our vision and mission.

Strategic planning is a process for defining and determining an organization's roles, priorities, and direction. A strategic plan sets forth what an organization plans to achieve, how it will achieve it and how it will know if it has achieved it. The strategic plan provides a guide for making decisions about allocating resources and taking action to pursue strategies and priorities. A health department's strategic plan focuses on the entire health department (Public Health Accreditation Board Standards and Measures).

Our Strategic Plan serves as a tool to help the department promote health in Adams, Arapahoe, and Douglas Counties by setting the foundation to drive organizational improvement. This strategic planning document serves as a road-map for TCHD for the next six years, and is supplemented by the Community Health Assessment, the Public Health Improvement Plan, and the Public Health Accreditation Board's Standards and Measures version 1.5 for public health accreditation.

Priority selection was based on the principle that the Strategic Plan should support TCHD in continuing its longstanding trajectory of excellence by combining continued high performance in current programs that support core public health functions with efforts to address new strategic priorities relevant to the changing landscape of public health. The four Priority Areas of focus are:

1. Employee Retention and Development
2. Excellence in Business Practices
3. Strengthen Organizational Culture
4. Partner for Healthy Communities

We are excited about the potential of this Strategic Plan to guide our leadership, bring together and advance our talented workforce, and better align Tri-County with the efforts of a growing array of key community partners.

Sincerely,



John M. Douglas, Jr., MD
Executive Director

Table of Contents

1	Letter from the Executive Director
2	Table of Contents
3	Executive Summary
4	Tri-County Health Department History, Governance and Background
5-15	Strategic Planning Process - Phase 1
5	Overview
6-7	Summary of 15 Contemporary Reports and Assessments
7-8	Staff Focus Groups
8-10	All-Staff Surveys
10-12	External Key Informant Interviews
12	Leadership Retreats
12-13	Board of Health Retreat
13	Financial Sustainability
13-14	Structure of Strategic Plan
14	Strategic Plan Priority Area Development
15-25	Strategic Priorities and Goals
	Priority Areas
	Goals
	Strategies
	Action Steps
	Measurement & Milestones
	Cross References to other TCHD work
26	Strategic Plan Phase 2- Implementation
27-29	Appendix A - Acknowledgements
30	Appendix B - All Staff Survey
31	Appendix C - Key Informant Questions
32-33	Appendix D - Role Matrix
34-35	Appendix E - Strategic Plan Work Plan Development Guide: Phase I

Executive Summary

Tri-County Health Department initiated planning for a new, six-year Strategic Plan in January 2019. TCHD staff in coordination with the TCHD Board of Health (BOH) and partners combined efforts to create the plan. The Strategic Plan is the culmination of seven months of activities to determine where TCHD will focus its attention over the next six years to reinforce its mission and advance the agency vision. This work builds off of our previous TCHD Strategic Plan, our 2018 Community Health Assessment, and our 2019-2024 Public Health Improvement Plan.

Vision: Optimal health across the lifespan for the populations we serve.

Mission: Promote, protect and improve the lifelong health of individuals and communities in Adams, Arapahoe and Douglas Counties through the effective use of data, evidence-based prevention strategies, leadership, advocacy, and partnerships, and the promotion of health equity.

The Strategic Plan process was informed by TCHD staff surveys, staff focus groups, leadership retreats, Board of Health retreat, summaries of previous internal and external reports and assessments, and key informant interviews with external partners. The combination of these data and discussions led to the selection of four Priority Areas: Employee Retention and Development, Excellence in Business Practices, Strengthen Organizational Culture, and Partner for Healthy Communities. The below goals were identified within each priority area:

Priority Area 1: Employee Retention and Development
Goal A - Address competitive pay and benefits
Goal B - Promote professional and leadership development
Goal C - Assess workload and balance across agency

Priority Area 2: Excellence in Business Practices
Goal A - Enhance technology and information systems
Goal B - Standardize and enforce policies and procedures
Goal C - Cultivate a culture of change management and quality improvement

Priority Area 3-Strengthen Organizational Culture
Goal A - Improve trust and transparency
Goal B - Improve staff collaboration and internal communication

Priority Area 4: Partner for Healthy Communities
Goal A - Increase policy and advocacy work
Goal B - Prioritize health equity and meaningful community engagement

The 2019-2024 Strategic Plan has great potential to strengthen TCHD as an organization and to enhance its impact in our communities. Maximizing the effect of the Plan will require careful attention to implementation, resource allocation, monitoring, and evaluation by TCHD leadership and staff over the next six years.

Tri-County Health Department History, Governance and Background

Tri-County Health Department (TCHD) serves over 1.5 million people in Adams, Arapahoe and Douglas Counties, and offers over 60 programs and services from 11 offices in this 3,000-square-mile area. Programs and services are diverse and range from birth certificates, immunizations, and health care referrals to restaurant inspections and infectious disease investigations. The agency's jurisdiction includes 26 municipalities and three unincorporated counties, 15 school districts with more than 360 public schools, 12 acute care hospitals, three Federally Qualified Health Centers with multiple facilities, three community mental health service providers, and one Regional Accountable Entity (Colorado Access). TCHD also provides limited nutrition, nursing, disease control and emergency preparedness and response services to Elbert County under contract with the Colorado Department of Public Health and Environment (CDPHE).

TCHD currently provides a full range of traditional public health services as well as a variety of innovative services to the diverse communities it serves. Public health efforts target those preventable conditions yielding the greatest public health benefits. Much of the work of public health agencies is population-based—that is, it focuses on improving the health of the entire community.

TCHD is governed by a Board of Health consisting of three members from each of the three counties the agency serves; each member is appointed by his/her County Commissioners. The key functions of the BOH include the following:

- Makes the final decision on policies concerning personnel, budget, and external communications
- Provides guidance and support on agency strategic planning, general policies for enforcing public health laws, orders, rules and regulations
- Serves in an advisory capacity to the public health director on all matters pertaining to public health
- Approves the Department budget and programs

In 2008, the Colorado Public Health Act specifically designated public health functions for health departments in Colorado, and subsequent resolutions from each of our three Boards of County Commissioners designated TCHD as their local public health agency (LPHA) and re-authorized the Department as it is today. More recently, in April 2019, the Colorado State Board of Health passed a new rule and updated framework for Core Public Health Services. This rule requires each LPHA to deliver or assure that core public health services are provided to the community, and it also requires LPHAs to complete a Public Health Improvement Planning process every five years. This rule contains some key definitions that guide TCHD activities.

• Core Public Health definition - BOH Rule: "… shall include but need not be limited to, the assessment of health status and health risks, the development of policies to protect and promote health, and the assurance of provision of the essential public health services."

4. Partnerships
5. Organizational Competencies
6. Emergency Preparedness and Support
7. Health Equity and Social Determinants of Health

B. Foundational Services
    1. Communicable Disease Prevention, Investigation and Control
    2. Environmental Public Health
    3. Maternal, Child, Adolescent and Family Health
    4. Chronic Disease, Injury Prevention and Behavioral Health Promotion
    5. Access to and Linkage with Health Care

Strategic Planning Process

Overview

In January 2019, TCHD staff, in coordination with the TCHD BOH, initiated a strategic planning process. TCHD initiated the process for several reasons: to align the organization around a shared vision of a local public health agency in rapidly changing local, state, and national environments; to align TCHD staff, leadership, and BOH efforts around priorities and strategies to accomplish that vision; and, to align the organization with Public Health Accreditation Board re-accreditation efforts. The Plan is intended to help TCHD heighten its excellence in carrying out core public health functions and as well as emerging health priorities over the next six years.

In addition to the Colorado Board of Health Rules, the Community Health Assessment, and the Public Health Improvement Plan, there are a number of additional factors that influence the plans and activities of local health agencies in Colorado. They include statutory mandates, Colorado Health and Environmental Assessment, other Local Public Health Agency plans, US Centers for Disease Control and Prevention (CDC) Winnable Battles, CDPHE Health Improvement Priorities, Public Health Accreditation Board accreditation requirements, and state and federal funding organizations' guidance and regulations.

Identification of External Factors that May Impact Community Health

External trends, events, and other factors impacting the health of our communities and the work of our department was extensively addressed through our recent 2018 Community Health Assessment (CHA) which detailed issues of importance for our communities, ranging from key social determinants of health to specific areas of health outcomes. This external assessment in turn guided the development of our new 2019-2024 Public Health Improvement Plan (PHIP) which focuses on four Priority Areas: Access to Mental and Physical Health Care Services, Mental Health, Health and Food, and Health and Housing. It was our intent to design a Strategic Plan that would consider these external factors and synergize with our PHIP.

Process

A strategic planning team from the Planning and Information Management (PIM) Division was selected to guide the TCHD planning process. The planning team summarized previous internal and external reports and assessments, conducted staff focus groups, surveyed staff, and assisted in the facilitation of internal Board of Health and TCHD Leadership retreats. A facilitator was also hired to conduct external Key Informant Interviews and facilitate internal Board of Health and TCHD Leadership retreats.

Summary of reports and assessments (January 2019)

An analysis of 15 internal and external contemporary reports and assessments was completed in January of 2019. These reports and assessments included partner and staff input from a variety of sources over the past five years.

Partner Input

- Regional Health Connector Alignment Assessment (2016)
- Local Government Work Group Qualitative Research Results (2017)
- Strategic Plans from Partnering LPHA's (2017-2019)
- TCHD Tobacco-Focused Community Profiles (2019)

Staff Input

- Questionnaire Responses and Policy & Partnership Opportunities (2015)
- TCHD Workforce Development Plan (2016)
- Prior Strategic Plan performance reports to Board of Health (2018)
- Internal Communications Research (2018)
- Public Health Workforce Interests and Needs Survey (PH WINS) (2018)
- All Staff Meeting feedback on organizational strengths and weaknesses (2018)
- TCHD Performance Management Key Performance Indicators (2018)
- TCHD Informatics Needs Assessment (2018)
- WIC Annual evaluation (2018)
- TCHD Health Equity Strategic Plan (2018-2020)
- Best Practices for Public Health Community Engagement in Advisory Groups (2019)

Identified Themes:

- Communication
- Community Engagement
- Employee Satisfaction
- Health Equity
- Informatics
- Partnerships
- Quality Improvement
- Workforce satisfaction

Staff Focus Groups

To gain more real-time staff input for the TCHD 2019-2024 Strategic Plan, the Office of Human Resources generated a list of all current employees employed at least six months. Forty-five staff members were randomly selected to attend one of three focus groups in early February. Forty-three (96%) staff responded to the invitation and participated. Each focus group was led by a member of the PIM planning team and another staff member acted as scribe. Participants were also given a sheet of

paper to record anonymous comments which they turned in at the end. Each focus group lasted an hour and a half.

Focus group questions were:

1. What needs to be in place at TCHD so you can do the best job you can do?
    a. If these things exist, are there barriers to getting what you need?
    b. Of these things, what are the most critical that you do not currently have?

2. The Community Health Assessment identified the top health needs of our communities as: mental health, social connection, economic security, housing, food insecurity, and access to physical and mental health care services.
    a. How does your work contribute to meeting these community needs?
    b. How well is the agency positioned to meet the needs of our community members?

3. People, places, and things are always changing. What changes do you anticipate happening that TCHD should be aware of and plan for?

One PIM team member analyzed the focus group data and identified common themes across the three focus group and two PIM staff members coded the responses according to these themes.

Identified Themes:

- Staff Training and Education
- Resources
- Technology
- Structure
- Communication
- Pay and Benefits
- Policy and Practice
- Creativity and Innovation
- Planning
- Authority/Decision-Making
- Customer Service
- Fairness
- Safety

Work Group Focus Groups

As an additional input for the new TCHD Strategic Plan, five focus groups were held with existing work groups within TCHD that meet regularly, deal with cross cutting issues, and are currently active. These work groups were the Public Health Improvement Plan Coordination Team, the Work Force Development work group, the Informatics Governance Group, the Health Equity work group, and the Local Government work group. A total of 75 staff were represented by these groups.

The questions asked were:

1. How well is the agency positioned to address the needs and goals identified by [this] work group? What are the barriers? What needs to be in place?

2. The Community Health Assessment identified the top needs of our communities as: mental health, social connection, economic security, housing, food insecurity, and access to physical and mental health care services. How do you see the work of [this workgroup] connecting to these areas?

The following categories were identified as common themes and then used to identify issues from each work group.

- Staff Training and Education
- Resources
- Technology
- Structure
- Communication
- Pay and Benefits
- Policy and Practice
- Creativity and Innovation
- Planning
- Authority/Decision-Making

All-Staff Surveys

To capture a broader range of staff input, in February of 2019, all staff members of TCHD were requested to participate in an electronic survey (Appendix B) developed to capture agency feedback on current TCHD values in their work unit as well as across the agency, identifying areas for agency improvement, and prioritizing agency areas of improvement. Responses were received from 214 (54%) of the approximately 400 full- and part-time staff of TCHD. This information was summarized and shared with the Board of Health and TCHD leadership teams in the development of the priority areas and goals. The graphs below depict the results of the staff prioritization survey.

Figure 1. Percent of staff who feel these values are practiced often or always, 2019 Staff Survey, n=214

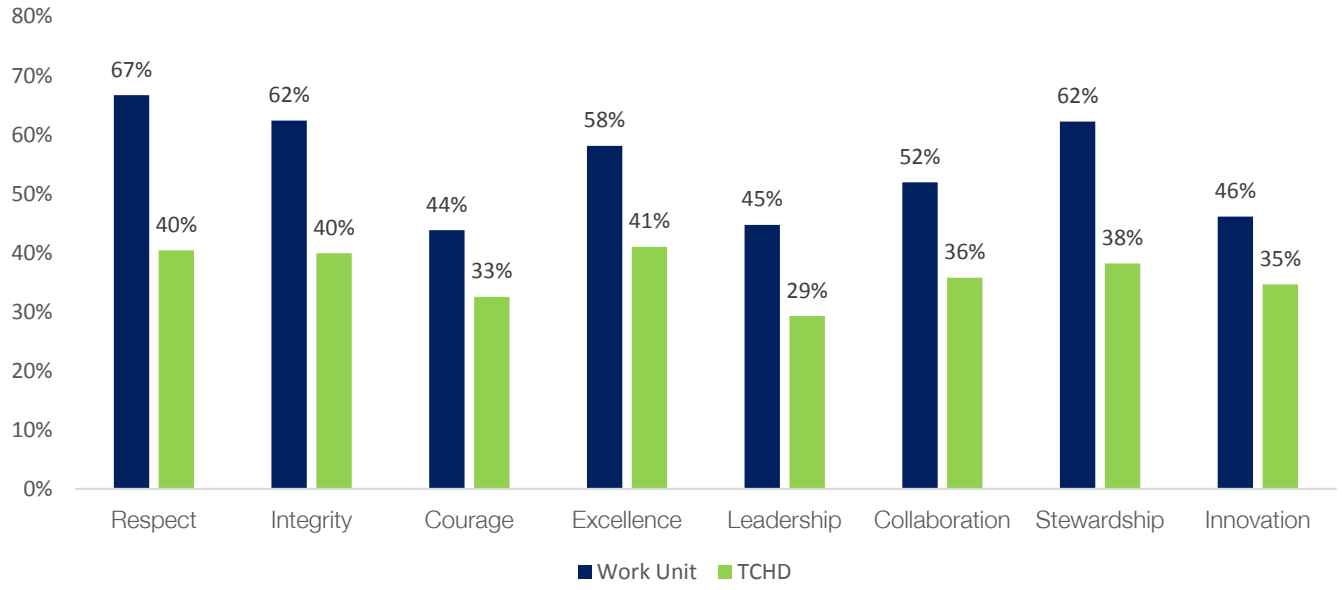
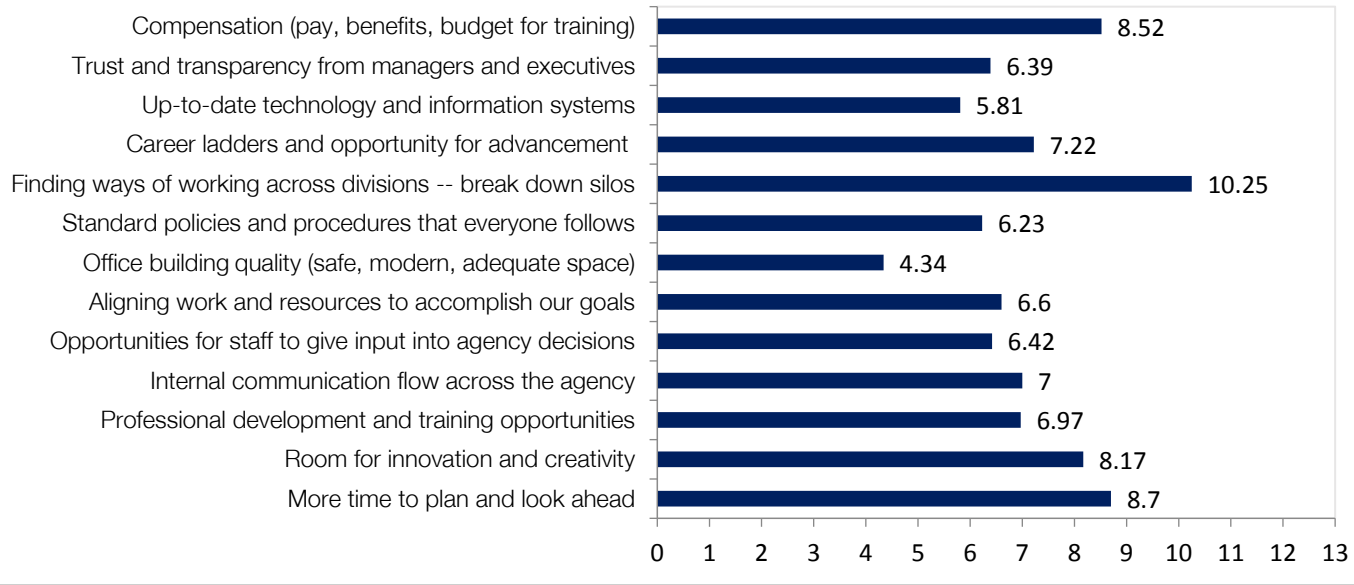


Figure 2. Weighted average ranking of 13 areas for improvement, 2019 Staff Survey, n=214



*The weighted average is based on the importance ranking (1-13) assigned to each item by participants with 13 being the highest importance.

Figure 3. Number of staff who picked each area as their number 1 priority for improvement, 2019 Staff Survey, n=214



External Key Informant Interviews

TCHD contracted with the Trebuchet Group to conduct key informant interviews in January and February of 2019. Eighteen interviews were conducted with key partners from various community sectors using a key informant interview guide developed by Tri-County (Appendix C). The themes of the interviews were the following:

- Public Health Issues and Trends
- Perceptions of Tri-County Health Department
- Communication
- Role of Public Health Strategist
- Partnering in Social Determinants of Health
- Health Equity

A report was prepared and presented in March 2019 summarizing the key themes from the interviews under each of these headers. The report provided highlights from each of the 18 individual interviews. Those highlights include:

Greatest Public Health Issues Facing Our Communities

- Behavioral Health
- Social Determinants of Health/Health Inequity
- Environmental Health
- [Childhood] Obesity
- Immunization Gaps

Role of a Cutting-Edge Public Health Department

- Community Convenor
- Public Policy
- Data and Analytics
- Public Awareness
- Social Determinants of health

Strengths of TCHD/What is TCHD known for

- Partnering/Connecting
- Core Public Health Services
- Strong Staff
- Leader in Colorado
- Respected, Credibility, Expertise
- Data Sharing and Analytics

Opportunities for Improvement

- More advocacy
- More partnering with other sectors
- Push further into social determinants of health
- More intentional sharing of information
- More flexible provision of service
- Determine role in provision of services
- Modify processes (e.g., restaurant inspections)
- Be mindful of differences among counties

Desired Support from Utilizing Public Health Strategist

- More data sharing
- Neutral convening is key role
- TCHD has been successful at this
- Use [this role] to engage policymakers and drive decisions

Barriers to Working Together to Address Social Determinants of Health Now

- Funding
- Turf issues, silos, human nature
- Really big, complicated issues; overwhelming
- Lack of understanding; inter-relationships

Infrastructure Needs for Working Together on Social Determinants of Health

- Leadership structure
- Shared data (Big Data) and analytics
- Clarity on shared outcomes

Resources and Skills Needed for Working Together on Social Determinants of Health

- Shared understanding of issues
- Systems thinking on interdependence

- Communication skills
- Cross-sectoral relationships

Health Equity

- Interviewees had a generally strong understanding of health equity
- High priority of equity and justice in interviewee's organization
- Clarifying the differences between Equity and Equality
- Some disagreement over whether healthcare should be considered a right

TCHD Leadership Retreats

TCHD staff, in coordination with and facilitated by the above listed contractor, conducted TCHD leadership retreats in March and April of 2019 to consider, rank, and select strategic priorities. The leadership retreat included the TCHD Executive Management Team and managerial staff from across the agency.

Input previously gathered for the Strategic Plan were shared prior to the first retreat in March, with a summary overview of those inputs provided at the retreat. Staff were divided into tables of 6-8 participants to complete an activity that identified what strategies were on target, what was missing, and what was unclear. During the table activity discussion participants were tasked with categorizing the priorities into three categories: Yes/Agree, No/Disagree, and Caution/Question/Clarification Needed. Once each table came to a consensus, a larger plenary discussion was facilitated. Each priority area was discussed again with tables voting Yes/Agree, No/Disagree, and Caution/Question/Clarification Needed. Priority wording and language was revised during the meeting, as needed.

The contractor and the TCHD planning team used the notes and feedback from the retreat to further refine the Strategic Priorities and Goals. The information cultivated from the initial TCHD leadership retreat was used to inform the planning of the Board of Health strategic planning retreat.

The second TCHD leadership retreat utilized the previous inputs as well as the input from the Board of Health retreat to determine how TCHD would address the strategies that had been identified. A small table exercise was used to capture how to prioritize the strategies, to brainstorm activities under prioritized strategies, and how to structure the work of the Strategic Plan going forward. Tables identified the 2-3 most strategic concepts. Potential activities were brainstormed and strategic concepts identified. Staff also discussed if there was an existing individual or group within the agency that could be identified to oversee the work. This process was repeated for each of the four priority areas. The summarized discussions were then shared in the larger plenary setting. The notes and feedback were shared and the TCHD planning team synthesized the information into a final recommendation that was shared with the TCHD Executive Management Team.

Board of Health Retreat

Tri-County Health Department's Board of Health (BOH) met on March 26, 2019 together with the Executive Management Team (EMT) to provide input on strategic priorities and work toward consensus on a framework for the 2019-24 Strategic Plan.

The BOH had consensus on the proposed framework provided for the Plan, including the recommendation of having four internal Priority Areas of focus for the Strategic Plan complementing the four external areas of emphasis in the PHIP

The BOH also provided input on Goals within each of the Priority Areas, and had general agreement on them, with follow-up consideration of the input. A timeline for completing the plan was agreed to, with final approval at the August BOH meeting.

Financial Sustainability

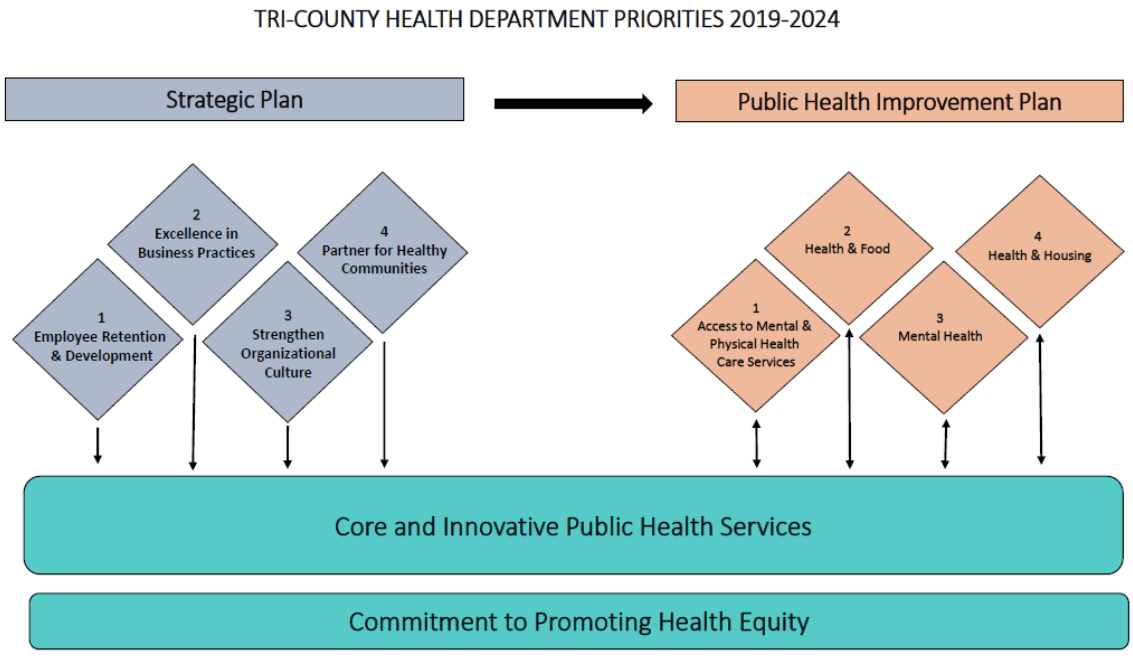
In developing this strategic plan, TCHD took capacity and allocation of resources to accomplish the goals into consideration. Most of the strategies in the plan require existing staff time and effort; the intended outcome will result in improved business processes. In addition, TCHD has budgeted funds for strategic initiatives and innovations. These funds are short-term in nature and are available to assist with the start-up or completion of a special project related to the strategic plan.

Structure of Final Strategic Plan

With all above inputs collected and evaluated, twenty-one goals were identified within the four Priority Areas (see figure below). The Executive Management Team (EMT), comprised of agency leadership (Executive Director, Deputy Director, and eight Division Directors), reviewed the feedback from all previous input phases and recommendations coming from the final leadership retreat. The feedback from EMT was used to confirm the four Priority Areas and the ten Goal Areas highlighted below for initial implementation in Year 1.



As noted, the Strategic Plan was designed to complement Priority Areas of the PHIP, as well as our Core and Innovative Public Health Services, all with a commitment to promoting health equity. These relationship are depicted in the Figure below.



Strategic Plan Priority Area Development

Priority Area sponsors and Goal leads were identified from across the agency to lead the work plan development in each of the Goals selected for Year 1. All staff were given the opportunity to participate on a Goal Task Force to generate strategy areas and action steps: "Phase 1." Sixty-two staff members from across all divisions signed up to participate on one or more Strategic Plan Task Forces. A Strategic Plan Role Matrix was developed to help define roles and responsibilities of those participating in the process (Appendix D).

Goal leads utilized a Strategic Plan Work Plan Development Guide for Phase 1 with each Task Force (Appendix E). Each Task Force carefully followed the methods laid out in the guide, including: (1) organizing, (2) reviewing the data, (3) exploring and refining the problem, (4) prioritizing solutions, (5) developing strategies and action steps, and (6) finalizing language and identifying next steps. At the conclusion of the ten-week-Phase 1 planning process, Task Forces created the following strategies and action steps to guide Year 1 of Strategic Plan implementation.

Strategic Priorities and Goals

Priority Area 1: Employee Retention and Development

Goal 1A: Address competitive pay and benefits

Lead: Cindy Jamieson

Task Force: Adam Anderson, Omar Awan, Jill Bonczynski, Keiana Choyce, Yesenia Enriquez, Keith Homersham, Callie Preheim, Ricky Ross, Nicole Watanabe, Alyson Shupe (PIM Staff)

Strategy	Action Items	Measurement/Milestones	Cross-Reference
1A.1 Develop and ensure enactment of clear policies and procedures which include the rationale for all phases of the pay and benefit process, informed by employees' work and by employee input from all levels.	• A short term, topic focused task force will identify gaps in the compensation plan and need for policies supporting, or in addition to, what is in the plan • Determine and implement an accountability structure for following and communicating the comp plan and associated policies and procedures • Provide transparency by engaging staff in development and communication of changes to policies, procedures, and processes	• Compensation plan is reviewed, by May, 2020 • Policies are communicated by September, 2020 • Accountability structure is operational by September, 2020 • Responses to engagement questions reflect increased awareness of company pay practices as measured by the end of 2020	• Strategic Plan 2B-Standardize and enforce policies and procedures • Strategic Plan 2C-Cultivate a culture of change management • Strategic Plan 3A-Improve trust and transparency from managers • Strategic Plan 2B- Improve staff collaboration and internal communication • PHAB Domain 11
1A.2 Research, identify, and implement mechanism(s) for decreasing inequities in pay and benefits.	• A short term, topic focused task force will assess and address current practices for providing benefits based on position or assignment. • Standardize recruitment process to include pay range on all positions • Model different scenarios to determine costs, benefits, and unintended consequences of a more equitable pay and benefits system	• Inequities by positions are addressed in an on-going basis in the context of total compensation. • Present scenarios which would reduce inequities in pay and benefits to the Executive Management Team on an on-going basis.	• Strategic Plan 2B-Standardize and enforce policies and procedures • Strategic Plan 4B-Prioritize health equity and meaningful community engagement

Goal 1B: Promote professional and leadership development and training opportunities for all

Leads: Tenesha DuBose and Michelle Harris

Task Force: Holly Adams, Stacey Baker, Patty Boyd, Heidi Fritz, Natasha Newlin, Kathleen Rebollo, Leslee Warren, Kelly Weidenbach (PIM Staff)

Strategy	Action Items	Measurement/Milestones	Cross-Reference
1B.1 Fully implement Learning Management System (LMS) to expand access to training/development opportunities and to track individual growth	• Track training/development by TCHD staff in the LMS • For training/development that cannot be tracked in LMS, create standard method for documenting • Use change management for implementing LMS across agency • Provide complete LMS course catalog to staff • Develop in-house training content for LMS to augment LMS content	• Creation of change management plan for LMS implementation across supervisor/manager group by September 1, 2019 • First supervisor/manager training on LMS in August 2019 • Create ongoing training plan development process for LMS for all staff by December 31, 2019 • Meet with Divisions and cross-Divisional subgroups to develop specific learning paths within LMS (ongoing) to meet identified training needs • Complete course list provided to staff by December, 2019 • Evaluation of LMS use/satisfaction by August 31, 2020	• Strategic Plan 2A-Enhance technology and information systems • Strategic Plan 2C-Cultivate a culture of change management and quality improvement • PHAB Domain 11
1B.2. Update the Workforce Development Plan to promote current and future training and development needs of TCHD staff	• On an ongoing basis, assess staff training and develop needs • Develop standardize onboarding for new employees as part of WFD plan • Align WFD plan with all training/development needs identified in strategic plan • Address PH core competencies in WFD plan	• Pilot training/development assessment with all staff by December 31, 2019 • Assess strengths and gaps in current onboarding procedures by December 31, 2019 • Create an outline for the revised Workforce Development Plan by April 30, 2020 • Completion of revised Workforce Development Plan by August 31, 2020	• Strategic Plan 1A-Competitive Pay and Benefits • Strategic Plan 2A-Enhance technology and information systems • Strategic Plan 2C-Cultivate a culture of change management and quality improvement • PHAB Domain 8

Goal 1C: Assess workload and balance across agency

Lead: Jessica Gomez

Task Force: Bernadette Albanese, Claudia Bernal, Sara Garrington, Carolyn Kwerneland, Callie Preheim (PIM Staff)

Strategy	Action Items	Measurement/Milestones	Cross-Reference
1C.1 Assess and evaluate current work and workload	• Design and conduct an agency-wide assessment of work and workload to include perspective from managers, supervisors, frontline staff, and executive management. • Use the assessment to describe and understand agency leadership practices and decision-making processes, and their impact on work and workload.	• Assessment report is completed that describes current work and workload and issues related to workload balance, and staff communication by September, 2020 • Recommend steps to address issues identified in the assessment by December, 2020	• Strategic Plan 1A-Competitive Pay and Benefits • Strategic Plan 3A-Improve Trust and Transparency • CO Core PH Services Foundational Capabilities
1C.2 Align work and right-size workloads	• Develop a process for ongoing review of work/workload and how to rebalance work/workload (addition of new work and elimination of existing work) • Develop process to align job descriptions and performance evaluations with work and workload • Recommend processes/procedures for staff to follow regarding workload balance. • Implement workload balance processes	• Set up a process for review and adjustment of workload based on assessment by March, 2021 • Implement processes developed to update job descriptions and performance evaluations and establish workload balance across the agency by June 30, 2021 • Processes/procedures are developed and staff are trained by September 30, 2021 • Supervisor Training is updated to include workload balance by September 30, 2021 • Process regarding workload balance is implemented September 30, 2021	• Strategic Plan 1B–Promote professional and leadership development and training opportunities for all • Strategic Plan 2B-Standardize and enforce policies and procedures • Strategic Plan 2C-Cultivate culture of change management and quality improvement

Priority Area 2: Excellence in Business Practices

Goal 2A: Enhance technology and information systems

Lead: Jordan Luke

Task Force: Informatics Governance Group: Holly Adams, Adam Anderson, Heather Baumgartner, Jill Bonczynski, Yushiuan Chen, Laura DeGolier, Theresa Fox, Penny Grande, Janet Harm, Melissa Spenser, Ryan Smith; and Lori Haas, Tim Glazier, Luisana Pedemonte, Alyson Shupe (PIM Staff)

Strategy	Action Items	Measurement/Milestones	Cross-Reference
2A 1. Develop an informatics governance structure that includes an accountability framework, delineates lines of authority, outlines the decision making process, and ensures compliance with state and federal laws, regulations, and mandates.	• Determine parameters for what is in scope and out of scope of informatics governance • Develop standard operating procedures for governance • Implement data capability model to ensure compliance with state and federal laws, regulations, and mandates.	• Governance structure and procedures finalized by March 31, 2020 • Roles and responsibilities defined by May 30, 2020 • Signed informatics governance policy by June 30, 2020	Strategic Plan 2B- Standardize and enforce policies and procedures Strategic Plan 2C- Cultivate culture of change management and quality improvement All PHIP Priorities CO Core PH Services Foundational Capabilities: Information Technology/Informatics (IT) PHAB Domain 11
2A 2 Develop a model technology and information systems training program for all TCHD staff	• Identify training needs • Determine a standardized training curriculum needed for new employee orientation and continuing education related to technical competencies • Work with workforce development coordinator to build training curriculum into the LMS	• Training needs by various groups (by work group, by longevity, etc.) identified by June 30, 2020	• Strategic Plan 1B-Promote professional and leadership development and training opportunities for all • All PHIP Priorities • CO Core PH Services Foundational Capabilities: Information Technology/Informatics • PHAB Domain 8
2A.3 Develop standardized methods for informatics project management	• Research and select standard methods for informatics project management • Develop resource materials, templates, and toolkit for informatics project management • Train relevant staff on informatics project management method • Develop procedure document to formalize informatics project management at TCHD	• Select a project management framework by December 31, 2019 • Develop resource materials, templates, and toolkit by March 31, 2020 • Conduct at least one informatics project management training by August 31, 2020 • Draft procedure document on informatics project management by August 31, 2020	• Strategic Plan 1B-Promote professional and leadership development and training opportunities for all • Strategic Plan 2B-Standardize and enforce policies and procedures • Strategic Plan 2C-Cultivate culture of change management and quality improvement • CO Core PH Services Foundational Capabilities: Information Technology/Informatics

2A.4 Develop strategy for multi-year planning for software and systems acquisition	• Explore a centralized informatics budget • Collaborate with Division of Administration and Finance to develop multi-year capital budget for software and information systems • Prioritize software and information systems and align with capital budget • Ensure capital budget and operational budgets consider funding for administrative support, training, maintenance, and essential upgrades of software and prioritized information systems	• Develop systematic prioritization criteria for software and information systems by March 31, 2020 • Prioritize known/expected informatics projects by March 31, 2020 • Develop 5-year software and informatics plan for TCHD by May 31, 2020 • Complete first draft of capital budget by May 31, 2020	• Strategic Plan 3B-Improve Staff Collaboration and Internal Communication • CO Core PH Services Foundational Capabilities: Information Technology/Informatics (IT) • PHAB Domain 11

Goal 2B: Standardize and enforce policies and procedures

Lead: Sue Bettermann

Task Force: Amy Armstrong, Roslyn Asuncion, Joan Eskens, Melissa Spencer, Kelly Weidenbach (PIM Staff)

Strategy	Action Items	Measurement/Milestones	Cross-Reference
2B1 Create a TCHD work group for policy and procedure management that establishes new policies/procedures, revises pre-existing policies/procedures, and vets the need for policy/procedures.	• Create diverse and inclusive work group that is representative of TCHD workforce (Division, geography, staff level). • Define roles and responsibilities of the work group. • Work group to create and implement process for prioritizing and creating new policies/procedures. • Work group to create and implement process for prioritizing, reviewing, and revising pre-existing policies.	• Creation of work group (i.e., charter that describes make-up of group, roles and responsibilities, how policies are prioritized, how decisions are made) by October 1, 2019. • Process (i.e., flow chart, written process) for creating new policies, revising old policies by March 31, 2020.	• Strategic Plan 2C-Cultivate a culture of change management and quality improvement • PHAB Domain 11
2B.2 Organize all existing TCHD policies and procedures to ensure that TCHD staff have access to the most up-to-date version	• Catalog existing policies and procedures and place them in established central location. • Review existing policies and procedures for content, format, and discrepancies. Recommend changes as necessary. • Ensure only the most recent version of the policy/procedure can be found (remove access to old versions). Establish process for version control. • Explore document management software as a solution for version control and access.	• Completion of catalog of existing policies and procedures by August 31, 2020. • Establish a central location of all policies and procedures with clear version control standards by December 31, 2019 • Completion of software vetting to examine document management options by August 31, 2020	• Strategic Plan 2A-Enhance technology and information systems • PHAB Domain 11
2B.3. Provide relevant training to TCHD staff on existing, new, and revised policies and procedures	• Update checklist of training on policies/procedures for New Employee Orientation • Determine training needed for supervisors and incorporate into supervisor training • Determine process for training staff on new policies/procedures	• Create outline for policies/procedures focused training plan by August 30, 2020 • Coordinate with Workforce Development Coordinator to align training needs on policies/procedures with revised Workforce Development Plan by April 30, 2020	• Strategic Plan 2B-Promote professional and leadership development and training opportunities for all • Strategic Plan 2C-Cultivate a culture of change management and quality improvement • PHAB Domain 8

Goal 2C: Cultivate a culture of change management and quality improvement

Lead: Kelly Weidenbach

Task Force: Daniel Barton, Laura DeGolier, Caitlin Gappa, Michele Haugh, Sandy Shafer, Alyson Shupe, Ryan Smith, Matt Jackson (PIM Staff)

Strategy	Action Items	Measurement/Milestones	Cross-Reference
2C.1 Research, select, and implement a change management framework for TCHD	• Utilize short-term taskforce to research and select change management frameworks • Pilot framework on change project • Adjust, implement, and use framework consistently	• Select change management framework by December 31, 2019 • Completion of pilot project of use of framework by March 31, 2020 • List of recommendations from pilot project by April 30, 2020 • Practice use of adapted framework on relevant projects by August 30, 2020 • Evaluate utility of framework at TCHD by August 30, 2020	• All Strategic Plan Goals • All PHIP Priorities
2C2 Foster formal quality improvement culture to empower staff to identify meaningful changes for improvement, which utilizes components of chosen change management framework	• Create a PM/QI council • Revise and update agency-wide QI plan • Increase training for QI, including beginner and advanced training • Identify methods to empower staff to innovate within their own role	• Creation of PM/QI council by October 1, 2019 • Completion of revised QI plan by March 31, 2020 • Creation of annual calendar of QI training by December 31, 2019 • Completion of Year 1 of QI training by August 30, 2020	• Strategic Plan 1B-Promote professional and leadership development and training opportunities for all • Strategic Plan 2C-Cultivate a culture of change management and quality improvement • PHAB Domain 8 • PHAB Domain 9

Priority Area 3: Strengthen Organizational Culture

Goal 3A: Improve trust and transparency

Lead: Jennifer Ludwig

Task Force: Michele Askenazi, Jaclyn Blitz, Yeraldie Caloca, Judy Fowler, Janet Harm, Mellissa Sager, Makena Slater, Alyson Shupe (PIM Staff),

Strategy	Action Items	Measurement/Milestones	Cross-Reference
3A.1. Establish set of principles for making and communicating agency decisions	• Describe the current state and future state of decision making (types of decisions, staff engagement, group vs individual, communication of decision) • Develop principles to include guidelines that establish clear expectations, roles and responsibilities, and communications plan (feedback loop) • Ensue alignment with and incorporation of agency's values • Pilot test (supervisor training) and evaluate process	• Principles developed by January 31, 2020 • Pilot projects are identified by February 28,2020 • Pilots completed by June30, 2020 • Evaluation data are used to assess and revised the new model August31, 2020	• All Strategic Plan Goals • All PHIP Priority Areas
3A.2. Actively promote inclusion of agency values in our work	• Engage staff in conversations about how values are important to them to improve trust and transparency • Develop stories on operationalizing values (garnered from staff engagement) • Explore how values can be included in performance management system (key performance indicator) • Develop and implement a sustainability plan for rolling out values and embedding them into our culture	• Examples of operationalizing values created by February 28, 2020 • Performance improvement metrics established by April 30, 2020 • Plan is implemented and evaluated by July 30, 2020	• Strategic Plan 1A-Address Competitive pay and benefits • Strategic Plan 4B-Prioritize health equity and meaningful community engagement

Goal 3B: Improve staff collaboration and internal communication

Leads: Becky O'Guin and Callie Preheim

Task Force: Sam Decker, Meredith Henry, Melanie Morrison, Kathy Staats, Courtney Tomlin, Matt Jackson (PIM Staff)

Strategy	Action Items	Measurement/Milestones	Cross-Reference
3B.1. Develop and Implement an Internal Communication Plan	• Assess and evaluate current communication channels and tools • Determine components of the communication plan • Develop internal communication processes and procedures: (What to whom, how, why, when) (Communication Matrix) • Develop a Communication Plan Training/Onboarding Process (LMS) • Consider and test innovative communication tools; develop recommendations based on testing	• Assessment is completed by January 31, 2020 • Completed outline of communication plan by March 31, 2020 • Completed communication matrix by May 31, 2020 1. Completed framework 2. Identified best practices • Plan Completed by August 31, 2020 • Recommendations ongoing	• All Strategic Plan Goals • All PHIP Priority Areas • CO Core PH Services Foundational Capabilities: Communications
3B.2. Research and Explore Collaborative Working Models (ex. Place based, Integration, etc.)	• Assess current state of collaborative work • Research existing collaborative models and best practices • Pilot test and evaluate new collaborative best practices and working model(s) • Develop recommendations around collaborative models	• Assessment and inventory and/or cross-walk completed by February 28, 2020 • Research completed by April 30, 2020 • At least two pilot projects will be completed by July 31, 2020 • Recommend collaborative models for use at TCHD by July 31, 2020	• All Strategic Plan Goals • All PHIP Priority Areas

Priority Area 4: Partner for Healthy Communities

Goal 4A: Increase policy and advocacy work

Lead: Mellissa Sager

Task Force: Dylan Garrison, Amanda Gersabeck, Emma Goforth, Annemarie Heinrich, Greta Macey, Angelica Moreno, Matt Jackson (PIM Staff)

Strategy	Action Items	Measurement/Milestones	Cross-Reference
4A.1 Create and implement a Policy and Advocacy Framework	• Define Policy and Advocacy work across the agency • Complete an internal assessment of roles and responsibilities related to policy and advocacy • Complete and internal assessment of TCHD policy and priority areas • Revise the TCHD staff guidance on public health policy education and advocacy	• Glossary of terms and definitions related to policy and advocacy by December 31, 2019 • Documentation of feedback of roles and responsibilities by January 31, 2020 • Clear program/policy priorities by March 31, 2020 • Completion of the revised TCHD staff guidance on public health policy education and advocacy by March 31, 2020 • Process for ongoing review of policy and advocacy needs March 31, 2020	• Strategic Plan 2C-Cultivate a culture of change management and quality improvement • Strategic Plan 3B-Improve Staff Collaboration and Internal Communication • CO Core PH Services Foundational Capabilities: Policy Development and Support
4A.2 Develop Policy and Advocacy Training Plan	• Assess policy and advocacy training needs across TCHD • Develop curriculum for policy and advocacy training • Create a Policy and Advocacy Toolkit and Guidelines • Develop ongoing policy and advocacy training schedule and structure for all staff	• Feedback received from diverse staff related to training needs Including knowledge/experience/expertise by December 31, 2019 • Complete external scan of training opportunities by December 31, 2019 • Training curriculum developed and completed to fill needs of the agency by February 28, 2020 • Schedule of trainings is developed and shared with all staff is ongoing	• Strategic Plan 2B-Promote professional and leadership development and training opportunities for all • CO Core PH Services Foundational Capabilities: Policy Development and Support

Goal 4B: Prioritize health equity and meaningful community engagement

Lead: Alix Hopkins

Task Force: Dani Egeberg, Haley Foster, Loribeth Mesa, Sharon Penna, Adrian Pidek, Kaitlin Wolff, Callie Preheim (PIM Staff)

Strategy	Action Items	Measurement/Milestones	Cross-Reference
4B.1 Determine Accountability, Responsibility, Authority, and Funding Structure(s) for Health Equity and Community Engagement Work (HE&CE) at TCHD	• Assess current capacity of Health Equity Work Group and Steering Committee and make recommendations for next steps • Determine at least three different staffing and funding scenarios for health equity and community engagement work at TCHD • Assess and clarify internal and external priority areas of focus for HE&CE • Clarify steps necessary for determining: (1) Accountability, responsibility, and authority (2) Staffing and funding structures • Implement steps	• Assessment completed by December 30, 2019 • At least three staffing and funding scenarios are developed by June 30, 2020 • Clear focus areas are recommended by September 30, 2020 • Clear steps for each area are recommended by December 30, 2020 • A process for implementing steps is determined and a plan is made to begin implementation by February 28, 2021	• Strategic Plan 3B-Improve Staff Collaboration and Internal Communication • CO Core PH Services Foundational Capabilities: Health Equity and the Social Determinants of Health
4B.2 Create shared definition and model(s) of Health Equity and Community Engagement that reflect TCHD Values and Align with Public Health Transformation (year 1-2)	• Research HE&CE best practices and models. ○ Develop recommendations based on this and previous research for TCHD's creation of a model and framework ○ CE Policies/Procedures (Guidance) • Modify, and adopt a (1) Community Engagement Spectrum and (2) a Health Equity Framework • Tie HE and CE framework/model together and align them to TCHD Values in a way that gives examples of what this looks like at different levels of interaction and for different types of jobs (direct service, systems level, etc.)	• Recommendations for TCHD HE&CE models are developed • Policies and procedures for CE is developed • CE spectrum and HE framework for the agency are adopted • A detailed crosswalk of model/framework and TCHD values is developed	• Strategic Plan 1B- Promote professional and leadership development and training opportunities for all • Strategic Plan 2C-Cultivate a culture of change management and quality improvement
4B.3 Identify existing, internal efforts and best practices related to HE&CE (year 1-2)	• Scan internal programmatic efforts of Community Engagement ○ Examine HE&CE efforts in Job Descriptions, Evaluations of Currently – Funded Projects, Work Force Development • Map efforts to CE spectrum and to HE framework	• Scan completed • Map completed	• Strategic Plan 3B- Improve Staff Collaboration and Internal Communication CO Core PH Services Foundational Capabilities: Health Equity and the Social Determinants of Health

Strategic Plan Phase 2- Implementation

The Strategic Plan will be evaluated using developed performance management measures for each prioritized area. A communication plan will be followed to ensure progress is shared regularly with staff, partners, and the public. Progress will be tracked and reported to the Board of Health on a regular basis throughout the next six years.

Appendix A

Acknowledgements

Key Informants

Local Public Health

- Mark Johnson, MD, Executive Director, Jefferson County Public Health
- Bill Burman, MD, Director, Denver Public Health
- Jeff Zayach, MS, Executive Director, Boulder County Public Health

Hospital Systems

- Deb Federspiel, BS, Community Partnerships, Children's Hospital Colorado

Colorado Department of Public Health & Environment

- Tista Ghosh, MD, Chief Medical Officer, CDPHE
- Jeff Lawrence, Environmental Health Sustainability, CDPHE
- Web Brown, MS, Office of Health Equity, CDPHE

Community Health

- Bebe Kleinman, MNM, Executive Director, Doctors Care
- Jessica Dunbar, MSPH, CEO, Every Child Pediatrics
- Ben Wiederholt, MHA, CEO Stride Community Health Center

County Commissioners

- Kathleen Conti, Arapahoe County Commissioner
- Barbara Drake, MS, Deputy County Manager, Douglas County

Health Foundations

- Chris Wiant, PhD, CEO, Caring for Colorado
- Ned Colange, MD, CEO, The Colorado Trust

Schools

- Tony Poole, MAED, ED of Student Achievement, Cherry Creek Schools
- Michelle Weinraub, MSN, RN, NCSN Director of Nursing, Cherry Creek Schools

Community Mental Health

- William (Bill) Henricks, PhD, CEO, AllHealth Network
- Kelly Phillips-Henry, Psy.D, CEO, Aurora Mental Health Center
- Rick Doucet, MA, CEO, Community Reach

Board of Health

Adams County
- Julie Mullica, MPH
- Rosanna Reyes, RN
- Naomi Steenson, RD

Arapahoe County
- Jan Brainard, RN
- Thomas Fawell, MD
- Kaia Gallagher, PhD

Douglas County
- Marsha Jaroch, NP
- Paulette Joswick, RN
- Zachary Nannestad, MPH

TCHD Staff

Executive Management Team
- John M. Douglas, Jr., MD, Executive Director
- Jennifer L. Ludwig, MS, Deputy Director
- Michele Askenazi, MPH, CHES, Director of Emergency Preparedness, Response, and Communicable Disease Surveillance
- Heather Baumgartner, MSS, Director of Community Health Promotion
- Jill Bonczynski, RD, MS, Director of Nutrition
- Theresa Fox, MBA, Director of Administration and Finance
- Mame Fuhrman, MPS, SPHR, Director of Human Resources
- Penny Grande, RN, MS, Director of Nursing
- Brian Hlavacek, MAS, REHS, Director of Environmental Health
- Kelly Weidenbach, DrPH, MPH, Director of Planning and Information Management

Executive Sponsors
- John M. Douglas, Jr., MD, Executive Director
- Jennifer L. Ludwig, MS, Deputy Director
- Mame Fuhrman, MPS, SPHR, Director of Human Resources

Strategic Plan Goal Leads
- Sue Bettermann
- Tenesha DuBose
- Jess Gomez, RN
- Michelle Harris, MPH, RD
- Alix Hopkins, RN, MPH
- Cindy Jamieson, SPHR
- Jennifer Ludwig, MS

- Jordan Luke
- Becky O'Guin, MPS
- Callie Preheim, MSPH
- Mellissa Sager, JD
- Kelly Weidenbach, DrPH, MPH

PIM Planning Team

- Matt Jackson
- Callie Preheim, MSPH
- Alyson Shupe, PhD, MSW
- Kelly Weidenbach, DrPH, MPH

Strategic Planning Task Force Members

All TCHD staff

Appendix B

All-Staff Survey

1) Below are TCHD's Values and Guiding Principles. To what extent are these practiced in your work unit? At TCHD in general?

   Respect: We treat others with the same dignity as we wish to be treated. We honor the whole person and recognize the importance of work-life balance and diverse perspectives. We recognize the power of teamwork and appreciate the unique contributions that each member of a team can make.
   Integrity: We maintain consistency in what we say and what we do. We uphold high ethical standards and maintain accountability to each other and the communities that we serve.
   Courage: We stand up for what is right in the face of adversity. We communicate openly and welcome honest feedback. We advocate for those who cannot do it for themselves.
   Excellence: We strive for the highest quality in everything that we do. We pursue opportunities and seek creative and innovative solutions to the challenges that face us.
   Leadership: We believe that everyone can be a leader. We empower others to act; we encourage everyone to reach their fullest potential; and we model our core values.
   Collaboration: We seek to sustain and enhance the reach and impact of our efforts through the respectful engagement with community partners (local, regional and state).
   Stewardship: We maintain good stewardship of public monies and facilities through active management and will always strive to provide high quality, targeted, and cost-effective services for the community.
   Innovation: We seek and encourage innovative approaches to address public health issues, reach diverse communities and improve agency operation.

2) The list below was identified in staff focus groups as areas for agency improvement. On a scale of 1 to 13 with 1 being the most important and 13 being the least important, please rank each item in terms of how important improvement is for optimal organizational performance.

   - Up-to-date technology and information systems
   - Career ladders and opportunity for advancement within TCHD
   - Standard policies and procedures that everyone follows
   - More opportunities for staff to give input into agency decisions -- and have management listen
   - Finding ways of working across divisions -- break down the silos
   - Internal communication flow across the agency
   - More time to plan and look ahead
   - Office building quality (safe, modern, adequate space)
   - Compensation (pay, benefits, budget for training)
   - Professional development and training opportunities for everyone
   - Room for innovation and creativity
   - Aligning work and resources to accomplish our goals
   - Trust and transparency from managers and executives

Appendix C

Key Informant Questions

Strategic Plan 2019

1. What are some of the most important trends and factors facing our communities over the next 3-6 years?
    a. What do you see as the greatest public health issues facing our communities now and in the future?
    b. What role should a cutting edge public health department play in addressing those issues?
    c. What are the greatest challenges your organization will be facing in the next 3-6 years?
    d. What role can TCHD play in supporting your work? In addressing those challenges?

2. Based on what you know about Tri-County's current work, what do you feel:
    a. it is best known for? (What do you think of when you hear Tri-County?)
    b. are its greatest strengths?
    c. are its opportunities for improvement?

3. Most communities are struggling with issues of affordable and safe housing, access to healthy affordable food, struggling schools, economic insecurity and poverty, homelessness, social isolation and stress, and safety. These are large cross-cutting issues that require strong and effective partnerships to address them.
    a. What do you think stands in our way of working together to address these issues now?
    b. What infrastructure needs must be met in order for us to work together to solve these issues facing our communities?
    c. What resources and skills are needed to work together on these issues?

4. The ability to communicate effectively with various audiences is a persistent challenge. What are the most effective communication strategies you employ or appreciate from others?
    a. How can TCHD be more effective in communicating with your organization?
    b. How can TCHD be more effective in communicating with your stakeholders about public health issues?

5. Nationally, public health leaders are being asked to play a Chief Health Strategist role in their communities by developing strong strategic partnerships with players in other sectors. Additionally, public health can provide current, geographically-specific data and practical, readily accessible tools for data analysis and an enhanced informatics workforce.
   How would you utilize someone in this role to:
    a. help support your work?
    b. accomplish joint goals and objectives?

6. Part of TCHD's mission is to promote health equity.
    a. What does health equity mean to you?
    b. How important is equity and justice in the mission of your organization?

Appendix D

2019-2024 Strategic Plan: Role Matrix

Strategic Plan Priority Area Sponsors

- Assure task force is making progress in accordance with SP timeline and deliverables
- Provide executive level review and input on developed activities
- Ensure implementation of work plans
- Communicate SP priorities as organizational priorities consistently
- Elevate Task Force concerns to appropriate leadership level
- Ensure knowledge/awareness of resource needs
- Advocate for resource needs (i.e., funding, human capital) to senior leadership
- Communicate timeline changes to Executive Management Team
- Update Leadership on task force progress
- Communicate Executive Management decisions or requirements that impact the work of the group in a timely and transparent manner
- Identify and promote opportunities for alignment between the SP and the PHIP
- Ensure equity is practiced and fostered among work group members

Strategic Plan Goal Leads – Phase 1

- Provide subject matter expertise for priority area
- Convene task forces weekly
- Build consensus around task force activities/timelines
- Ensure equity is practiced and fostered among Task Force members
- Provide focus for task force on solutions that work across divisions and positions
- Consistently communicate SP strategy area action steps as organizational priorities
- Connect work by communicating regularly with Executive Sponsors and PIM staff
- Adhere to established team work plans, timelines, and deliverables
- Provide leadership to task force
- Understand potential resource needs around activities and communicate those needs to Executive Sponsor
- Ensure that Executive Sponsors are aware and knowledgeable of work plan/implementation plan

Task Force Members – Phase 1

- Provide expertise and knowledge to task force, and represent colleagues' expertise and knowledge, when known
- Actively participate in task force meetings weekly
- Provide input on problem statements, goals, action steps, and timelines
- Communicate concerns to SP lead and PIM Staff
- Focus on desired future state of the organization [on goals and how to get there]
- Bring solutions to perceived barriers
- Consider other staff who may be needed to carry out implementation activities. Communicate this with Task Force lead

PIM Planning Support Group – Phase 1

- Provide technical assistance with creating appropriate activities for each workgroup and developing appropriate outcome measures
- Provide facilitation so that leads can participate
- Assist SP Leads and task forces with completion of tools/products, as necessary
- Provide existing data to inform each phase of implementation
- Ensure the quality and proper use of data
- Provide technical assistance around SP evaluation
- Assure alignment of SP activities, outcomes, population measures with PHAB requirements, and evidence-based public health practice.
- Develop and disseminate performance metrics

Appendix E

2019-2025 Strategic Plan Work Plan Development Guide: Phase I

The components of a strategic plan are difficult to operationalize unless task forces make a deliberate connection between the root causes of identified problems to defined, best-practice strategies and subsequent implementation throughout the organization. While the 2019-2015 Strategic Plan contains externally-focused priorities, the majority of priorities are internally focused. As such, all employees should feel connected to the strategic plan – both in their individual, day-to-day work as well as in their experience as an employee of TCHD. The TCHD Planning and Information Management Division has created this guide to assist task forces in developing the 2019-2025 Strategic Plan Work Plan: defining goals for each priority area and identifying effective, best-practice action steps that will enable us to reach these goals.

Step 1: Organize

Week 1 | May 27-31, 2019

By the end of this step, each task force will:

- *Have reviewed this guide to understand the overall process, timeline, and deliverables*
- *Held its first task force meeting*
    - *Defined norms, roles, and expectations of the group*
    - *Defined the objectives of the task force*

Step 2: Review Data

Week 2 | June 3-7, 2019

By the end of this step, each task force will:

- *Review priority area input (survey, focus group, and key informant data) and problem statement*
- *Identify if additional information or clarification is needed*

Step 3: Explore and Define Problem

Weeks 3-4 | June 10-21, 2019

By the end of this step, each task force will:

- *Thoughtfully discuss the problem and root causes*
- *Conduct a root cause analysis of your priority area*
- *Complete brainstorming exercise*

Step 4: Prioritizing Solutions

Weeks 5-6 | June 24-July 5, 2019

By the end of this step, each task force will:

- *Prioritize root causes and solutions on which to focus in year one*

Step 5: Develop Goals and Action Steps

Weeks 7-8 | July 8-19, 2019

By the end of this step, each task force will:

- *Develop measurable action steps for each of the year-one strategic plan priority areas*

Step 6: Finalize plans; identify next steps and lessons learned

Week 9 | July 22-26, 2019

By the end of this step the work group will:

- *Discuss next steps beyond year one*

What is Public Health?



Tri-County Health Department is the largest local health department in Colorado. It is our mission to protect, promote and improve the health, environment and quality of life of the 1.5 million residents of Adams, Arapahoe and Douglas Counties.

Most of the work of public health agencies is population based—that is, it focuses on improving the health of the entire community. We help you to make the healthy choice the easy choice!

11 Offices to Serve You

Visit www.tchd.org for directions
See the list of services on the back page →

Administration
6162 South Willow Drive, Suite 100
Greenwood Village, CO 80111 • 303-220-9200
Services: 1 3 4 5 10 12
RTD: Arapahoe Station E,F

Aurora West: Alton/Colfax
9000 E. Colfax Avenue (Wells Fargo Building)
Aurora, CO 80011 • 303-361-6010
Services: 10 14
RTD: 15

Aurora East: Colfax/Chambers
15400 E. 14th Place (Altura Plaza Building)
Aurora, CO 80011 • 303-341-9370
Services: 2 5 6 7 8 9 10 11 12 14
RTD: 15, 153

Aurora South: Hampden/Chambers
15192 E. Hampden Ave. (Hampden Villa)
Aurora, CO 80014 • 303-873-4400
Services: 10 12 14
RTD: 133, 153

Brighton
30 South 20th Ave. Suites F/G
Brighton, CO 80601 • 303-659-2335
Services: 10 14

Castle Rock
410 South Wilcox Street
Castle Rock, CO 80104 • 303-663-7650
Services: 1 2 5 6 8 10 14

Commerce City
4201 E. 72nd Avenue, Unit D
(Adams County Service Center Building)
Commerce City, CO 80022 • 303-288-6816
Services: 1 5 10 12 14
RTD: 48, 72/72W

Englewood
4857 S. Broadway
Englewood, CO 80113 • 303-761-1340
Services: 2 6 7 8 9 10 12 13 14
RTD: 0

Lone Tree
9350 Heritage Hills Circle
(Douglas County Building)
Lone Tree, CO 80124 • 303-784-7860
Services: 6 8 10 14
RTD: 403 • Lincoln Station E, F

North Broadway: 70th/Broadway
7000 Broadway #400
Denver, CO 80221 • 303-426-5232
Services: 6 9 10 14
RTD: 6, 72

Westminster
1401 W. 122nd Ave., #200 (Park Centre)
Westminster, CO 80234 • 303-452-9547
Services: 2 6 7 8 9 10 12 14
RTD: 8, 120

Key to Services:

Note: Not all services are offered at each location.

1. Birth and Death Certificates
2. Children with Special Needs Referrals
3. Disease Control / Epidemiology
4. Emergency Preparedness and Response
5. Environmental Health Services
6. Family Planning / Birth Control/ STI Testing
7. HIV/STI/Hepatitis Testing and Counseling
8. Immunizations for Children and Adults
9. Medicaid Assistance and Outreach
10. Nutrition Services / Registered Dietitians
11. Occupational Health / Industrial Hygiene
12. Prenatal and Parenting Case Management
13. Senior Dental / Arapahoe County, Ages 55+
14. WIC Nutrition Services

About the Cover:

L-R, top to bottom: Immunizations; disease control and prevention; handwashing. Prenatal and parenting case management; birth certificates. Restaurant inspections; disease prevention; sanitation. Chronic disease screenings and referrals; tobacco prevention; emergency preparedness and response. Family planning; WIC nutrition services.

Tri-County Health Department
www.tchd.org
General Information: 303-220-9200

Tri-County Health Department has achieved national public health accreditation– the measurement of health department performance against a set of nationally-recognized, evidenced-based standards.

Many programs have age, residency or income requirements. Some are offered for free or on a sliding-fee scale. Not all services are offered at each location. Tri-County Health Department values and welcomes people of all ages; ethnicities; genders and gender identities/expressions; sexual orientations; languages spoken; nationalities and cultures; physical, mental and developmental abilities; races; religions; and, socio-economic, insurance and immigration status. Printed on recycled paper.

Revised 12/2018

Tri-County Health Department

Public Health Services for the Residents of Adams, Arapahoe and Douglas Counties



Tri-County Health Department

Birth and Death Certificates



Certified birth certificates are needed for work, passport applications and many school programs

- Birth certificates are available for people born in any county in Colorado
- Death certificates are issued for deaths that occurred in any county in Colorado
- Call 720-200-1401 for information and fees, or order online at www.tchd.org

Nutrition Services

Our nutrition programs promote good food and activity choices for healthy living

WIC – Women, Infants and Children

The supplemental nutrition program provides nutritious foods, education and referrals for income-eligible women who are pregnant or breastfeeding, and their children up to age five



Nutrition Education

Registered Dietitians are available for nutrition presentations:

- Community organizations
- Child care staff
- Schools and health fairs
- Breastfeeding support

Health Promotion

- Obesity prevention
- Older adult fall prevention
- HIV/STI/Hepatitis testing
- Chronic disease screenings
- Injury prevention
- Worksite wellness
- Mental health
- Tobacco prevention/cessation
- Substance abuse prevention



Health Services

Our services focus on promoting good health for children and adults through clinical, preventive and health education programs

Children's Health



- Children's immunizations 303-451-0123
- Medicaid and Child Health Plan Plus (CHP+) benefit questions 303-873-4404
- Health care referrals
- Resources for children with special healthcare needs 303-783-7139

Expectant and New Mothers

- Referrals to prenatal care and other support services
- Nurse Family Partnership 303-255-6246
- Breastfeeding education and support
- Parenting education
- Medicaid and Child Health Plan Plus benefit questions 303-873-4404



Health Care Services



- Immunizations for uninsured, Medicaid, CHP+, and most private insurance 303-451-0123
- Pregnancy testing 303-363-3018
- Birth control 303-363-3018
- HIV/STI/Hepatitis testing 303-363-3018
- Syringe access and harm reduction
- Tuberculosis (TB) screening 303-451-0123
- Dental care for Arapahoe County residents age 55 and older 303-783-7106

Environmental Health

Our environmental health programs focus on preventing communicable disease and environmental conditions that could be harmful to your health

Food Safety and Education



- Inspections of almost 5,000 restaurants and food service facilities
- Inspection results available online at www.tchd.org
- Food safety training classes

Health, Education and Inspections



- Child care center inspections
- Swimming pool and spa inspections
- Occupational Health/ Industrial Hygiene
- Oversight of meth lab cleanup
- Body art facility inspections
- Consumer health information
- Mosquito and rodent surveillance

Land Use and Water Quality

- Household chemical roundups
- Land use and built environment planning
- Solid and hazardous waste disposal site monitoring and spill response
- Rocky Mountain Arsenal and Lowry Landfill cleanup monitoring
- Septic system permits and inspections
- Water quality outreach and education



Disease Control and Prevention

Tri-County Health Department helps prevent infectious diseases that can be spread from animals, through food/water, and by person-to-person contact



- Chronic and infectious disease surveillance
- Outbreak response
- Infectious disease investigation and control
- Community health data
- To report diseases, call 303-220-9200



Emergency Preparedness and Response

We participate in all levels of emergency preparedness planning, training and response; and coordinate with other local, state and federal operations



- Manage and dispense medications and supplies during public health emergencies
- Rapidly communicate with a large network of hospitals, physicians, schools and emergency response agencies

Health Communication

Website • Twitter • Facebook • Pinterest • Instagram

www.tchd.org

Tri-County Health Department
Revenue Contracts FY20

	Contract Type	New or Renew	Program Name / Contract Name	Funding Agency	Contract Amount	Start Date	End Date	Auto Renew
	January-20		**Below**					
1	O	Renew	**SHW Sedalia Landfill - Construction / Sedalia Landfill (MOU amendment #1)**	Douglas County	$ 75,000.00	01/01/20	12/31/24	no
2	R	New	**Clinical Scholars / University of Colorado Anschutz Medical Campus**	TCHD	$ 21,888.00	09/01/20	08/31/20	Yes
3	R	Renew	**Regional Health Connectors / CDPHE Regions 3 & 14 & 15 (RTC)**	CDPHE	$ 52,500.00	01/31/20	06/30/20	no
4	R	New	**EH / Air Quality - amendment #1**	CDPHE	$ 25,337.00	01/01/20	07/31/20	no
5	R	Renew	**Land Use - CCPD Food Systems Grant / Grant from City & County of Denver for Food Systems - Amendment**	City & County of Denver	$ 191,160.00	07/01/19	06/30/20	no
6	R	Renew	**Water Supplies - Private / Adams County**	Adams Co	$ 51,789.00	01/01/20	12/31/20	no
7	R	Renew	**Admin / Douglas County Per Capita**	Douglas County	$ 2,486,145.00	01/01/20	12/31/20	no
	February-20		**Below**					
1	R	New	**WIC Referral Project / CDPHE**	CDPHE	$ 174,302.00	02/01/20	09/30/21	no
2	R	Renew	**??MIECHVP / CDPHE Option Letter**	CDPHE	$ -	09/29/19	09/29/20	no
3	R	Renew	**Immunizations / Additional funds - Option Letter #3**	CDPHE	$ 83,632.00	03/01/20	06/30/20	no
4	R	Renew	**HIV STI - HIV LTC Linkage to Care / CDPHE (Amendment #2)**	CDPHE	$ 83,588.00	02/01/20	06/30/20	no
5	R	New	**Sexual Health / CDPHE Option Letter #7**	CDPHE	$ 80,000.00	02/10/20	03/31/20	no
6	R	Renew	**PHEP / CDHPE (Amendment #1)**	TCHD	$ -	07/01/19	06/30/20	no
7	R	New	**Admin Finance / BerryDunn (Amendment #2) more demos**	TCHD	$ 2,371.00	when signed	05/31/20	none
	March-20		**Below**					
1	R	Renew	**Advanced Breastfeeding in CO / STRIDE BFF MOU (Breastfeeding Friendly Clinic)**	TCHD	$ -	when signed	infinity	Yes
2	R	New	**CHP / DHHA FDP Cost Reimbursement Subaward**	DHHA	$ 20,145.19	03/01/20	12/14/21	no
3	R	Renew	**Immunizations / Additional funds - Amendment #3 (HEP A)**	CDPHE	$ 15,756.00	03/01/20	06/30/20	no
4	R	Renew	**Tower Landfill - Ops & Construction Oversight / Tower Landfill MOU**	Adams CO	$125,000 ($25,000/yrs)	07/01/19	06/30/24	Yes
	April-20		**Below**					
1	R	New	**Hunger Free Outreach / Hunger Free Colorado (SNAP) - Policy for Telephonic Signature**	CDPHE	$ -	When signed	09/30/20	no
2	R	New	**Sexual Health / CDPHE Option Letter #8**	CDPHE	$ 113,881.00	04/01/20	06/30/20	no
	May-20		**Below**					
1	R	Renew	**NFP Continuation / NHVP Holdover Notice**	CDHS	$ 521,483.00			no
2	O	New	**Tobacco / Sub Grantee: Douglas County Schools**	CDPHE	$ 80,000.00	10/01/19	06/30/21	no
3	O	Renew	**PIM / MCH - Alix's Program - Interagency**	TCHD	$ 7,800.00	04/20/20	03/31/21	no
4	R	Renew	**Arapahoe Nurse Support / Child First & Child NSP - Arapahoe MOU**	ACDHS	$ 1,109,291.30	06/01/20	05/31/21	no
5	R	New	**EPRCDS / COVID-19 Response from CDPHE**	CDPHE	$ 829,361.00	03/16/20	03/15/21	no
6	R	New	**COVID-19 Response / The Colorado Trust**	Colorado Trust	$ 40,000.00	**05/06/20**	**none**	no

Tri-County Health Department
Revenue Contracts FY20

	Contract Type	New or Renew	Program Name / Contract Name	Funding Agency	Contract Amount	Start Date	End Date	Auto Renew
7	R	Renew	SHW Tires / CDPHE Waste Tires	CDPHE	$ 16,060.00	07/01/20	06/30/21	no
	June-20		Below					
1	R	Renew	WIC Referral Project / CDPHE Amendment #1	CDPHE	$ -	05/15/20	09/30/21	no
2	R	Renew	Achieving Equitable Access to Health through Gov't Settings and Workplace / CDHPE - CCPD Option Letter #3	CDPHE	$ 300,300.00	07/01/20	06/30/21	no
3	R	Renew	Healthy Beverage Initiative / FDP Cost Reimbursement Subaward Agreement - A35 Healthy Beverage Partnership 2.0 (MHBP)	CDPHE	$ 53,395.00	07/01/20	06/30/21	no
4	R	New	Diabetes Prevention / Healthy Interactions, LP	CCPD	$ 53,395.00	when signed	06/30/21	no
5	R	New	Cancer & Diabetes / CCPD	CDPHE	$ 335,000.00	07/01/18	06/30/21	no
6	R	Renew	Advanced Breastfeeding in CO - Colorado Health Inst / CHI (CCPD Subcontract) Colorado Health Inst.	CHI	$ 138,182.00	07/01/20	06/30/21	no
7	R	Renew	Communities That Care (CTC) / CDPHE Amendment #2	CDPHE	$ 349,690.00	07/01/20	06/30/21	no
8	R	Renew	NFP / Arapahoe County TANF	Arapahoe County	$ 137,378.64	07/01/20	06/30/21	no
9	R	New	Regional Health Connectors (RTC) / University of Colorado Anschutz		$ 142,500.00	01/03/20	06/30/21	no
10	R	Renew	Immunizations / Additional funds - Amendment #4	CDPHE	$ 804,634.00	07/01/20	06/30/21	no
11	R	Renew	Sexual Health (formerly Family Planning Title X) / Task Order Contract	CDPHE	$ 886,119.00	07/01/20	06/30/21	no
12	R	Renew	Senior Dental / HCPF	HCPF	$ 38,513.00	07/01/20	06/30/21	no
13	R	Renew	PHEP / CDHPE (Amendment #2)	TCHD	$ 926,841.00	07/01/20	06/30/21	no
14	R	Renew	CRI / CDHPE Amendment #1	CDPHE / CDC	$ 253,537.00	07/01/20	06/30/21	no
15	R	Renew	Land Use - General /Adams County Land use MOU	Adams Co		2020	2021	no
16	R	New	OPPI / State Per Capita / Child Fatality Funding, Amendment #4	CDPHE	$ 1,966,074.00	07/01/20	06/30/21	no
	July-20		Below					
1	R	New	WIC / City of Thornton - CARES Act Funding / Health Farmers Markets	WIC	$ 17,418.00	06/25/20	11/13/20	no
2	R	Renew	CDPHE / WIC - Amendment #2	WIC	$ 23,000.00	07/15/20	09/30/20	no
3	R	Renew	Tobacco / CDPHE - Option Letter #3	CDPHE	$ 1,318,075.00	07/01/20	06/30/21	no
4	R	Renew	Clinical Scholars / University of Northern Colorado	UNC	$ 21,888.00	07/01/20	06/30/21	no
5	R	Renew	Nurse Support Program / Adams County Human Services -Pregnancy Support Services	ACHS	$ 372,761.00	06/01/20	05/31/21	no
6	R	Renew	Nursing / Adams County Human Services - Adams County / TCHD Contract Cost Amendment for 2020	Adams Co	$ 11,526.48	01/01/20	12/31/20	Yes
7	R	Renew	HIV STI - HIV LTC Linkage to Care / CDPHE (Option Letter #1)	CDPHE	$ 138,858.00	07/01/20	03/31/21	no
8	R	Renew	HIV / CHAPP HIV Prevention Contract Option Letter #2	CDPHE	$ 83,607.00	07/01/20	06/30/21	no
9	R	Renew	HIV / Option Letter #1	CDPHE	$ 120,605.00	05/15/20	12/31/20	no
10	R	Renew	Sexual Health / CDPHE Option Letter #9	CDPHE	$ 110,000.00	06/17/20	06/30/20	no

Tri-County Health Department
Revenue Contracts FY20

	Contract Type	New or Renew	Program Name / Contract Name	Funding Agency	Contract Amount	Start Date	End Date	Auto Renew
11	R	Renew	Sexual Health (formerly Family Planning Title X) / Option Letter #1	CDPHE	$ (58,268.00)	07/09/20	06/30/21	no
12	R	New	EPRCDS / CARES Act - Adams County	CDPHE	$ 2,936,421.00	05/01/20	12/04/20	no
13	R	New	EPRCDS / CARES Act - Arapahoe County	CDPHE	$ 3,661,990.00	03/01/20	11/30/20	no
14	R	New	EPRCDS / CARES Act - Douglas County	CDPHE	$ 1,937,696.00	07/14/20	11/30/20	no
15	R	New	EPRCDS / ELC Enhanced Detection COVID Funds	CDPHE	$ 11,331,263.58	06/17/20	12/29/22	no
16	R	New	EPRCDS / CARES Act - CDPHE	CDPHE	$ 1,431,860.00	06/15/20	12/30/20	no
17	R	New	EH / Air Quality - Option Letter #1	CDPHE	$ -	07/01/20	12/31/20	no
18	R	Renew	Biosolids / CDHPE (Revised SOW, same amount)	CDPHE	$ 7,200.00	07/01/20	06/30/22	no
	August-20		Below					
1	R	New	CHP / SAMHSA (notice of award)	NIH Nat'l Institute of Health	$ 168,881.00	09/30/20	09/29/21	no
2	R	Renew	MCH Block Grant / CDPHE	CDPHE	$ 1,306,374.00	10/01/20	09/30/21	no
3	R	Renew	NFP Continuation / NHVP Award Letter - Amend #2	CDHS	$ 3,263,371.00	07/01/20	06/30/21	no
4	R	Renew	Immunizations / Option Letter # 4	CDPHE	$ 558,250.00	08/01/20	06/30/21	no
5	R	Renew	HIV STI CTR / CDPHE Amendment #3	CDPHE	$ 67,500.00	07/27/20	12/31/20	no
6	R	renew	CDPHE / CDPHE Syndromic Surveillance Grant OL #1	CDPHE (CDC)	$ 175,006.01	08/01/20	07/31/21	no
7	R	New	Overdose To Action / SyS Overdose to Action - Option Letter #1	CDPHE (CDC)	$ 154,049.35	09/01/20	08/31/21	no
8	R	New	Retail Food - Modernization / U.S. Food & Drug	USDA	$ 20,000.00	01/06/20	09/30/20	no
9	R	New	Retail Food - Food Safety Edu / U.S. Food & Drug	USDA	$ 3,000.00	02/01/20	08/31/20	no
	September-20		Below					
1	O	Renew	Syndromic Surveillance / Denver Health & Hospital Authority (ECL Grant) sub award	CDPHE / DHHA	$ 83,669.00	08/01/20	07/31/21	no
2	R	Renew	WIC Program / CDPHE WIC Option Letter #2	CDPHE	$ 5,398,285.00	10/01/20	09/30/21	no
3	R	New	WIC / Colorado Access - R3/R5 Community Innovation Pool - (CIP Award)	Colorado Access (UCDE sub)	$ 67,525.88	when signed	09/30/22	no
4	R	Renew	WIC Peer Counseling / WIC BFPC Services Amend 1	CDPHE	$ 221,226.00	10/01/20	09/30/21	no
5	R	New	Denver Regional Accountable Health Communities Model (ACH) / DRCOG	DRCOG	$ 193,000.00	when signed	04/30/21	no
6	R	New	WIC / City of Thornton - CARES Act Funding / Health Farmers Markets Round 2	WIC	$ 65,000.00	when signed	11/13/20	no
7	R	Renew	AR Nurse Support / Arapahoe County Adult First NSP	Arapahoe County	$ 70,837.93	07/01/20	06/30/21	no
8	R	Renew	Arapahoe Nurse Support / Child First & Child NSP - Arapahoe MOU - Amend #1	ACDHS	$ 20,053.13	06/01/20	05/31/21	no
9	R	new	MIECHVP / CDPHE - Amendment #5	CDHS	$ 903,119.00	10/01/20	09/30/21	no
10	R	New	PHEP / Adams County (R) PON Planning Grant	CDPHE	$ 50,000.00	09/22/20	12/30/20	no
11	R	New	PHEP / Adams Arapahoe - Protect our Neighbors Infrastructure Grant - PON	TCHD	$ 115,500.00	09/22/20	12/30/20	no
12	R	New	PHEP / Arapahoe County (R) Planning Grant Grant App - PON	CDPHE	$ 50,000.00	09/14/20	12/30/20	no

Tri-County Health Department
Revenue Contracts FY20

	Contract Type	New or Renew	Program Name / Contract Name	Funding Agency	Contract Amount	Start Date	End Date	Auto Renew
13	R	Renew	PHEP / CDHPE (Amendment #3)	TCHD	$ -	09/30/20	06/30/21	no
14	R	New	PHEP / Douglas County (R) Planning Grant - PON	TCHD	$ 50,000.00	08/27/20	12/30/20	no
15	R	New	PHEP / Immunize Colorado (R) - Infrastructure - PON	CDPHE	$ 50,000.00	09/14/20	12/30/20	no
	October-20		Below					
1	R	Renew	Hunger Free Outreach / Hunger Free Colorado (SNAP)	CDPHE	$ 105,037.00	10/30/20	09/30/21	no
2	R	Renew	Denver Regional Accountable Health Communities Model (ACH) / DRCOG - Amend #1	DRCOG	$ -	when signed	04/30/21	no
3	R	new	MIECHVP / CDPHE - Amend #6 (missing Exhibit A SOW)	CDHS	$ -	10/01/20	09/30/21	no
4	R	New	PHEP / CDPHE Healthy Staffing PON	TCHD	$ 284,500.00	10/12/20	12/30/20	no
5	R	renew	PHEP / CARES Act - Adams County - Amend 1	Adams	$ 82,750.00	when signed	12/04/20	no
	November-20		Below					
1	O	Renew	HCR / Board of County Commissioners of Douglas County IGA	Douglas County	$ 77,000.00	11/01/21	07/01/21	no
2	R	New	WIC Referral Project / CDPHE Amendment #2	CDPHE	$ -	11/30/20	09/30/21	no
3	R	renew	Hunger Free Outreach / Hunger Free Colorado (SNAP)	CDPHE	$ 105,037.00	10/01/20	09/30/21	no
4	R	Renew	Clinical Scholars / Regis	Regis	$ 18,816.00	09/01/20	08/31/21	yes
5	R	Renew	Clinical Scholars / UCD Anschutz	UNC	$ 14,592.00	09/01/20	08/31/21	yes
6	R	New	Immunizations / IMM #2	CDPHE	$ 279,125.00	11/02/20	06/30/21	no
7	R	Renew	Arapahoe Senior Dental / Direct 2 You, Inc.	State of Colorado	$ 3,625.00	11/10/20	12/31/20	no
8	R	Renew	Communicable Disease - Foodnet / DCEED	CDPHE	$ 69,893.00	01/01/20	12/31/21	no
9	R	New	Communicable Disease Pertussis / CDPHE DCEED (Amendment #2)	CDPHE	$ 26,398.00	01/01/21	12/31/21	no
10	R	New	PHEP / CARES Act - Arapahoe County MOU - Amend 1	Arapahoe Co	$ 82,750.00	11/16/20	11/30/20	no
11	R	renew	EPRCDS / CARES Act - Douglas County - Colorado DHSEM - Amend #2	CDPHE	$ -	07/14/20	12/30/20	no
12	R	Renew	HCR / Centennial Metro District (1 of 5) (MOU)	Douglas County	$ 15,000.00	01/01/20	07/01/21	no
13	R	Renew	HCR / Highlands Ranch (2 of 5) (MOU)	Douglas County	$ 15,000.00	01/01/20	07/01/21	no
14	R	New	Admin Finance / BerryDunn (Amendment #4)	TCHD	$ 28,860.00	when signed	12/31/21	no
	December-20		Below					
1	R	New	Nurse Support Program (NSP) / Douglas County IGA	Douglas County	$ 125,000.04	11/01/20	10/31/21	no
2	R	Renew	Immunizations / Community Ambassador - Option Letter # 5	CDPHE	$ 100,000.00	12/01/20	06/30/21	no
3	R	Renew	Immunizations / CDC Supplemental COVID-19 Vaccine Redistribution Agreements	CDPHE	$ -	12/29/20	12/29/20	no
4	R	Renew	HIV-CHAPP / CDPHE Amendment #3 2021*0561	TCHD	$ 84,265.00	01/01/21	06/30/21	no
5	R	Renew	HIV-CHAPP / CDPHE Amendment #3 2021*0561	CDPHE	$ 268,504.78	01/11/21	12/31/21	no

Tri-County Health Department
Revenue Contracts FY20

	Contract Type	New or Renew	Program Name / Contract Name	Funding Agency	Contract Amount	Start Date	End Date	Auto Renew
6	R	New	**MCH WORA / Human Impact Partners Amend #1**	TCHD	$ 34,500.00	08/10/20	12/31/20	no
7	R	New	**EH / Air Quality - Option Letter #2**	CDPHE	$ -	01/01/21	06/30/21	no
8	R	Renew	**Land Use - CCPD Food Systems Grant / Colorado Access - Food in Communities**	City & County of Denver	$ 100,000.00	12/28/20	12/17/21	no
9	R	Renew	**Land Use - CCPD Food Systems Grant / Grant from City & County of Denver for Food Systems - Amend #2**	City & County of Denver	$ 191,160.00	07/01/20	06/30/21	no
10	R	New	**EH Special Response - Well Monitoring / Adams County**	CDPHE	$ 12,000.00	no less than 20 wells	ongoing	no
11	R	Renew	**HCR / Plum Creek WRA (4 of 5)**	Douglas County	$ 33,000.00	01/01/20	07/01/21	no
					$ 51,144,409.31			

INTERGOVERNMENTAL AGREEMENT FOR SEDALIA RECYCLING CENTER AND LANDFILL OVERSIGHT SERVICES

THIS AGREEMENT is made and entered into as of the 7th day of October 2019, by and between the Board of County Commissioners of the County of Douglas, Colorado (hereafter "County") and Tri-County Health Department, a political subdivision of the Counties of Adams, Arapahoe, and Douglas and the State of Colorado, with its principal offices located at 6162 S. Willow Drive, Suite 100, Greenwood Village, Colorado (hereafter "TCHD").

RECITALS:

WHEREAS, pursuant to the provisions of Article XIV, Section 18(2)(a) of the Colorado Constitution, and Section 29-1-203, C.R.S., there is established a means whereby governmental units may cooperate or contract with one another to make the most efficient and effective use of their powers and responsibilities; and

WHEREAS, the Sedalia Land Company, Inc. owns the subject land; and

WHEREAS, the Sedalia Land Company, Inc. operates a recycling center and a construction debris landfill for the site operated by Waste Connections, Inc. ("WCI"); and

WHEREAS, TCHD has submitted a proposal to the County to perform independent oversight services at the Sedalia Recycling Center and Landfill ("Sedalia Landfill"); and

WHEREAS, the essential elements of the proposal by TCHD, as referenced above, are set forth in a document entitled "Tri-County Health Department, Solid Waste Disposal Site Oversight Services for Sedalia Recycling Center and Landfill", a copy of which is attached hereto as Exhibit A and incorporated herein by reference; and

WHEREAS, implementation of said proposal by TCHD would assist in protecting the health and safety of the citizens of Douglas County; and

WHEREAS, the County has accepted the proposal from TCHD, as described above; and

WHEREAS, funds will be provided from service charges collected by Douglas County pursuant to Resolution numbers R-005-067 and R009-089, attached hereto and incorporated herein as Exhibit B, to compensate TCHD for the costs of the oversight program; and

WHEREAS, the County and TCHD mutually desire to embody their understanding and agreement in a written document as herein set forth.

NOW THEREFORE, IN CONSIDERATION OF the mutual obligations of the County and TCHD, as hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the County and TCHD hereby agree as follows:

1. Performance by TCHD: TCHD shall perform independent solid waste disposal site oversight pursuant to the terms and conditions set forth in Exhibit A. The County and TCHD shall review this agreement and the oversight services set forth in Exhibit A every year and make adjustments, if any, as necessary to meet the needs of each party signing this agreement.

2. Limited Obligation: The obligation of the County and TCHD shall be limited to the independent oversight as set forth in Exhibit A, and subsequent oversight services, if any, shall be subject to subsequent review and negotiation.

3. Oversight Funding: TCHD shall submit quarterly invoices to the County for approval. Payment will be made to TCHD within sixty (60) days of the date of each invoice. TCHD's annual program cost (Work Elements 1.0, 2.0, 4.0, and 5.0 of Exhibit A) shall not exceed twenty-five thousand dollars ($25,000) per year, unless authorized in writing by the County. Additionally, each quarterly full scope site visit identified in Sub Element 2.1 shall be funded in accordance with Condition Number Five (5) of the Conditions of Approval for the Certificate of Designation for Sedalia Recycling Center and Landfill which is attached hereto and incorporated herein as Exhibit C.

4. TCHD Insurance: TCHD shall be required to maintain insurance as set forth in Exhibit D, attached hereto and incorporated herein. TCHD shall provide evidence that such requirements have been met and shall provide updated information to the County in the event any changes are made to TCHD's insurance coverage during the term of this agreement.

5. Period Reports: TCHD shall verbally report any important findings to the County as soon as practicable. TCHD shall provide written interpretation of any water quality reports available for the site. The County may request a written report at any time for any specific oversight activity that is performed by TCHD. Oversight activities shall be summarized at a semi-annual meeting with the County.

6. Applicable Laws and Regulations: Nothing in this agreement relieves the County or TCHD from any obligation imposed upon them by law, regulation and other applicable requirements.

7. Conflict of Interest: TCHD agrees that no official, officer or employee of the County shall have any personal or beneficial interest whatsoever in the services or property described herein, and TCHD further agrees not to hire, pay or contract for services of any official, officer or employee of the County. A conflict of interest shall include transactions, activities or conduct that would affect the judgment, actions or work of TCHD by placing

TCHD's own interests, or the interest of any party with whom TCHD has a contractual arrangement, in conflict with those of County.

8. Indemnification: The County cannot and by this agreement does not agree to indemnify, hold harmless, exonerate or assume the defense of TCHD or any other person or entity whatsoever for any purpose whatsoever. To the extent allowed by law, specifically the Colorado Governmental Immunity Act, C.R.S. sections 24-10-101, *et seq.*, TCHD shall defend, indemnify and hold harmless the County, its commissioners, officials, officers, directors, agents and employees from any and all claims, demands, suits, actions or proceedings of any kind or nature whatsoever, including workers' compensation claims, in any way resulting from or arising from this agreement; provided, however, that TCHD need not indemnify or save harmless the County, its officers, agents and employees from damages resulting from the sole negligence of the County's commissioners, officials, officers, directors, agents and employees.

9. Independent Contractor: TCHD is an independent contractor and is free to perform services for other clients. Notwithstanding any provision of this agreement, all personnel assigned by TCHD to perform work under this agreement shall be and remain at all times, employees of TCHD for all purposes. THE INDEPENDENT CONTRACTOR IS NOT ENTITLED TO WORKERS' COMPENSATION OR UNEMPLOYMENT BENEFITS THROUGH THE COUNTY AND IS OBLIGATED TO PAY FEDERAL AND STATE INCOME TAX ON ANY MONIES EARNED PURSUANT TO THE CONTRACT RELATIONSHIP.

10. Assignment: TCHD covenants and agrees that it will not assign or transfer its rights hereunder, either in whole or in part without the prior written approval of the County. Any attempt by TCHD to assign or transfer its rights hereunder shall, at the option of the County, void the assignment or automatically terminate this agreement and all rights of TCHD hereunder.

11. County Review of Records: TCHD agrees that, upon reasonable request of the County, at any time during the term of this agreement, or three (3) years thereafter, it will make full disclosure to the County and make available for inspection and audit upon request by the County, the County Director of Finance or any of their authorized representatives, all of its records associated with work performed under this agreement for the purpose of making an audit, examination or excerpts. TCHD shall maintain such records until the expiration of three (3) years following the end of the term of this agreement.

12. Ownership of Documents: The intellectual property derived pursuant to the terms of this Agreement, such as drawings, specifications, guidelines and any other documents prepared by TCHD shall be jointly owned by TCHD and the County.

13. Liaisons:

For TCHD:

Lisa Oliveto
Solid Waste Specialist
Tri-County Health Department
4201 East 72nd Avenue Suite D
Commerce City, CO 80022

Phone: (303) 288-6816

For the County:

Billing Notices:

Andrew Copland
Director of Finance
Finance Department
100 Third Street
Castle Rock, CO 80104

Compliance Notices:

Michael Cairy
Department of Community Development
100 Third Street
Castle Rock, CO 80104
Phone: (303) 660-7460

14. Effective Date: This agreement shall become effective as of 12:00 a.m. on September 16, 2019 and terminate 11:59 p.m. December 31, 2019 unless modified pursuant to section 20 or terminated pursuant to section 21.

15. Annual Maximum Dollar Amount: Any other provision of this agreement notwithstanding and pursuant to section 29-1-110, C.R.S., the amount of funds appropriated for this agreement is twenty-five thousand dollars ($25,000.00) for fiscal year 2019. In no event shall the County be liable for payment under this agreement for any amount in excess thereof. The County is not under obligation to make any future apportionment or allocation to this agreement nor is anything set forth herein a limitation of liability for TCHD. Any potential expenditure for this agreement outside the current fiscal year is subject to future annual appropriation of funds for any such proposed expenditure.

16. Nondiscrimination: In connection with the performance of work under this agreement, TCHD agrees not to refuse to hire, discharge, promote or demote, or to discriminate in matters of compensation against any person otherwise qualified, solely

because of race, color, religion, national origin, gender, age, military status, sexual orientation, marital status or physical or mental disability.

17. Governing Law; Venue: This agreement shall be deemed to have been made in, and construed in accordance with the laws of the State of Colorado. Venue for any action hereunder shall be in the District Court, County of Douglas, State of Colorado. TCHD expressly waives the right to bring any action in or to remove any action to any other jurisdiction, whether state or federal.

18. Severability: In the event any of the provisions of this agreement are held to be unenforceable or invalid by any court of competent jurisdiction, the validity of the remaining provisions shall not be affected. Should either party fail to enforce a specific term of this agreement it shall not be a waiver of a subsequent right of enforcement, nor shall it be deemed a modification or alteration of the terms and conditions contained herein.

19. No Third Party Beneficiaries: The enforcement of the terms and conditions of this agreement and all rights of action relating to such enforcement, shall be strictly reserved to the County and TCHD, and nothing contained in this agreement shall give or allow any such claim or right of action by any other or third person under such agreement.

20. Entire Agreement: The parties acknowledge and agree that the provisions contained herein constitute the entire agreement and that all representations made by any commissioner, official, officer, director, agent or employee of the respective parties unless included herein are null and void and of no effect. No alterations, amendments, changes or modifications to this agreement shall be valid unless they are contained in writing and executed by all the parties with the same formality as this agreement.

21. Termination: The County or TCHD shall have the right to terminate this agreement, with or without cause, by giving written notice to the respective party of such termination and specifying the effective date thereof, which notice shall be given at least thirty (30) days prior to the effective date of such termination. In the event of termination, TCHD shall cease work as of the effective date of the termination, but shall be compensated for all work accomplished prior to the effective date of the termination. Notwithstanding the above, TCHD shall not be relieved of liability to the County for damages sustained by the County by virtue of any breach of the agreement by TCHD.

22. Priority of Provisions: In the event that any terms of this agreement and any Exhibit are inconsistent, the following order of priority shall control:

1st	Exhibit C
2nd	This agreement, sections 1 through 22
3rd	Exhibit B
4th	Exhibit D
5th	Exhibit A

[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK.
SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF the County and TCHD, by and through their authorized officers and agents, have executed this agreement on the respective dates set forth below.

THE BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF DOUGLAS, COLORADO,

BY: Doug DeBord
Douglas J. DeBord, County Manager

Date: 10/7/2019

APPROVED AS TO LEGAL FORM:

Dawn Johnson
Asst. County Attorney
Dawn Johnson
Date: 10/5/2019

APPROVED AS TO FISCAL CONTENT:

Andrew Copland
Andrew Copland, Director of Finance

Date: 10/7/2019

TRI-COUNTY HEALTH DEPARTMENT

By:
Dr. John M. Douglas, Jr., M.D.
Executive Director

Date: 10/3/19

ATTEST

Theresa Fox
Theresa Fox
Finance Director

Exhibit A
SOLID WASTE DISPOSAL SITE OVERSIGHT SERVICES
FOR SEDALIA RECYCLING CENTER AND LANDFILL

INTRODUCTION

Tri-County Health Department (TCHD) is pleased to submit this proposal to Douglas County (the County) to provide oversight services for the Sedalia Recycling Center and Landfill (Sedalia Landfill). Services would include oversight of design, construction, and operation of the Sedalia Landfill. Over time, TCHD has developed a high level of expertise related to oversight of solid waste disposal sites and maintains a staff of highly qualified engineers and specialists to perform these tasks. TCHD currently provides oversight services to facilities in Adams County (Conservation Services, Inc. and the Rocky Mountain Arsenal) and Commerce City (Tower Road Landfill). These services encompass both the solid and hazardous waste spectrum.

This particular oversight program is designed to be a public/private "partnership" that we believe will benefit the landfill operator, the County, and the community. TCHD's role in this partnership is to perform as an independent third party to assist the County in addressing community concerns related to the operation and construction of the facility. TCHD understands that the Colorado Department of Public Health and Environment (CDPHE) plays the lead role in terms of enforcing the Regulations Pertaining To Solid Waste Disposal Sites and Facilities, 6 CCR 1007-2 (Regulations). The scope of services performed by TCHD in this oversight program is not intended to duplicate or usurp CDPHE's role at the Sedalia Facility.

Presented below is a description of the scope of services to be conducted by TCHD for the County at the Sedalia Facility.

SCOPE OF SERVICES

TCHD proposes to provide services in the following areas:

- Review of changes to the Engineering Design and Operations Plan (EDOP) for the facility
- Operations Oversight
- Construction Oversight
- Consultation Services
- Reporting

Each of these specific service areas is described in the following Work Elements (WE):

WE 1.0 ENGINEERING DESIGN AND OPERATIONS PLAN (EDOP) REVIEW

TCHD proposes to assist the County, at their request, in reviewing changes to the approved EDOP for the facility. TCHD's objective under this WE would be to focus on design and operational changes that are of local concern. It is not our intent to make recommendations to the County that would result in design or operational requirements that are more stringent than required by the Solid Waste Disposal Sites and Facilities Act (Sections 30-20-100, *et seq.,* C.R.S.) and Regulations, but to make recommendations that will enhance the compatibility of the facility with the surrounding community. This section will only be implemented and billed to the County upon its specific request. Design and operational issues that TCHD may review and comment on include:

- Proposed amendments to the EDOP
- Provisions for windblown litter control and retrieval
- Odor control
- Bird control
- Fugitive dust control
- Vector Control
- Contaminated runoff control
- Recycling
- Revegetation timelines and criteria
- Final Cover

WE 2.0 OPERATIONAL OVERSIGHT

The Sedalia Landfill may come under significant scrutiny from area residents. TCHD believes that the County will benefit from having an independent third party with a public health focus provide additional oversight beyond the inspections that CDPHE conducts. Our increased level of oversight will help identify areas in operations that may need attention. This will enable operations to be adjusted at that point in time rather than after they have become a problem.
TCHD proposes to conduct 4 full scope site visits and 8 limited scope site visits per year. Activities pertaining to each type of site visit are described in the following Sub Elements (SE):

SE 2.1 Full Scope Site Visits

Each quarterly full scope site visit shall be performed in accordance with Section Five (5) the Conditions of Approval for the Certificate of Designation Sedalia Recycling Center and Landfill and shall include:

- A review of the operating record for the facility including groundwater and landfill gas monitoring records

- Observation of waste placement techniques
- A field visit to observe provisions for controlling wind blow refuse
- Observation of fugitive dust control techniques
- A field visit to observe provisions to control stormwater runoff from the site
- Monitor for compliance with bird control program
- An exit meeting with Waste Connections Incorporated (WCI) personnel to discuss any concerns that may require immediate attention
- A phone conversation, e-mail or brief meeting with the County to discuss the findings of the site visit
- A full written report prepared and delivered to County

SE 2.2 Limited Scope Site Visits

Limited scope site visits are intended to address WCI's operational procedures related to litter control, dust control, observation of groundwater monitoring, or in response to a complaint. TCHD will conduct 8 limited scope site visits per contract year.

WE 3.0 CONSTRUCTION OVERSIGHT

Proper construction of landfill liners, covers, and leachate collection and removal systems is vital to the long-term performance of any landfill. TCHD has developed a high level of expertise related to landfill construction oversight. We have provided this service at several landfill facilities including the Highway 36 Hazardous Waste Disposal Site, Conservation Services, Inc., Tower Road Landfill, and the RMA Hazardous Waste Landfills. Proposed oversight services would consist of providing limited field observation of landfill construction. This oversight allows TCHD to speak confidently to the public regarding the Quality Assurance/Quality Control (QA/QC) provisions that are implemented by the Owner/Operator to ensure that a high quality facility is constructed.

TCHD proposes to implement a landfill construction oversight program at the Sedalia Facility. The specifics of the construction oversight program will be developed with WCI and the County on a project specific basis and will be dependent on the type of construction being performed. Fees for construction oversight would not be subject to the $25,000 per year maximum as specified in Paragraph 3 of the Agreement between the County and TCHD but shall be subject to the maximum contract liability of Paragraph 16 of the Agreement. Because it is difficult to estimate how much time will be spent on a given construction project, TCHD estimates it's fees for construction oversight as follows:

Landfill liner and leachate collection system:	$1,500 per acre
Landfill cover system:	$1,500 per acre

WE 4.0 CONSULTATION SERVICES

The Solid Waste Disposal Sites and Facilities Act (Sections 30-20-100, *et seq.,* C.R.S.) and the Regulations promulgated by the CDPHE (6 CCR 1007-2) identify:

A. Issues requiring local approval or concurrence from the local governing body, which in this case is the County
B. Issues where CDPHE will seek consultation from the local governing body
C. Other areas of local responsibility
D. Information that is required to be submitted to the local governing body

Examples of each of these areas are listed below:

A. Issues Requiring Local Approval or Concurrence

- Certificate of Designation and revisions to the CD
- Financial assurance
- Alternative wind measuring devices
- Closure extensions
- Waste isolation demonstration
- Alternative daily cover
- Completion of Post-Closure care
- Reports documenting that groundwater contamination is not from the facility
- Assessment Monitoring Program Corrective Measures Study timeframe
- Sludge disposal
- Liquids disposal

B. Issues Where CDPHE Will Seek Local Consultation

- Waivers of regulatory requirements
- Adequacy of financial assurance
- Justifications for changing financial assurance
- Closure Plan
- Post-Closure Plan
- Proposed deletion of parameters from the Detection Monitoring Program
- Addition of parameters to the Detection Monitoring Program
- Determination that a Corrective measure is unnecessary
- Selection of alternative groundwater protections standards
- Determinations that standards at the point of compliance are not being achieved and that an alternative remedy is necessary

C. Other Areas Of Local Responsibility

- Enforcement of local ordinance or rule

- Issuance of the CD
- Enforcement of CD stipulations and conditions precedent
- Suspension of CD for insufficient financial assurance
- Suspension of CD for failure to release financial assurance
- Seek to have the facility enjoined for being a public nuisance
- Inspection for compliance with Act and Regulations (optional)
- 30-Day Public Comment Period on Corrective Measures Assessment

D. Information that is Required To Be Submitted To The Local Governing Body

- Proof of financial assurance
- Violations of the Act and Regulations
- Conditions or events likely to cause a release of a substance on the groundwater monitoring list
- Exceedance of explosive gas limits within site buildings or the boundary
- Explosive gas remediation plans
- Operating Record Notification – Location restriction demonstration
- Operating Record Notification – Inspection records
- Operating Record Notification – Training procedures
- Operating Record Notification – Gas monitoring results
- Operating Record Notification – Design documentation for leachate and gas
- Operating Record Notification – Closure and Post-Closure Care Plans
- Operating Record Notification – Cost estimates and financial assurance documentation
- Operating Record Notification – Information demonstrating compliance with waivers
- Bird Hazard Mitigation Plan
- Unstable Area Demonstration
- Notification of Closure Deed Restriction
- Notification of significant change to background groundwater quality levels
- Remedy Completion Reports
- Results of initial sampling events from the Groundwater Assessment Monitoring Program
- Results of subsequent sampling events from the Groundwater Assessment Monitoring Program
- Documentation that Assessment Monitoring Program Appendix II results are at or below background
- Reports regarding Appendix II results that are above background
- Notification of Intent to implement interim measure for groundwater corrective measure
- Groundwater Corrective Measures Selection Report
- Periodic progress reports on corrective measures implementation

TCHD is available to assist the county by providing consultation services associated with any of the above listed areas. TCHD will make specific recommendations to the County when, in TCHD's opinion, there is a need for such services based on TCHD's assessment of any specific situation. This WE would also include conducting complaint investigations or other services associated with the Sedalia Landfill that are requested by the County.

WE 5.0 REPORTING

TCHD proposes to include a semi-annual meeting with the County. Each meeting will include:

- A summary of all oversight activities
- A synopsis of each full and limited scope site visit
- The resolution of any complaints that TCHD assists in resolving
- A six-month look ahead for the oversight activities that will be conducted in the next reporting period

Exhibit B
RESOLUTIONS

Exhibit C
CERTIFICATE OF DESIGNATION

Exhibit D
INSURANCE REQUIREMENTS

1. TCHD agrees to procure and maintain with insurers with an A- or better rating as determined by Best's Key Rating Guide, at its own expense, the following policies of insurance:

   a) Workers' Compensation insurance to cover obligations imposed by applicable laws for any employee engaged in the performance of work under this agreement, and Employers' Liability insurance with the following limits:

Workers' Compensation:	Statutory
Employers' Liability:	$1,000,000

   b) Commercial General Liability insurance with minimum combined single limits of ONE MILLION DOLLARS ($1,000,000) each occurrence and ONE MILLION DOLLARS ($1,000,000) aggregate. The policy will be applicable to all premises and operations. The policy will include coverage for bodily injury, broad form property damage (including completed operations), personal injury (including coverage for contractual and employee acts), blanket contractual, independent contractors, products, and completed operations. The policy will include coverage for explosion, collapse and underground hazards. The policy will contain a severability of interests provision.

   c) Commercial Automobile Liability insurance with minimum combined single limits for bodily injury and property damage of not less than ONE MILLION DOLLARS ($1,000,000) each occurrence with respect to each of TCHD'S owned, hired and non-owned vehicles assigned to or used in performance of the services. The policy will contain a severability of interests provision.

   d) Professional Liability Insurance Coverage - TCHD shall be self-insured for professional liability. TCHD shall provide evidence of excess liability coverage for all other hazards.

2. The required Commercial General Liability and Commercial Automobile Liability policies will be endorsed to include Douglas County as a Certificate Holder and name Douglas County, its officers and employees as additional insureds. The required Workers' Compensation policy will be endorsed to include Douglas County as a Certificate Holder. Douglas County reserves the right to request and receive a certified copy of any policy and any endorsement thereto.

3. The certificates of insurance will be attached to this agreement as evidence that policies providing the required coverages, conditions, and minimum limits are in full force and effect. The completed certificates of insurance and any notices, within 20 days of cancellation, termination, or material change will be sent to:

Megan Datwyler
Douglas County
Risk Management
100 Third Street
Castle Rock, Colorado 80104

4. TCHD will not be relieved of any liability, claims, demands, or other obligations assumed by its failure to procure or maintain insurance, or its failure to procure or maintain insurance in sufficient amounts, durations, or types.

5. Failure on the part of TCHD to procure or maintain policies providing the required coverages, conditions and minimum limits will constitute a material breach of contract upon which Douglas County may immediately terminate this agreement.

6. The parties hereto understand and agree that Douglas County is relying on, and does not waive or intend to waive by any provision of this contract, the monetary limitations (presently $350,000 per person and $990,000 per occurrence) or any other rights, immunities, and protections provided by the Colorado Governmental Immunity Act, Sections 24-10-101, *et seq.*, C.R.S., as from time to time amended, or otherwise available to Douglas County, its officers, or its employees.

7. The parties agree that TCHD will request professional liability insurance acceptable to Douglas County from any subcontractors or consultants utilized in connection with this agreement. TCHD shall provide evidence of such insurance prior to authorizing any work to be performed by such subcontractor or consultant.

Approved by: _____
Megan Datwyler
Risk Manager

Pocket Guide

for Local Boards of Health

In Accordance with
the Colorado Public Health Act of 2008
C.R.S. 25-1-501 et seq.

revised March, 2015

COLORADO
Office of Planning,
Partnerships & Improvement
Department of Public Health & Environment

Table of Contents

Public Health Practice 1

Public Health Legislation 2

Local Public Health Agency:
Organization and Personnel 3

Local Public Health Agency: Duties 4

Local Public Health Agency:
Funds and Treasurer 5

Local Board of Health Structures 6

Local Board of Health Appointments 7

Selection of a Public Health Director 8

Powers and Duties: Boards and Directors 10

Public Health Resources 13

Public Health Practice

Public Health Practice is the utilization of science-based strategies to promote the health of the community; prevent disease, injury and premature death; and respond to environmental threats and emergencies that could impact human health. In practice, state and local public health agencies work to ensure:

- Community health status is regularly assessed and plans made to improve health
- Infectious diseases are monitored and investigated to prevent their spread
- Children and adults have the opportunity to be vaccinated against disease
- Screening programs are available for early identification of chronic diseases
- Reproductive health services are available
- Health care services are available to all populations within the community
- Emergency response plans are in place for disasters
- Hazards that cause injury or disease are mitigated
- Drinking water is safe
- Air is healthy
- Sewage is contained
- Restaurants serve safe, untainted food

Public Health Legislation

The Colorado Public Health Act of 2008, C.R.S. 25-1-501 et seq., is intended to improve the performance of the public health system statewide. Within the Act, the Colorado General Assembly declared the following:

> *The public health system reduces health care costs by preventing disease and injury, promoting healthy behavior, and reducing the incidents of chronic diseases and conditions. Thus, the public health system is a critical part of any health care reform. Each community in Colorado should provide high-quality public health services regardless of its location. A strong public health infrastructure is needed ...and is a shared responsibility among state and local public health agencies and their partners within the public health system.*

In general, the Act:

- Restructured the local governmental public health system.
- Defined the duties of a local public health agency.
- Directed the Colorado Board of Health to establish by rule:
  - minimum qualifications for directors
  - core public health services
  - minimum quality standards for public health services, and
  - a funding formula for allocating moneys to county and district public health agencies.
- Defined new roles for the state board of health and local boards of health.
- Established a collaborative, five-year planning cycle at the state and local levels.

Local Public Health Agency Organization & Personnel

The Act requires that each county establish and maintain a county public health agency or participate in a district public health agency. Any two or more contiguous counties may establish a district public health agency.

According to the Act, an agency shall consist of a county or district board of health, a public health director and a medical officer (if the director is not a physician), and other relevant personnel necessary to carry out the duties of the agency. The type of personnel will vary, given community needs and population size. Agencies may choose to employ professionals with specific expertise, share FTEs with other agencies, or contract with another agency for services. The following are examples of common positions held within local public health agencies.

- Emergency Preparedness Coordinator
- Environmental Health Specialist
- Epidemiologist
- Health Educator
- Health Planner
- Nutritionist
- Public Health Nurse

Local Public Health Agency Duties

The Act defines a public health agency as an organization operated by a federal, state, or local government or its designees that acts principally to protect and preserve the public's health. The Act established the duties of all local public health agencies, including carrying out the public health laws and rules of the state board and commissions.

In addition to other powers and duties, an agency shall:

- Complete a community health assessment and to create a county or district public health plan at least every five years.
- Advise the local board of health on public policy issues necessary to protect public health and the environment.
- Provide or arrange for the provision of quality, core public health services as defined by the Colorado Board of Health.

Core Public Health Services and minimum quality standards for providing core public health services were established by Colorado Board of Health rules(6 CCR 1014-7 and 6 CCR 1014-9).

- Assessment, Planning, and Communication
- Vital Records and Statistics
- Communicable Disease Prevention, Investigation, & Control
- Prevention and Population Health Promotion
- Emergency Preparedness and Response
- Environmental Health
- Administration and Governance

Note: the local public health agency can provide the service itself, refer to another organization, or contract with another agency or organization to provide the service, including neighboring counties. The agency has met this requirement if it can demonstrate that other providers offer this service sufficient to meet the local need.

Local Public Health Agency Funds & Treasurer

The Act (C.R.S. 25-1-511) states that the county treasurer shall serve as the treasurer of the county public health agency. In the case of a district agency, the treasurer of the county having the largest population shall serve as treasurer to the agency. The agency treasurer shall create a public health agency fund, to which shall be credited:

- Any moneys appropriated from a county general fund.
- Any moneys received from state or federal appropriations or any other gifts, grants, donations, or fees for local public health purposes.

The agency treasurer assures that moneys from the fund shall be expended only for the purposes of the public health agency. all claims or demands against the fund shall be allowed only if certified by the public health director and the president of the county or district board or their designee.

On or before September 1 of each year, the public health director, along with the local board of health, shall estimate the total cost of maintaining the public health agency for the ensuing fiscal year. The estimates shall be submitted in the form of a budget to the board of county commissioners in a single county agency, and a committee composed of the chairs of the boards of county commissioners in a district agency.

The board of county commissioners (or the respective boards if in a district agency) are authorized to provide any moneys necessary to cover the cost of maintaining the agency for the next fiscal year, by an appropriation from the county general fund or general funds from all counties (proportionately) in a district. In order to qualify for state assistance, the counties shall contribute a minimum of one dollar and fifty cents per capita for its local or district health services, and may contribute additional amounts as it may determine to be necessary to meet its local health needs.

Local Board of Health Structures

COUNTY AGENCIES

- Each county board of health shall consist of at least five members.
- The terms of the initial appointments are staggered, and then for five years thereafter.
- Members of the county board of health shall reside within the county where the public health agency is located.
- No business or professional group or governmental entity shall constitute a majority of the board.
- In counties with populations of less than 100,000, a three member board may be appointed. The board of county commissioners may designate itself as the county board ofhealth if there was not a separate board of health prior tothe effective date of the Act.

DISTRICT AGENCIES

- Each district board of health shall consist of a minimum of five members, and include at least one representative from each county in the district.
- Members of the district board of health shall be residents of one of the counties within the district.
- No business, professional group or governmental entity shall constitute a majority of the board.

Electing Local Board of Health Officers

Once a local board of health is established, a president and other officers should be elected at an organizational meeting. The Public Health Director may serve as secretary, at the board's discretion, but shall not be a member of the board.

Meetings

Regular meetings of a board of health must be held at least once every three months. Special meetings may be called with three days notice, or in the case of an emergency twenty-four hours notice by the public health director, the president of the board, or by the majority of the members of the board.

Adopting By Laws

A county or district board may adopt, and at any time, may amend bylaws in relation to its meetings and the transaction of its business. A majority of the board shall constitute a quorum.

Local Board of Health Appointments

The Act (C.R.S. 25-1-508) states that members of a county board of health shall be appointed by the board of county commissioners. Furthermore, members of a district board shall be appointed by an appointments committee, composed of one commissioner from each county comprising the district.

Because local boards of health play a vital role in the public health system by providing oversight, recommending budgets, and developing policies to keep the public safe and healthy, the National Association of Local Boards of Health (NALBOH) has developed recommendations for appointing authorities to consider. NALBOH recommends that board membership reflect the diversity of the community it serves, and board members have expertise in the areas of:

- Public Health
- Environmental Health
- Medicine/Nursing
- Health Promotion/Health Education
- Mental Health/Social Work
- Education
- Community Advocacy
- Media Relations
- Business

In addition, the Act specifies that members of the board shall serve without compensation, with the exception of necessary travel and subsistence expenses to attend meetings.

Public Health Director Selection

The Act directs local boards of health to select a public health director, who meets the following minimum qualifications established in rule (6 CCR 1014-6) and listed below:

Physician Director Candidate:

- Licensed to practice in Colorado within six months of hire.
- Medical school graduate (MD or DO) & preferably board certified in preventive medicine.
- Within the past ten years, have five years of administrative experience in public health or related field; two years supervising public health professionals.
- A candidate with one year of graduate study in a recognized school of public health is preferred.

Non-Physician Director Candidate:

- Master's degree in public health or related discipline.
- Within the past ten years, have five years of administrative experience in public health or related field; two years supervising public health professionals.
- If candidate is a nurse, he/she shall have a license to practice in Colorado within six months of hire.

Note: If the public health director is not a licensed physician, a designated medical officer (advisor) shall be employed or contracted (paid or volunteer) by the district or county board of health to advise the public health director on medical decisions and be available at all times to the public health director. The medical officer must be a graduate from an approved medical school (MD or DO) and licensed to practice medicine in the state of Colorado.

Public Health Director Selection

Substitutions: The local board of health may substitute professional public health work experience for certain academic requirements, or exceptional academic preparation for certain experience requirements, when a candidate is otherwise prepared to fulfill the duties.

Waivers: Under certain conditions, the local board of health may waive the minimum qualifications set forth in 6 CCR 1014-6, under the following criteria:

- The population of the jurisdiction for the county or district served and its ability to recruit a qualified candidate;
- Whether the candidate for public health director will seek to obtain additional public health education and experience within five years of the waiver; and
- The county or district board of health has explored joining with a county or establishing a district public health agency with a qualified public health director.

If the state board of health determines that the waiver does not meet the criteria the state board of health shall direct the department to work with the county or district board of health to assist the appointed director in obtaining the needed skills or experience.

Note: Within 30 days of substituting a requirement or allowing the waiver, the local board of health shall submit the information to the Colorado Board of Health for review, through Form 1014-6.

Boards and Directors Powers & Duties

Administrative Oversight

Local Boards of Health
Select a Public Health Director to serve at the pleasure of the board. Employ/contract with a medical officer to advise the director, if not a physician. In the event of either vacancy, employ/contract with a qualified person, or request temporary assistance from another county or state health department.
Hold regular Board of Health meetings at least once every three months.
Request Director or another to serve as board secretary, responsible for maintaining all records required by Part 2 of Article 72 of Title 24, C.R.S., and ensuring public notice of meetings in accordance with Part 4 of Article 6 of Title 24, C.R.S.
Provide, equip, and maintain suitable offices and facilities for the proper administration and provision of Core Public Health Services.
Follow orders, rules, and standards of the Colorado Board of Health.
Hold hearings, administer oaths, subpoena witnesses, and take testimony in all matters relating to the respective powers and duties of a local board of health, (e.g., local regulation variances, appeal of a cease and desist order, removal of a license, etc).
Act in an advisory capacity to the public health director on all matters pertaining to public health.
Approve the five-year local public health plan, and then submit to the State Board of Health for review.
Determine necessary services and set local priorities consistent with state public health laws and rules, according to local needs and the resources available, and consistent with the state and local public health improvement plans.

Boards and Directors
Powers & Duties

Administrative Oversight

Public Health Director
Act as custodian of all property and records of the agency. Maintain an office location designated by the county or district board.
Select all personnel required by the agency and prescribe the duties.
Serve as secretary to the county or district board of health, if requested by the board.
Administer and enforce 1) the public health laws of the state, 2) the orders, rules, and standards of the state department,commissions and/or board of health; and the orders and rules of the local board of health.
Hold hearings, administer oaths, subpoena witnesses, and take testimony in all matters relating to the respective powers and duties.
Act as the local registrar of vital statistics or contract the responsibility.
Direct the completion of a community health assessment and local/regional public health plan, every five years.

Policy Making

Local Boards of Health
Determine general policies to be followed by the public health director, in administering & enforcing public health laws, orders, & rules.
Develop and promote the public policies needed to secure the conditions for a healthy community, by considering the advice and expertise of the local public health agency.
Issue orders & adopt rules consistent with the laws, rules & orders of the state & the state board, for public or environmental health issues that pose no immediate health threat (e.g. nuisance abatement).
Public Health Director
Issue orders & adopt rules consistent with the laws, rules & orders of the state, & the state board in the event of a public health emergency (e.g. quarantine & isolation, water boil, evacuation, closure of a public place, etc.).

Boards and Directors Powers & Duties

Financial Oversight

Local Boards of Health
Annually review the costs of maintaining the local public health agency for the ensuing year. These estimates shall be submitted in the form of a budget to the board of county commissioners or to a committee composed of the chairs of the boards of all counties comprising a district agency.
Assess fees to offset the actual, direct costs of environmental health services, with the exception of any person who has already paid a fee to the state or federal government, and using the already-established fee for annual retail food establishment inspections, set forth in section 25-4-1607.
Accept and, through the public health director, use, disburse, and administer all appropriated county general funds, federal and state aid or other property and services or money allotted to an agency for county or district public health functions.
Board President (or designee) and Public Health Director certify that claims or demands made against the local public health agency fund were expended only for the duties of the agency.
Public Health Director
Annually estimate the total cost of maintaining the local public health agency for the ensuing year, submit the budget to the local board of health for review, and then the board of county commissioners, or a committee composed of the chairs of the boards of all counties comprising a district, for approval.
Direct the resources necessary to carry out the county or district public health plan, based on service priorities from the local board of health.
Along with Board President or their designee, certify that claims or demands made against the local public health agency fund were expended only for duties of the agency.

Public Health Resources

COLORADO Office of Planning, Partnerships & Improvement Department of Public Health & Environment	Office of Planning, Partnerships and Improvement: www.colorado.gov/cdphe/opp
NALBOH	National Association of Local Boards of Health (NALBOH): www.nalboh.org
The Public Health ALLIANCE of Colorado	Public Health Alliance of Colorado www.publichealthalliance.org
COLORADO Department of Public Health & Environment	Colorado Department of Public Health & Environment: www.colorado.gov/cdphe
	Boards & Commissions Established by Statute: State Board of Health, Water Quality Control Commission, Solid and Hazardous Waste Commission, and Air Quality Control Commission: www.colorado.gov/cdphe/categories/boards-and-commissions
	Department Rules & Regulations www.colorado.gov/cdphe/regulations
	SB08-194: The Public Health Act of 2008: www.colorado.gov/cdphe/Public-Health-Act
COLORADO PUBLIC HEALTH ASSOCIATION	Colorado Public Health Association: www.coloradopublichealth.org
PHAB Advancing public health performance	Public Health Accreditation Board: www.phaboard.org
NACCHO National Association of County & City Health Officials	National Association of City and County Health Officials (NACCHO): www.naccho.org

For more information

On the Colorado Public Health Act of 2008, or to request technical assistance on board of health orientation, please contact the Office of Planning, Partnerships and Improvement, Colorado Department of Public Health and Environment at:

303.692.2350

or visit

www.colorado.gov/cdphe/opp

COLORADO
Office of Planning, Partnerships & Improvement
Department of Public Health & Environment

CALPHO
Colorado Association of Local Public Health Officials

COLORADO
Department of Public Health & Environment

COLORADO PUBLIC HEALTH SYSTEM TRANSFORMATION

Core Public Health Services Operational Definitions Manual

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Table of Contents

Introduction **2**
Colorado's CPHS Framework 2
How to Use this Manual: Understanding and Implementing Operational Definitions **4**
Colorado Core Public Health Services Definitions Summary **6**
Colorado Core Public Health Services Full Operational Definitions **16**
A. Foundational Capabilities 16
1. Assessment and Planning 16
2. Communications 18
3. Policy Development and Support 20
4. Partnerships 21
5. Organizational Competencies 22
6. Emergency Preparedness and Response 27
7. Health Equity and the Social Determinants of Health 29
B. Foundational Services 30
1. Communicable Disease Prevention, Investigation and Control. 30
2. Environmental Public Health. 35
3. Maternal, Child, Adolescent, and Family Health. 37
4. Chronic Disease, Injury Prevention, and Behavioral Health Promotion 40
5. Access to and Linkage with Health Care. 42
Appendix A: Acknowledgements **44**
Subject Matter Expert Subgroups 45
Steering Committee 46
Project Management Team 47
Appendix B: Acronyms **48**
Appendix C: Glossary **50**
Appendix D: Sources and Resources **52**

Introduction

Colorado's Public Health Act (SB08 194) took effect in 2008, calling for major reforms to the state's governmental public health system, made up of the Colorado Department of Health and Environment (CDPHE), and 53 local public health agencies (LPHAs). The Act's purpose was to ensure that Core Public Health Services were available with a consistent standard of quality, to every person in Colorado regardless of where they live. Over the decade since this Act was passed, Colorado has seen many achievements and advancements in public health.

However, public health in Colorado, and around the nation, still faces dramatic changes and challenges. The Colorado Association of Local Public Health Officials (CALPHO) and CDPHE have identified that these changes will require them to think differently and creatively about the governmental public health system's work and are choosing to embrace that need to develop a comprehensive strategy for transforming the public health system to best serve its mission: to protect and improve the health of Colorado's people and the quality of its environment. CALPHO and CDPHE have identified that the Foundational Public Health Services (FPHS) system transformation model is the best model for Colorado's public health system transformation efforts and are following the example of other states engaged in similar public health system transformation efforts.

The FPHS system transformation model establishes that there is a foundational level of public health services that are needed everywhere for services to work anywhere. This foundation, called FPHS are a subset of all public health services and include foundational capabilities and services that (1) must be available to all people served by the governmental public health system, and (2) meet one or more of the following criteria:

- Services that are mandated by federal or state laws.
- Services for which the governmental public health system is the only or primary provider of the service, statewide.
- Population-based services (versus individual services) that are focused on disease prevention and protection and promotion of health.

National FPHS Framework

In 2009, the Institute of Medicine (IOM) formed a committee to consider three topics related to population health: data and measurement, law and policy, and funding. Their work culminated in a report, *For the Public's Health: Investing in a Healthier Future (2012),* in which the IOM recommended that a minimum package of public health services be defined. In April 2013, the Public Health Leadership Forum, funded by the Robert Wood Johnson Foundation and facilitated by RESOLVE, developed the national Foundational Public Health Service framework (FPHS) to define this "minimum package of services." The FPHS framework included foundational capabilities and programs that the group felt were needed everywhere for public health to work anywhere, and for which costs could be estimated. This national model is now stewarded by the Public Health National Center for Innovations (PHNCI) has been and continues to be adopted and localized by states across the nation, including Colorado. More information on the national FPHS framework is available here.

For consistency with Colorado's Public Health Act, Colorado has elected to refer to its FPHS framework as Core Public Health Services.

Colorado's CPHS Framework

The Colorado State Board of Health adopted Colorado's CPHS framework April 17, 2019 into the Code of Colorado Regulations (CCR; 6 CCR 1014-7 Core Public Health Services), the official publication of Colorado's state administrative rules. This framework goes into effect January 1, 2020.

Colorado's CPHS Framework defines seven foundational capabilities and five foundational services:

A. Foundational Capabilities

1. Assessment and Planning
2. Communications
3. Policy Development and Support
4. Partnerships
5. Organizational Competencies
6. Emergency Preparedness and Support
7. Health Equity and Social Determinants of Health

B. Foundational Services

1. Communicable Disease Prevention, Investigation and Control
2. Environmental Public Health
3. Maternal, Child, Adolescent and Family Health
4. Chronic Disease, Injury Prevention and Behavioral Health Promotion
5. Access to and Linkage with Health Care

Together, the foundational capabilities and foundational services are the limited statewide set of core public health services that must exist everywhere for services to work anywhere.

However, for the governmental public health system to successfully and consistently implement CPHS, more detail was needed in the definitions. In 2019, the Colorado Public Health System Transformation Steering Committee oversaw the development of operational definitions that:

- Describe "what" CPHS provides for Colorado's communities, but not "how" the governmental public health system should provide it,
- Are agnostic to which governmental public health provider should provide it,
- Are reduced to discreet activities (define as few actions as possible per statement) and begin with a verb identifying the action to be taken and,
- Align with existing statutes, rules, regulations and guidelines.

These operational definitions add detail by adding functions, definitions, and operational definitions that define the functions, elements, and activities that the governmental public health system must deliver for residents for CPHS to be fully implemented.

These definitions are published in this document, the *Foundational Public Health Services Functional Definitions Manual.*

It is expected that these definitions will continue to evolve alongside the public health practice. A process will be established for periodic updates to the CPHS operational definitions, as documented in this *Core Public Health Services Operational Definitions Manual*.

How to Use this Manual: Understanding and Implementing Operational Definitions

This document provides operational definitions for Colorado's foundational capabilities and services meant to help governmental public health agencies operationalize this framework statewide across the public health system, and within their organizations. Each foundational capability and service definition includes:

A. Foundational Capability or Foundational Service.

CPHS in Colorado include both foundational capabilities and foundational services. Foundational capabilities are denoted by "A." and are the crosscutting capacity and expertise needed to support public health programs. Foundational services are denoted by "B." and are the subset of services in each public health program area that are defined as foundational.

Example: A. denotes foundational capabilities, while B. denotes foundational services.

1. Actual Foundational Capability or Service.

Colorado's CPHS framework includes seven foundational capabilities and five foundational services denoted by numerals and individually assigned as either a foundational capability or service, such that they are represented as "[Foundational Capability (A) or Foundational Service (B)].[Foundational Capability or Service number].".

Example: A.1. denotes the foundational capability "Assessment and Planning."

a. Function.

Colorado's foundational capabilities and services are further reduced to 53 "functions" which organize the different elements and activities of CPHS to describe the work being done. Functions are denoted by lowercase letters and individually assigned to one foundational capability or service, such that they are represented as "[Foundational Capability (A) or Foundational Service (B)].[Foundational Capability or Service number].[Function lowercase letter].".

Example: A.1.a. denotes the first Assessment and Planning function "Data Collection and Distribution."

I. Definitions.

Colorado's CPHS functions are described in detail by 114 "definitions" that represent the various work elements of each function. Definitions are denoted by uppercase Roman numerals and individually assigned to one function, such that they are represented as "[Foundational Capability (A) or Foundational Service (B)].[Foundational Capability or Service number].[Function lowercase letter].[Definition uppercase Roman numeral].".

Example: A.1.a.I. denotes the first definition "I. Colorado's governmental public health system will be a trusted source of clear, consistent, accurate, and timely health and environmental information. The system will consistently use equitable, multi-directional communication strategies, interventions, and tools to support all public health goals" under the first Assessment and Planning function "Data Collection and Distribution."

i. Operational Definition.

In some cases, "definitions" are not reduced down to discrete "activities;" that is they may define more than one action per statement. Where that is the case, they are further described by 346 "operational definitions" which describe the various work activities under each definition. Operational definitions are denoted by lowercase Roman numerals and individually assigned to one function, such that they are represented as "[Foundational Capability (A) or Foundational Service (B)].[Foundational Capability or Service number].[Function lowercase letter].[Definition uppercase Roman numeral].[Operational Definition lowercase Roman numeral].".

Example: A.1.a.I.i. denotes the first operational definition, "i. Ensure capacity to collect primary qualitative data" under the first definition, "I. Colorado's governmental public health system will be a trusted source of clear, consistent, accurate, and timely health and environmental information. The system will consistently use equitable, multi-directional communication strategies, interventions, and tools to support all public health goals" under the first Assessment and Planning function "Data Collection and Distribution."

It is important to remember that there is significant interplay among the foundational capabilities and services, so governmental public health agencies and their staff members should be familiar with this full operational definitions manual, and not simply the definitions specific to the work they do.

Statutory and regulatory sources and relevant quality standards are cited throughout the document through footnotes on the relevant operational definitions, definitions, functions and foundational capabilities and services.

Appendix B provides any relevant acronyms. These acronyms are referenced where the terms they summarize are used, however, the full term is spelled out for each operational definitions, definitions, functions and foundational capabilities and services. This is to provide clarity when the individual definitional components are used independently from one another and this manual.

Colorado Core Public Health Services Definitions Summary

A. Foundational Capabilities

1. **Assessment and Planning:** Colorado's governmental public health system will apply the principles and skilled practice of epidemiology, laboratory investigation, surveillance, and program evaluation to support planning, policy and decision making in Colorado. The public health system will monitor, diagnose, and investigate health problems and hazards in communities including public health emergencies, outbreaks, and epidemics, and collect and analyze data.[1]
    - **a. Data Collection and Distribution**
        - **I.** Colorado's governmental public health system will be a trusted source of clear, consistent, accurate, and timely health and environmental information. The system will consistently use equitable, multi-directional communication strategies, interventions and tools to support all public health goals.
        - **II.** Operate and maintain confidential, continuous public health surveillance systems that systematically collect health and behavioral data for public health practice.
    - **b. Data Access, Analysis and Interpretation**
        - **I.** Use epidemiological practices to explain the distribution of disease, death, health outcomes, health disparities and systemic inequities, including links to biological, environmental, economic and social determinants.
        - **II.** Provide and use the results of health data analysis to develop recommendations regarding public health policy, processes, programs or interventions.
        - **III.** Translate data, analyses, technical descriptions and scientific literature into information that is valid, accurate, understandable and meaningful for intended audiences.
    - **c. Health Assessment Development, Implementation and Evaluation**
        - **I.** Complete a comprehensive community health assessment (CHA) at a minimum every five years.
        - **II.** Develop, implement and evaluate a public or community health improvement plan (PHIP/CHIP) that is informed by a comprehensive community health assessment (CHA) and priorities identified by communities, at a minimum every five years.
        - **III.** Conduct and disseminate topical or population-specific assessments focused on certain issues facing the community.
    - **d. Vital Records**
        - **I.** Record and report vital events (e.g., births and deaths) and act as the local registrar of vital statistics or ensure provision of the responsibility of registrar for each jurisdiction.
    - **e. Public Health Laboratory (State and Regional Lab Role Only)**
        - **I.** Maintain laboratory resources capable of providing rapid detection and investigation of health problems and environmental public health hazards.
2. **Communications:** Colorado's governmental public health system will be a trusted source of clear, consistent, accurate, and timely health and environmental information. The system will consistently use equitable, multi-directional communication strategies, interventions, and tools to support all public health goals.[2]
    - **a. Media Communications**
        - **I.** Maintain ongoing relations with local and statewide media through proactive and compelling press releases, press conferences and story pitching.

[1] 6 CCR 1014-7, 3.1 A1
[2] 6 CCR 1014-7, 3.1 A2

b. Public Communications

I. Increase the visibility and understanding of public health issues and the value of public health initiatives through consistent, strategic communications that are culturally and linguistically appropriate to the communities served.

II. Maintain the ability to transmit and receive communications to and from the public in an appropriate, timely and accurate manner. Adapt this ability to emerging communications technologies and the preferred mediums in each jurisdiction.

III. Develop and maintain customer service standards for regular public interactions in manner that are culturally and linguistically appropriate to the communities served.

c. Internal and Partner Communications

I. Maintain and encourage frequent internal communications between staff, leadership and close partners.

3. Policy Development and Support: Colorado's governmental public health system will inform and implement policies to meet the community's changing health needs. Public health policies will aim to eliminate health disparities, reduce death and disability, and improve environmental quality and health outcomes for all people in Colorado.[3]

a. Policy Development

I. Serve as a primary and expert resource for developing, establishing and maintaining evidence-informed public health policy recommendations that support individual, community and environmental health efforts.

II. Inform policies that impact the physical, environmental, social and economic conditions affecting health that are beyond the immediate scope or authority of governmental public health.

b. Policy Enactment

I. Partner with community members and stakeholders to build support for evidence-informed policies that promote healthy behaviors and environments for individuals, families, and communities.

c. Policy Evaluation

I. Use evidence-informed data and analytics to assess policy recommendations for unintended consequences or disparate impact.

II. Use assessment, surveillance and epidemiology to evaluate the outcomes of public health policies.

III. Disseminate information regarding policy results and outcomes to promote continued understanding and support for strategies that will improve the public's health.

4. Partnerships: Colorado's governmental public health system will create, convene, and support strategic partnerships, engage community members and cross-sectoral partners, agencies, and organizations to achieve public health goals.[4]

a. Partner and Community Relationships

I. Create, convene, support and evaluate strategic partnerships.

II. Maintain the ability to strategically select and articulate governmental public health roles in programmatic and policy activities and coordinate with partners.

III. Maintain the ability to identify and enable collaborative opportunities with other government sectors and across jurisdictional boundaries to effectively and efficiently deliver services and/or improve public health outcomes.

IV. Earn and maintain the trust of community residents by working towards common goals through inclusive engagement that is culturally and linguistically appropriate for the communities served.

[3] 6 CCR 1014-7, 3.1 A3
[4] 6 CCR 1014-7, 3.1 A4

5. Organizational Competencies

a. Accountability, Performance Management and Quality Improvement: Colorado's governmental public health system will be accountable and transparent in such a way that the general public can understand the value received from investments made in the system. Accountability, organizational performance management and quality improvement are essential to creating a system that provides high-quality public health services regardless of location. To sustain the culture of quality, performance will be tied to improvements in public health outcomes and other measures, the public health system will be monitored, and public health service delivery will be tracked.[5]

- **I.** Follow accountability, performance and quality standards in accordance with local, state, and federal laws, regulations and policies. Standards refer to a level of recommended achievement against which a state department or local public health agency (LPHA) may compare its current activities, and may include, but is not limited to, performance standards, performance management standards, descriptive standards and/or quality standards.
- **II.** Develop and/or utilize accountability, performance and quality standards that are tied to improvements in public health outcomes and processes.
- **III.** Establish, utilize and maintain a system to monitor accountability, performance and quality standards to align with the national Public Health Accreditation Board (PHAB) Standards.[6]
- **IV.** Assess the delivery and performance of Colorado's foundational capabilities and services.
- **V.** Establish, utilize and maintain a system of continuous quality improvement processes, integrated into organizational practice, programs and interventions, to align with the national Public Health Accreditation Board (PHAB) Standards.[7]
- **VI.** Communicate to appropriate governmental officials and the public on progress made by public health agencies and the state with meeting performance standards and on the delivery of Colorado's foundational capabilities and services.
- **VII.** Develop, coordinate, implement and evaluate an agency strategic plan that that defines and determines the agency's roles, priorities and direction.

b. Human Resources: Colorado's governmental public health system will develop and maintain a competent workforce and provide adequate human resources support to ensure the Public Health Director meets minimum qualifications, and staff are able to perform the functions of governmental public health.[8]

- **I.** Assure the agency has a public health director that possess the minimum qualifications as prescribed by the State Board of Health. The qualifications shall reflect the resources and needs of the county or counties covered by the agency.[9]
- **II.** Develop and maintain a competent public health workforce with the necessary knowledge, skills and abilities to perform the functions required of governmental public health.
- **III.** Develop and implement a workforce development plan that identifies needed skills, competencies and/or positions.
- **IV.** Provide or have access to adequate human resources support, including recruitment, retention, succession planning, training, performance review and other necessary human resource activities.
- **V.** Support leaders and employees in understanding equity principles and using inclusionary practices in all aspects of workforce management and workforce culture.

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[5] 6 CCR 1014-7, 3.1 A5 a
[6] https://www.phaboard.org/wp-content/uploads/2019/01/PHABSM_WEB_LR1.pdf
[7] https://www.phaboard.org/wp-content/uploads/2019/01/PHABSM_WEB_LR1.pdf
[8] 6 CCR 1014-7, 3.1 A5 b
[9] CRS 25-1-508 &509

c. **Legal Services and Analysis:** Colorado's governmental public health system will access and appropriately use legal services and tools to plan, implement and analyze public health activities, including due process requirements as necessary. The system will understand, communicate and utilize appropriate entities in regards to public health's legal authority, and understand and use legal tools such as laws, rules, ordinances and litigation to carry out its duties.[10]
   I. Interpret and assess public health laws, policies and procedures regarding agency operations in compliance with statutes, ordinances, rules and regulations.[11]
   II. Enforce public health laws regarding agency operations in compliance with statutes, ordinances, rules and regulations.[12]
   III. Employ or retain and compensate an attorney to be the legal adviser of the agency to defend all actions and proceedings brought against the agency or the officers and employees of the agency through the agency's county or district board of health or through its public health director with the approval of the state board.

d. **Financial Management, Contract and Procurement Services, and Facilities Management:** Colorado's governmental public health system will establish and maintain access to the appropriate systems and facilities necessary to deliver public health services in an efficient and effective manner. The system will establish policies and procedures, and provide financial, procurement, budgeting and auditing services in compliance with federal, state and local standards and laws.[13]
   I. Ability to comply with local, state and federal standards and policies.
   II. Establish and maintain budgeting, billing, contracting and financial system(s) in compliance with local, state and federal standards and policies.
   III. Conduct sound financial analyses to inform decisions about policies, programs and services.
   IV. Work with partners to seek and sustain funding for additional public health priority work.
   V. Ability to procure, maintain and manage safe, accessible facilities and efficient operations.

e. **Information Technology/Informatics (IT):** Colorado's governmental public health system will maintain access to information technology, information management systems and ensure informatics capacities to store, protect, manage, analyze, and communicate data and information to support effective, efficient, and equitable public health decision making.[14]
   I. Design, develop, manage and evaluate information systems to support all public health activities.
   II. Establish and adhere to data management and data governance best practices. Comply with federal and state laws and regulations, such as the Heath Insurance Portability and Accountability Act (HIPAA), when storing, analyzing, and disseminating data.

f. **Leadership and Governance:** Colorado's governmental public health system will serve as the face of public health, lead internal and external stakeholders in consensus development, engage in policy development and adoption.[15]
   I. Engage with local health agencies to define a strategic direction for public health initiatives.
   II. Engage in health policy development, discussion and adoption with local public health agencies (LPHAs) to define a strategic direction for public health initiatives.
   III. Engage with appropriate governing entities about public health's legal agencies and what new legislative concepts, laws and policies may be needed.

[10] 6 CCR 1014-7, 3.1 A5 c
[11] 6 CCR 1014-9, 3.1 F and 6 CCR 1014-7, 4.1 G
[12] 6 CCR 1014-9, 3.1 F and 6 CCR 1014-7, 4.1 G
[13] 6 CCR 1014-7, 3.1 A5 d
[14] 6 CCR 1014-7, 3.1 A5 e
[15] 6 CCR 1014-7, 3.1 A5 f

6. **Emergency Preparedness and Response:** Colorado's governmental public health system, in coordination with federal, state and local agencies and public and private sector partners, will have the capability and capacity to prepare for, respond to, and recover from emergencies with health, environmental and medical impacts.[16]
   a. **Public Health Preparedness and Response Strategies and Plans**
      I. Develop, exercise, maintain and use public health preparedness and response strategies and plans, in accordance with established guidelines and the United States Department of Health and Human Services (HHS).
      II. Develop, maintain and execute a Continuity of Operations Plan (COOP) that includes access to financial resources for emergency response and recovery operations.
      III. Establish plans to reach all persons within our communities through multiple communications methods before, during and after incidents using the inclusive Federal Emergency Management Agency (FEMA) "Whole Community"[17] approach.
      IV. Assure the inclusion of functional and operational considerations to enhance community inclusion for all genders, races, religions, social and health strata before, during and after incidents.
   b. **Emergency Support Function 8**
      I. Serve as Emergency Support Function 8 – Public Health & Medical (ESF8) and/or a public health response for the county, region, jurisdiction and state.
   c. **Emergency Response**
      I. Issue public health orders and coordinate with partner agencies to enforce orders.
      II. Maintain ability to provide essential and core public health laboratory testing and reporting functioning as a Laboratory Response Network (LRN). For biological threats, operate as a Biological Reference Laboratory (LRN-B); for chemical threats operate as a Chemical Reference Laboratory (LRN-C) all at levels designated by the CDC.
      III. Monitor the burden on the public health and medical system utilizing epidemiology to identify the problem, agent and transmission route, collect data and implement control measures to prevent additional transmission of illness.
   d. **Community Preparedness**
      I. Establish and promote basic ongoing community preparedness, readiness and resilience by educating, communicating to and encouraging the public to take necessary action before, during and after an incident.
         i. Promote community preparedness by communicating steps that can be taken before, during or after an incident.
7. **Health Equity and the Social Determinants of Health**: Colorado's governmental public health system will intentionally focus on improving systems and institutions that create or perpetuate socioeconomic disadvantage, social exclusion, racism, historical injustice, or other forms of oppression so that all people and communities in Colorado can achieve the highest level of health possible. Governmental public health will have the requisite skills, competencies, and capacities to play an essential role in creating comprehensive strategies needed to address health inequities, and social and environmental determinants of health.[18]
   a. **Leadership and Workforce Training and Diversity**

[16] 6 CCR 1014-7, 3.1 A6
[17] https://www.fema.gov/media-library-data/20130726-1813-25045-3330/whole_community_dec2011__2_.pdf
[18] 6 CCR 1014-7, 3.1 A7

I. Implement and evaluate training to support the governmental public health workforce in understanding and applying equity principles and inclusionary practices in all aspects of workforce management and workforce culture.
II. Implement and continuously improve staff and volunteer recruitment, retention and promotion practices to ensure that the governmental public health workforce understands the values of the communities served, and has the education, training and experience to address inequitable social and environmental conditions.
III. Develop relationships and partnerships to cultivate a public health workforce and governance that is more representative of communities served.
IV. Through use of health equity leadership development strategies, strengthen governmental public health leadership to be competent in addressing health inequities.
V. Cultivate boards of health and elected officials' understanding of equity concepts and the social and environmental determinants of health through orientations and other learning strategies.
VI. Ensure adequate resources are available to support health equity work within the governmental public health system—for example, by devoting staff time or combining efforts and resources across jurisdictions.

b. Health Equity Policy

I. Advocate for population-based, primary prevention policies that improve physical, environmental, social and economic conditions that affect the public's health.
II. Support statutes, regulations, rules, codes, policies and procedures and revisions to those that govern public health to ensure equity in the distribution of public health benefits and interventions across all populations.
III. Ensure that health equity principles are infused across governmental public health programs, initiatives, strategies and investments.
IV. Use performance management and quality improvement principles to continuously improve all policies, processes and programs to advance health equity.
V. Assess the governmental public health system's capacity to act on root causes of health inequities, including organizational structure, policies, processes, culture and historic institutional biases and barriers.

c. Health Equity Data

I. Collect, analyze and report data on the social and environmental determinants of health to better understand health inequities.

d. Health Equity Partnerships

I. Engage and partner with the community and stakeholders to assess social and environmental determinants of health and health inequities.
II. Build strategic public health partnerships to address social, economic, and environmental determinants and health disparities, and recognize root issues for these disparities including, but not limited to, discrimination on the basis of race, ability, age, sexual preference, gender and gender identity.

e. Health Equity Communications

I. Develop, support and inform communication efforts regarding social, economic, and environmental determinants of health disparities and inequities.
II. Ensure that all communications and engagement activities with the public align with federal standards such as Culturally and Linguistically Appropriate Services (CLAS).[19]

[19] https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

B. Foundational Services

1. **Communicable Disease Prevention, Investigation and Control:** Colorado's governmental public health system will carry out state and locally coordinated surveillance, disease investigation, laboratory testing, and prevention and control strategies to monitor and reduce the incidence and transmission of communicable diseases. Programs will target illnesses that are vaccine-preventable, zoonotic, vector-borne, respiratory, food- or water-borne, bloodborne, healthcare associated, and sexually transmitted as well as emerging threats. Communicable Disease Control will collaborate with national, state, and local partners to ensure mandates and guidelines are met and timely, actionable information is provided to the public and to health professionals.[20]
   - **a. Communicable Disease Prevention**
     - **I.** Provide timely, statewide, locally relevant and accurate information to public health partners, health care system partners and the community on communicable disease risks and preventive strategies to reduce those risks.
     - **II.** Conduct routine surveillance for reportable conditions. Monitor data to prevent and detect outbreaks and maintain awareness of communicable disease trends.
   - **b. Identify Communicable Disease Prevention, Investigation and Control Assets**
     - **I.** Identify local community, regional and statewide assets and ensure disease surveillance, investigation and control of communicable diseases, in accordance with local, state and federal mandates and guidelines.
     - **II.** Ensure access to communicable disease prevention services through partnerships with community providers or direct service provision.
   - **c. Communicable Disease Investigation and Control**
     - **I.** Investigate case reports, outbreaks, unusual trends and uncommon cases of communicable diseases. Implement disease control measures to prevent communicable disease transmission.
     - **III.** Issue public health orders and coordinate with partner agencies to enforce orders.
   - **d. Communicable Disease Laboratory Services**
     - **I.** Ensure availability of public health laboratory services for disease investigations and response, and for reference and confirmatory testing related to communicable diseases.
   - **e. Immunization**
     - **I.** Promote and provide immunization through evidence-informed strategies and in collaboration with schools, health care providers and other community partners to increase vaccination rates.
   - **f. Coordination of Other Communicable Disease Services with Foundational Capabilities and Services**
     - **I.** When other public health services are delivered regarding prevention and control of communicable disease, ensure they are well coordinated with foundational capabilities and services.
2. **Environmental Public Health:** Colorado's governmental public health system will use evidence-informed practices to understand the cause and effect relationships between environmental changes and ecological and human health impacts, to protect, promote, and enhance the health of the community and environment. Agencies will participate in the protection and improvement of air quality, water, land, and food safety by identifying, investigating, and responding to community environmental health concerns, reducing current and emerging environmental health risks, preventing communicable diseases, and sustaining the environment in a coordinated manner with agencies at the federal, state, and local levels as well as industry stakeholders and the public.[21]
   - **a. Environmental Health Data**

[20] 6 CCR 1014-7, 3.1 B1
[21] 6 CCR 1014-7, 3.1 B2

I. Use available community specific environmental and health data to ensure protection of public health, assess health impacts, reduce risk and communicate risk information to the community.

b. Identify Environmental Health Assets

I. Identify local community, regional and statewide assets to perform environmental health assessments, inspections, investigations and monitoring programs in accordance with local, state and federal mandates and guidelines.

c. Environmental Health Investigations, Inspections, Sampling, Lab Analysis and Oversight

I. Implement public health laws, policies and procedures to ensure the safety of food provided to the public from all parts of the local food system.

II. Take appropriate steps to support the protection of surface water and groundwater, including recreational waters and drinking water sources; collect and use community specific water quality data to assure community health and assure appropriate local regulatory oversight of onsite wastewater treatment systems.

III. Implement public health laws, policies and procedures to ensure the sanitation of institutional facilities (e.g., child care facilities, local correctional facilities and schools).

IV. Collect and analyze air quality data throughout the state to better understand the sources of air pollution and develop mitigation strategies.

V. Ensure proper management of solid and hazardous waste, maximizing waste diversion and ensuring safe storage, collection, treatment and disposal of solid and hazardous waste.

VI. Issue public health orders related to environmental health, and coordinate with partner agencies to enforce orders.

d. Zoonotic Conditions

I. Identify and mitigate zoonotic and vector-borne (e.g., insects, rodents), air-borne, water-borne, foodborne and other public health threats related to environmental hazards and consumer-oriented facilities (e.g., body art facilities, swimming pools, and marijuana-related facilities).

e. Land Use Planning and Climate Change

I. Use community-specific data to decrease vulnerability to and mitigate risks related to climate impacts.

II. Participate in land use and sustainable development decision making processes to encourage practices that promote positive public health outcomes (e.g., consideration of housing, development approaches, recreational facilities and transportation systems), and that protect and improve air and water quality, promote water conservation, effectively manage solid and hazardous waste and promote energy efficiency and clean energy resources.

f. Coordination of Other Environmental Health Services with Foundational Capabilities and Services

I. When public health services are delivered regarding environmental health, ensure they are coordinated with foundational capabilities and services.

3. **Maternal, Child, Adolescent, and Family Health:** Colorado's governmental public health system will develop, implement and evaluate state-wide, regional and local strategies related to maternal, child, adolescent and family health to increase health and wellbeing, reduce adverse health outcomes and advance health equity across the life course. Strategies may include but are not limited to identifying and providing information, promoting evidence-informed and multi-generational approaches, identifying community assets, advocating for needed initiatives, and convening partners.[22]

a. Maternal, Child, Adolescent and Family Health Information

[22] 6 CCR 1014-7, 3.1 B3

I. Provide timely and relevant federal, state and local evidence-informed information on maternal, child, adolescent and family health using health equity and life course frameworks.

b. Identify Maternal, Child, Adolescent and Family Health Assets

I. Identify local community, regional and statewide assets to improve maternal, child, adolescent, and family health in accordance with local, state and federal mandates and guidelines.

c. Collaborative Efforts around Maternal, Child, Adolescent, and Family Health

I. Lead systems improvements and coordinate efforts across sectors to ensure access to services such as primary care, oral health care, specialty care, mental health prevention and treatment, social services and early intervention for development.

II. Collaborate with cross sector partners, including community members, to promote and build will for policies, practices and strategies that improve maternal, child, adolescent and family health.

d. Maternal, Child, Adolescent and Family Health Improvement

I. Improve the health status of infants, children, adolescents, youth, women and their families, and protect critical stages of a child's physical and mental development during pregnancy and early childhood.

II. Identify and develop maternal, child, adolescent and family health prevention approaches, using life course expertise to advance equity, and advocate and seek resources for related initiatives.

e. Mandated Newborn Screening (State Role Only)

I. Ensure mandated newborn screening to test every infant born in Colorado to detect and prevent developmental impairments and life-threatening illnesses associated with congenital disorders that are specified by the State Board of Health.

f. Coordination of Other Maternal, Child, Adolescent and Family Health Services with Foundational Capabilities and Services

I. Coordinate and align categorically-funded maternal, child, adolescent and family health programs and services to work in synergy toward improved health outcomes.

4. **Chronic Disease, Injury Prevention, and Behavioral Health Promotion:** Colorado's governmental public health system focuses on common risk and protective factors that affect social, emotional and physical health and safety. To prevent chronic disease and injuries and promote behavioral health, Colorado's governmental public health system will use policy, systems and environmental change strategies to comprehensively address the root causes of poor health outcomes and advance health equity. Priority areas include, but are not limited to, nutrition, physical activity, oral health, access to care and disease management, injury prevention, violence prevention, suicide prevention, mental health and substance use (including tobacco, alcohol and other substances).[23]

a. Chronic Disease, Injury Prevention and Behavioral Health Promotion Data

I. Provide timely, relevant and accurate information statewide and to communities on chronic disease prevention and management, injury and violence prevention and behavioral health promotion.

b. Chronic Disease, Injury Prevention and Behavioral Health Promotion Assets

I. Work with partners to identify community assets and develop state and local plans to prevent and manage chronic disease, prevent injury and violence, and promote behavioral health.

II. Seek resources for policies, programs and strategies that support the prevention and management of chronic disease, prevention of injuries and violence and promotion of behavioral health.

c. Chronic Disease, Injury Prevention and Behavioral Health Promotion Policies

[23] 6 CCR 1014-7, 3.1 B4

I. Develop, implement and evaluate evidence-informed strategies, policies and programs that aim to prevent, delay or detect the onset of chronic diseases and injuries, and promote behavioral health to protect and enhance the health and wellbeing of communities.

II. Advocate for policies, programs and strategies that support the prevention and management of chronic disease, prevention of injuries and violence and promotion of behavioral health.

d. Coordination of Other Chronic Disease, Injury Prevention, and Behavioral Health Promotion Services with Foundational Capabilities and Services

I. When public health services are delivered regarding chronic disease and injury prevention and behavioral health promotion, ensure they are coordinated with foundational capabilities and services.

5. **Access to and Linkage with Health Care:** All Coloradans should be connected with and have access to needed personal health care services that include primary care, maternal and child health care, oral health care, specialty care, and mental health care. Colorado's governmental public health system will coordinate governmental and community partners to link individuals to and ensure the provision of health care within their jurisdictions.[24]

a. Collaborative Efforts Around Access to Clinical Care

I. Participate actively in state, regional and local level collaborative efforts regarding primary, maternal/child, oral, behavioral, and specialty health care systems planning to improve health care quality and effectiveness, reduce health care costs and improve population health

b. Access to Clinical Care Data

I. Provide data and information to health care providers, coalitions, decision-makers, legislators and other stakeholders to support health care planning.

c. Health Facility Inspection and Licensure (State Role Only)

I. Conduct timely inspection and review of regulated health facilities and ensure compliance with all licensing rules and minimum standards.

d. Linkage to Clinical Care

I. Link people to needed personal health care services and ensure the provision of health care.[25]

[24] 6 CCR 1014-7, 3.1 B5
[25] 6 CCR 1014-7, 2.1 E7

Colorado Core Public Health Services Full Operational Definitions

A. Foundational Capabilities

1. **Assessment and Planning:** Colorado's governmental public health system will apply the principles and skilled practice of epidemiology, laboratory investigation, surveillance, and program evaluation to support planning, policy and decision making in Colorado. The public health system will monitor, diagnose, and investigate health problems and hazards in communities including public health emergencies, outbreaks, and epidemics, and collect and analyze data.[26]

a. Data Collection and Distribution

I. Colorado's governmental public health system will be a trusted source of clear, consistent, accurate, and timely health and environmental information. The system will consistently use equitable, multi-directional communication strategies, interventions and tools to support all public health goals.
- **i.** Ensure capacity to collect primary qualitative data.
- **ii.** Ensure capacity to collect primary quantitative data.
- **iii.** Ensure capacity to gather secondary data.
- **iv.** Ensure epidemiological capacity to combine primary data with secondary data.

II. Operate and maintain confidential, continuous public health surveillance systems that systematically collect health and behavioral data for public health practice.
- **i.** Maintain and implement written processes and/or protocols to collect surveillance data.
- **ii.** Participate in statewide or national surveillance systems which are directed by standard protocol (for instance, the Healthy Kids Colorado Survey [HKCS] or the Behavioral Risk Factor Surveillance System [BRFSS]).
- **iii.** Ensure that data are regularly disseminated and available.
- **iv.** Maintain the ability to develop and adapt surveillance systems as needed.

b. Data Access, Analysis and Interpretation

I. Use epidemiological practices to explain the distribution of disease, death, health outcomes, health disparities and systemic inequities, including links to biological, environmental, economic and social determinants.

II. Provide and use the results of health data analysis to develop recommendations regarding public health policy, processes, programs or interventions.

III. Translate data, analyses, technical descriptions and scientific literature into information that is valid, accurate, understandable and meaningful for intended audiences.
- **i.** Respond to appropriate and legal data requests.
- **ii.** Work collaboratively with communities to co-create communication and dissemination strategies that align with federal standards such as Culturally and Linguistically Appropriate Services (CLAS).[27]

c. Health Assessment Development, Implementation and Evaluation

I. Complete a comprehensive community health assessment (CHA) at a minimum every five years.

[26] 6 CCR 1014-7, 3.1 A1

[27] https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

i. Include primary and secondary data in the assessment.
ii. Include quantitative and qualitative data in the assessment.
iii. Engage a wide range of community partners and stakeholders in the assessment process, especially including representatives of populations experiencing inequities (Describe how representatives of the local community develop and implement the local plan.)[28]
iv. Ensure comprehensive community health assessments (CHAs) describe the health of a community using a wide variety of measurements including social context and other metrics in addition to traditional health outcomes.
v. Publish and disseminate the community health assessment to stakeholders and community members.

II. Develop, implement and evaluate a public or community health improvement plan (PHIP/CHIP) that is informed by a comprehensive community health assessment (CHA) and priorities identified by communities, at a minimum every five years.
i. Engage a wide range of community partners and stakeholders in the planning process, especially including representatives of populations experiencing inequities.
ii. Compile data on community or regional resources, assets, and strengths (e.g., schools, parks, housing, transportation, economic well-being, environmental quality, existing partnerships) to determine capacity to address priorities selected in the PHIP/CHIP.
iii. Coordinate with partners to implement PHIP/CHIP action plans.
iv. Publish, disseminate and promote PHIP/CHIP to stakeholders and community members.
v. Work with partners to obtain sufficient funding for PHIP/CHIP priorities and plan implementation.
vi. Assess the capacity and performance of the local public health system.

III. Conduct and disseminate topical or population-specific assessments focused on certain issues facing the community.

d. Vital Records

I. Record and report vital events (e.g., births and deaths) and act as the local registrar of vital statistics or ensure provision of the responsibility of registrar for each jurisdiction.
i. Collect, compile and tabulate reports of marriages, dissolutions of marriage and declarations of invalidity of marriage; births, deaths and morbidity; and require any person having information, with regard to the same, to make such reports and submit such information as is required by law or the rules of the State Board of Health.

e. Public Health Laboratory (State and Regional Lab Role Only)

I. Maintain laboratory resources capable of providing rapid detection and investigation of health problems and environmental public health hazards.
i. Maintain and develop, as needed, appropriate laboratory certification and quality assurance, and ensure compliance with relevant accreditation and regulations.
ii. Coordinate with clinical laboratories to promote quality assurance, consistency in testing methodologies, result interpretations and safe laboratory practices among clinical and public health laboratories.

[28] CRS 25-1-505 2d

iii. Develop and maintain surge capacity agreements with other public health laboratories (regionally and nationally) to ensure testing capacity during emergency events or large outbreaks.

iv. Maintain laboratory resources to provide public health services for essential and core Public Health Laboratory testing and reporting functioning as a Laboratory Response Network (LRN). This should include a Biological Reference Laboratory (LRN-B) resources for biological threats, and a Chemical Reference Laboratory (LRN-C) resources for chemical threats, operating at all levels as designated by the CDC.[29]

v. Maintain laboratory resources to provide public health laboratory services for disease investigations and response and for reference and confirmatory testing related to communicable diseases.[30]

vi. Maintain laboratory resources that are certified and supported by the FDA for milk and food testing, and that participate in the Food Emergency Response Network.[31]

vii. Maintain laboratory resources that are EPA-certified for testing water.[32]

viii. Maintain laboratory resources that are EPA-certified for zoonotic disease specimens.[33]

ix. Maintain laboratory resources to support newborn bloodspot screening, including repeat or confirmatory testing, as needed.[34]

2. Communications: Colorado's governmental public health system will be a trusted source of clear, consistent, accurate, and timely health and environmental information. The system will consistently use equitable, multi-directional communication strategies, interventions, and tools to support all public health goals.[35]

a. Media Communications

I. Maintain ongoing relations with local and statewide media through proactive and compelling press releases, press conferences and story pitching.

i. Build and maintain relationships with media outlets.

ii. Respond to media requests.

iii. Develop and maintain media relations plans, policies and/or protocols for leveraging media in communicating with the public effectively.

iv. Regularly evaluate and improve media engagement plans, policies and/or protocols.

b. Public Communications

I. Increase the visibility and understanding of public health issues and the value of public health initiatives through consistent, strategic communications that are culturally and linguistically appropriate to the communities served.

i. Promote the community's understanding of and support for policies and strategies that will improve the public's health.

[29] See A.6.c.II for more information on the public health laboratory services that need to be available.
[30] See B.1.d. for more information on the public health laboratory services that need to be available.
[31] See B.2.c.I.iii for more information on the public health laboratory services that need to be available.
[32] See B.2.c.II.i for more information on the public health laboratory services that need to be available.
[33] See D.1.c.III.i for more information on the public health laboratory services that need to be available.
[34] See B.3.e.I.ii for more information on the public health laboratory services that need to be available.
[35] 6 CCR 1014-7, 3.1 A2

- **ii.** Educate individuals and organizations in the meaning, purpose and benefit of public health laws and how to comply.
- **iii.** Develop and implement strategic communications plans that align with public health improvement plans (PHIP).
- **iv.** Work collaboratively with communities to co-create communication strategies to that promote and align with federal standards, such as Culturally and Linguistically Appropriate Services (CLAS).[36]
- **v.** Regularly evaluate and improve of communications efforts using qualitative and quantitative methods.

II. Maintain the ability to transmit and receive communications to and from the public in an appropriate, timely and accurate manner. Adapt this ability to emerging communications technologies and the preferred mediums in each jurisdiction.

- **i.** Maintain an up-to-date public website and social media presence through a variety of channels to provide public health information, as part of regular monitoring and responding to community concerns, both routinely and during an emergency.
- **ii.** Develop and evaluate a risk communication plan that includes protocols for urgent 24/7 communications.
- **iii.** Establish or participate in a public alert network or similar system to receive and issue alerts 24/7 through phone and text messaging.
- **iv.** Regularly evaluate and improve public engagement activities, plans, policies and/or protocols.

III. Develop and maintain customer service standards for regular public interactions in manner that are culturally and linguistically appropriate to the communities served.

- **i.** Ensure that communications and interactions with the public are delivered in a courteous and professional manner that aligns with federal standards such as Culturally and Linguistically Appropriate Services (CLAS).
- **ii.** Provide visitors and clients with correct and appropriate information, including through easy-to-understand signage.
- **iii.** Provide contact information, including a names, telephone numbers and online addresses in all communications.
- **iv.** Provide a channel (e.g., online and paper forms) for public feedback on customer and client services performance.
- **v.** Regularly evaluate and improve customer service engagement plans, policies and/or protocols.

c. Internal and Partner Communications

I. Maintain and encourage frequent internal communications between staff, leadership and close partners.

- **i.** Develop internal communications protocols.
- **ii.** Provide shared learning opportunities, including through emerging communications technologies.
- **iii.** Share important public information with agency staff before it is released to the public.
- **iv.** Provide channels for agency staff to give feedback to leadership.
- **v.** Provide ongoing formal and informal opportunities for staff and workgroups to evaluate programs, quality improvement efforts, staff and leadership capabilities, and tactics.
- **vi.** Regularly evaluate and improve internal engagement plans, policies, or protocols.

[36] https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

3. **Policy Development and Support:** Colorado's governmental public health system will inform and implement policies to meet the community's changing health needs. Public health policies will aim to eliminate health disparities, reduce death and disability, and improve environmental quality and health outcomes for all people in Colorado.[37]

a. Policy Development

I. Serve as a primary and expert resource for developing, establishing and maintaining evidence-informed public health policy recommendations that support individual, community and environmental health efforts.
- **i.** Research and analyze policies (policies include legislation, rules, regulations, internal policies, etc.).
- **ii.** Research evidence-informed or innovative practices for policy recommendations
- **iii.** Determine fiscal impacts of policies.
- **iv.** Determine social, economic and health impacts of policies including possible unintended consequences or inequitable impacts.
- **v.** Articulate the impact of policies to decision makers, partners, stakeholders, community members, governmental agencies and others, as appropriate.
- **vi.** Use Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIP) to inform policy recommendations.

II. Inform policies that impact the physical, environmental, social and economic conditions affecting health that are beyond the immediate scope or authority of governmental public health.
- **i.** Research and analyze policies (policies include legislation, rules, regulations, internal policies, etc.).
- **ii.** Determine fiscal impacts of policies.
- **iii.** Determine social, economic and health impacts of policies, including possible unintended consequences or inequitable impacts.
- **iv.** Articulate the impact of policies to decision makers, partners, stakeholders, community members, governmental agencies and others, as appropriate.

b. Policy Enactment

I. Partner with community members and stakeholders to build support for evidence-informed policies that promote healthy behaviors and environments for individuals, families, and communities.
- **i.** Build relationships with partners and stakeholders related to public health policy priorities.
- **ii.** Collaborate with other entities as appropriate to support public health policy priorities.
- **iii.** Maintain relationships with partners and collaborations to support public health policy priorities including attending relevant meetings and events.
- **iv.** Communicate with partners and stakeholders about policies.
- **v.** Outreach to communities about policies.
- **vi.** Testify and/or provide comment on policies.

c. Policy Evaluation

I. Use evidence-informed data and analytics to assess policy recommendations for unintended consequences or disparate impact.

[37] 6 CCR 1014-7, 3.1 A3

i. Research and analyze policies (policies include legislation, rules, regulations, internal policies, etc.).
ii. Research evidence-informed or innovative practices for policy recommendations.
iii. Determine fiscal impacts of policy recommendations.
iv. Determine social, economic and health impacts of policies or policy recommendations, including possible unintended consequences or inequitable impacts.

II. Use assessment, surveillance and epidemiology to evaluate the outcomes of public health policies.
i. Research and analyze policies (policies include legislation, rules, regulations, internal policies, etc.).
ii. Determine fiscal impacts of policies.
iii. Determine social, economic and health impacts of policies including possible unintended consequences or inequitable impacts.
iv. Use community health assessments (CHAs) and community health improvement plans (CHIP) to inform policy recommendations.

III. Disseminate information regarding policy results and outcomes to promote continued understanding and support for strategies that will improve the public's health.
i. Communicate with partners and stakeholders about policies.
ii. Outreach to communities about policies.
iii. Bring policies before appropriate entities such as those with authority to adopt or influence policies.
iv. Testify and/or provide comment on policies.
v. Prepare facts sheets, briefs or other necessary documents that provide information about policies.
vi. Disseminate information about policies as appropriate.

4. **Partnerships:** Colorado's governmental public health system will create, convene, and support strategic partnerships, engage community members and cross-sectoral partners, agencies, and organizations to achieve public health goals.[38]

a. Partner and Community Relationships

I. Create, convene, support and evaluate strategic partnerships.
i. Dedicate resources to community partnership development (i.e., workforce, training, technical assistance, facilitation, meeting spaces, etc.).
ii. Engage with the public health system -- including local boards of health, the community, and populations experiencing health disparities and affected by systemic inequities -- to identify and address health problems through collaborative processes.
iii. Evaluate the quality of partnerships (i.e., their efficiency, effectiveness, equity, level of integration, impact, etc.).

II. Maintain the ability to strategically select and articulate governmental public health roles in programmatic and policy activities and coordinate with partners.
i. Coordinate policy agendas with partner organizations to advance cross-cutting, strategic goals.
ii. Use the state and/or community health improvement plan (SHIP/CHIP) as the basis for collaborative work with partners, and to coordinate activities and use of resources.

[38] 6 CCR 1014-7, 3.1 A4

III. Maintain the ability to identify and enable collaborative opportunities with other government sectors and across jurisdictional boundaries to effectively and efficiently deliver services and/or improve public health outcomes.

IV. Earn and maintain the trust of community residents by working towards common goals through inclusive engagement that is culturally and linguistically appropriate for the communities served.

- **i.** Build trust through transparency, reliability, and community engagement best practices (such as the Community Engagement IMPACT Practice Model[39]), including federal standards such as Culturally and Linguistically Appropriate Services (CLAS).[40]
- **ii.** Ensure participation of community partners and leverage shared resources in local and state public health assessment and/or planning efforts.

5. Organizational Competencies

a. Accountability, Performance Management and Quality Improvement: Colorado's governmental public health system will be accountable and transparent in such a way that the general public can understand the value received from investments made in the system. Accountability, organizational performance management and quality improvement are essential to creating a system that provides high-quality public health services regardless of location. To sustain the culture of quality, performance will be tied to improvements in public health outcomes and other measures, the public health system will be monitored, and public health service delivery will be tracked.[41]

I. Follow accountability, performance and quality standards in accordance with local, state, and federal laws, regulations and policies. Standards refer to a level of recommended achievement against which a state department or local public health agency (LPHA) may compare its current activities, and may include, but is not limited to, performance standards, performance management standards, descriptive standards and/or quality standards.

II. Develop and/or utilize accountability, performance and quality standards that are tied to improvements in public health outcomes and processes.

- **i.** Engage leadership and staff in determining appropriate accountability, performance and quality standards.
- **ii.** Develop and/or utilize and maintain goals, objectives and performance measures related to state or agency strategic plans and improvement plans.
- **iii.** Establish, implement and maintain operational policies and procedures that support the attainment of public health goals, objectives and performance measures.
- **iv.** Collect and analyze data related to public health outcomes and processes.

III. Establish, utilize and maintain a system to monitor accountability, performance and quality standards to align with the national Public Health Accreditation Board (PHAB) Standards.[42]

- **i.** Establish meaningful measures, milestones and targets for accountability, performance and quality standards.
- **ii.** Ensure appropriate levels and frequency of data are available to monitor established standards.
- **iii.** Evaluate and analyze performance measures, milestones and targets related to established standards.
- **iv.** Assess the extent to which accountability, performance and quality standards are being used.

[39] https://coloradohealth.org/sites/default/files/documents/2018-06/IMPACT_PracticeModel_March2018.pdf
[40] https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf
[41] 6 CCR 1014-7, 3.1 A5 a
[42] https://www.phaboard.org/wp-content/uploads/2019/01/PHABSM_WEB_LR1.pdf

IV. Assess the delivery and performance of Colorado's foundational capabilities and services.
- **i.** Routinely monitor and evaluate goals, objectives, targets and performance measures included in strategic plans; improvement plans and foundational capability and service plans; interventions and programs.
- **ii.** Generate regular progress reports that analyze data and performance results related to Colorado's foundational capabilities and services.
- **iii.** Use financial data as appropriate to evaluate foundational capabilities and services.
- **iv.** Collect, maintain and analyze feedback from customers and the community regarding the delivery of Colorado's foundational capabilities and services.
- **v.** Facilitate review and discussion of the assessment of the delivery of Colorado's foundational capabilities and services.

V. Establish, utilize and maintain a system of continuous quality improvement processes, integrated into organizational practice, programs and interventions, to align with the national Public Health Accreditation Board (PHAB) Standards.[43]
- **i.** Use performance management and quality improvement methods, tools and coaching to promote organizational objectives and to sustain a culture of quality.
- **ii.** Provide expertise in the use of quality improvement methods and tools to utilize continuous quality improvement processes that align with national Public Health Accreditation Board (PHAB) Standards.[44]
- **iii.** Provide access to training and workforce development on continuous quality improvement methods and tools.
- **iv.** Engage staff in continuous quality improvement processes.

VI. Communicate to appropriate governmental officials and the public on progress made by public health agencies and the state with meeting performance standards and on the delivery of Colorado's foundational capabilities and services.
- **i.** Generate and communicate regular progress reports on state and agency performance related to established standards and performance measures.
- **ii.** Produce reports that describe the impact of public health policies, programs and strategies.
- **iii.** Evaluate the cost-effectiveness or cost-benefit of public health services as appropriate.

VII. Develop, coordinate, implement and evaluate an agency strategic plan that that defines and determines the agency's roles, priorities and direction.
- **i.** Where possible, adhere to Public Health Accreditation Board (PHAB) Standard 5.3[45] when developing the strategic plan.

b. Human Resources: Colorado's governmental public health system will develop and maintain a competent workforce and provide adequate human resources support to ensure the Public Health Director meets minimum qualifications, and staff are able to perform the functions of governmental public health.[46]

I. Assure the agency has a public health director that possess the minimum qualifications as prescribed by the State Board of Health. The qualifications shall reflect the resources and needs of the county or counties covered by the agency.[47]

[43] https://www.phaboard.org/wp-content/uploads/2019/01/PHABSM_WEB_LR1.pdf
[44] https://www.phaboard.org/wp-content/uploads/2019/01/PHABSM_WEB_LR1.pdf
[45] https://www.phaboard.org/wp-content/uploads/2019/01/PHABSM_WEB_LR1.pdf
[46] 6 CCR 1014-7, 3.1 A5 b
[47] CRS 25-1-508 &509

II. Develop and maintain a competent public health workforce with the necessary knowledge, skills and abilities to perform the functions required of governmental public health.
- **i.** Develop and maintain an operational infrastructure to support the performance of public health function.[48]
- **ii.** Maintain administrative and management capacity.[49]
- **iii.** Develop public health leaders to effectively support and manage the workforce from hire to retire.
- **iv.** Ensure access to public health expertise and capacity to address public health problems and hazards.[50]
- **v.** Support overall workforce development by providing resources to improve the skills, capabilities and leadership of the public health workforce.

III. Develop and implement a workforce development plan that identifies needed skills, competencies and/or positions.
- **i.** Coordinate or perform, when necessary, assessments of leadership, staff and organizational capabilities to understand capacity, identify gaps.
- **ii.** Make available organizational and individual training and development opportunities.[51]

IV. Provide or have access to adequate human resources support, including recruitment, retention, succession planning, training, performance review and other necessary human resource activities.
- **i.** Develop and maintain a human resources manual or set of human resources policies and procedures.
- **ii.** Maintain current operational definitions and statements of the public health roles, responsibilities and authorities.[52]

V. Support leaders and employees in understanding equity principles and using inclusionary practices in all aspects of workforce management and workforce culture.
- **i.** Assure workforce competency with ongoing access to training and supervision.
- **ii.** Increase cultural competency and health equity skills.

c. Legal Services and Analysis: Colorado's governmental public health system will access and appropriately use legal services and tools to plan, implement and analyze public health activities, including due process requirements as necessary. The system will understand, communicate and utilize appropriate entities in regards to public health's legal authority, and understand and use legal tools such as laws, rules, ordinances and litigation to carry out its duties.[53]

I. Interpret and assess public health laws, policies and procedures regarding agency operations in compliance with statutes, ordinances, rules and regulations.[54]
- **i.** Review existing laws and work with governing entities, elected/appointed officials and legal counsel to update and revise laws as needed.
- **ii.** Identify gaps in the law that contribute to or exacerbate health disparities or systemic inequities.

[48] 6 CCR 1014-9 3.1 K 1
[49] 6 CCR 1014-9 3.1 K
[50] 6 CCR 1014-9 3.1 B 3)
[51] 6 CCR 1014-9 3.1 H
[52] 6 CCR 1014-9 3.1 L1
[53] 6 CCR 1014-7, 3.1 A5 c
[54] 6 CCR 1014-9, 3.1 F and 6 CCR 1014-7, 4.1 G

iii. Develop and share legal tools, such as public health orders and memoranda of understanding (MOUs).

iv. Monitor and evaluate public health enforcement processes and outcomes.

II. Enforce public health laws regarding agency operations in compliance with statutes, ordinances, rules and regulations.[55]

i. Communicate and educate individuals and organizations, as needed, in the meaning, purpose, and benefit of public health laws and how to comply.

ii. Conduct public health enforcement activities using legal tools as appropriate, provide due process and coordinate notification of violations among appropriate agencies.

III. Employ or retain and compensate an attorney to be the legal adviser of the agency to defend all actions and proceedings brought against the agency or the officers and employees of the agency through the agency's county or district board of health or through its public health director with the approval of the state board.

d. Financial Management, Contract and Procurement Services, and Facilities Management: Colorado's governmental public health system will establish and maintain access to the appropriate systems and facilities necessary to deliver public health services in an efficient and effective manner. The system will establish policies and procedures, and provide financial, procurement, budgeting and auditing services in compliance with federal, state and local standards and laws.[56]

I. Ability to comply with local, state and federal standards and policies.

i. Provide financial management and contract and procurement services, including records management, in accordance with generally accepted accounting principles (GAAP), governmental accounting standards board (GASB), Government Finance Officers Association (GFOA) and Office of Management and Budget (OMB) or other compliance requirements.

ii. The county treasurer, as a part of his or her official duties as county treasurer, shall serve as treasurer of the LPHA. In the case of a district local public health agency (LPHA), the county with the largest population shall serve as treasurer[57].

iii. Annually estimate the total cost of maintaining the local public health agency (LPHA).[58]

II. Establish and maintain budgeting, billing, contracting and financial system(s) in compliance with local, state and federal standards and policies.

i. Utilize effective financial management systems and ensure management of the public health fund in accordance with C.R.S. 25-1-511.[59]

ii. Develop and maintain financial management and procurement policies and procedures.

iii. Produce and monitor an effective governmental public health agency-specific budget.

iv. Ensure access to auditing services to evaluate financial management practices and transparency around collection of revenues and disposition of expenditures.

III. Conduct sound financial analyses to inform decisions about policies, programs and services.

i. Assess the sufficiency of the resources necessary to provide public health services.

ii. Evaluate the cost-effectiveness or cost-benefit of public health services.

IV. Work with partners to seek and sustain funding for additional public health priority work.

[55] 6 CCR 1014-9, 3.1 F and 6 CCR 1014-7, 4.1 G
[56] 6 CCR 1014-7, 3.1 A5 d
[57] CRS 25-1-511 1a
[58] CRS 25-1-511 5a,b
[59] CRS 25-1-511 (CCR 1014-7)

i. Accept and expend on behalf of and in the name of the state gifts, grants, donations and federal funds.[60]

ii. The treasurer of a LPHA shall credit (a) any moneys appropriated from a county general fund; and (b) any moneys received from state or federal appropriations or any other gifts, grants, donations or fees for local public health purposes.[61]

V. Ability to procure, maintain and manage safe, accessible facilities and efficient operations.

i. Ability to procure, maintain and manage safe, accessible facilities and efficient operations.

ii. Develop plans for future facility and space requirements that align with operational needs.

iii. Plan for, acquire and maintain fleet vehicles.

iv. Ensure compliance with local, state and federal laws concerning facility accessibility.

e. Information Technology/Informatics (IT): Colorado's governmental public health system will maintain access to information technology, information management systems and ensure informatics capacities to store, protect, manage, analyze, and communicate data and information to support effective, efficient, and equitable public health decision making.[62]

I. Design, develop, manage and evaluate information systems to support all public health activities.

i. Cultivate informatics competencies.

ii. Categorically (agency size, scope and region) assess informatics capacity and implementation/expansion readiness.

iii. Inventory data or data systems, either collected by the health department or by others, available to the health departments.

iv. Review and develop information management business system requirements to guide systems changes and development.

v. Identify and propose group purchasing agreements for secure cloud services and other development needs.

vi. Identify and monitor innovations in technology that could improve public health practice.

vii. Regularly evaluate performance of information technology (IT) systems in supporting all public health foundational capabilities and services, as well as additional programs and activities.

II. Establish and adhere to data management and data governance best practices. Comply with federal and state laws and regulations, such as the Heath Insurance Portability and Accountability Act (HIPAA), when storing, analyzing, and disseminating data.

i. Conduct and document vulnerability audits, security policies and/or internal controls to ensure the privacy and security of information.

ii. Develop and enact a policy that the department adheres to federal, state and local privacy protection regulations for handling data.

f. Leadership and Governance: Colorado's governmental public health system will serve as the face of public health, lead internal and external stakeholders in consensus development, engage in policy development and adoption.[63]

I. Engage with local health agencies to define a strategic direction for public health initiatives.

II. Engage in health policy development, discussion and adoption with local public health agencies (LPHAs) to define a strategic direction for public health initiatives.

[60] CRS 25 1.5 101 1 ml, and others.
[61] CRS 25-1-511 2a,b
[62] 6 CCR 1014-7, 3.1 A5 e
[63] 6 CCR 1014-7, 3.1 A5 f

III. Engage with appropriate governing entities about public health's legal agencies and what new legislative concepts, laws and policies may be needed.

6. **Emergency Preparedness and Response:** Colorado's governmental public health system, in coordination with federal, state and local agencies and public and private sector partners, will have the capability and capacity to prepare for, respond to, and recover from emergencies with health, environmental and medical impacts.[64]

a. Public Health Preparedness and Response Strategies and Plans

I. Develop, exercise, maintain and use public health preparedness and response strategies and plans, in accordance with established guidelines and the United States Department of Health and Human Services (HHS).
- **i.** Maintain an All-Hazards Emergency Operations plan.
- **ii.** Participate in All-Hazards planning, training, exercises and response activities within the local jurisdiction.
- **iii.** Conduct training and exercise on the jurisdiction's public health emergency operations plan and procedures and Emergency Support Function 8 – Public Health & Medical (ESF8) response plans for staff who serve in the agency or jurisdiction Emergency Operations Center.
- **iv.** Ensure public health preparedness training addresses how the public health and Emergency Support Function 8 – Public Health & Medical (ESF8) responses are coordinated within the jurisdiction's incident command system.
- **v.** Write after action reports (AARs) documenting lessons learned from exercises. Identify corrective actions and track progress in completing those actions.
- **vi.** Use the Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness Capabilities National Standards[65] as the foundation for planning efforts and the measure of readiness.
- **vii.** Develop and sustain local and state-level emergency response teams to provide surge capacity in incident response and recovery.
- **viii.** Plan or participate in, and document annual emergency preparedness and response exercises.
- **ix.** Develop and sustain local and statewide mutual aid and partnership agreements with and among governmental public health system pharmacies, health care organizations, private sector, community organizations and other agencies as appropriate.

II. Develop, maintain and execute a Continuity of Operations Plan (COOP) that includes access to financial resources for emergency response and recovery operations.
- **i.** Ensure continuity plans include definition and identification of mission-essential functions, orders of succession and written delegations of authority for select critical positions, and protocols for temporarily suspending specific functions to sustain critical services.
- **ii.** Define roles and responsibilities of public health agencies in establishing short- and long-term community recovery goals.

III. Establish plans to reach all persons within our communities through multiple communications methods before, during and after incidents using the inclusive Federal Emergency Management Agency (FEMA) "Whole Community"[66] approach.

[64] 6 CCR 1014-7, 3.1 A6
[65] https://www.cdc.gov/cpr/readiness/00_docs/CDC_PreparednesResponseCapabilities_October2018_Final_508.pdf
[66] https://www.fema.gov/media-library-data/20130726-1813-25045-3330/whole_community_dec2011__2_.pdf

i. Implement an emergency communication strategy to inform the community and to activate emergency response personnel in the event of a public health crisis.
ii. Train appropriate public health emergency response staff on information management systems.
iii. Maintain and annually exercise procedures and various tools to inform the public of threats to health and safety in a manner that that aligns with federal standards such as Culturally and Linguistically Appropriate Services (CLAS).[67]
iv. Create and maintain templates for news releases and social media messages for public health hazards.

IV. Assure the inclusion of functional and operational considerations to enhance community inclusion for all genders, races, religions, social and health strata before, during and after incidents.
i. Utilize the Communications, Medical Care, Independence, Self Determination and Safety Support Services, and Transportation (C-MIST) framework to assure the unique needs of all communities are addressed before, during and after incidents.
ii. Develop and maintain strategic partnerships with local agencies, non-profit organizations, private sector, health care organizations, state agencies and associations to support public health preparedness, mitigation, response, recovery and resilience efforts.

b. Emergency Support Function 8

I. Serve as Emergency Support Function 8 – Public Health & Medical (ESF8) and/or a public health response for the county, region, jurisdiction and state.
i. Maintain written procedures for Emergency Support Function 8 – Public Health & Medical (ESF8) in the State or County Comprehensive Emergency Management Program (CEMP) and/or Emergency Operations Plan and/or the Public Health Response Plan.
ii. Develop, train and exercise a decision-making protocol to support agency leadership in making policy-level decisions during public health incidents.
iii. Develop and maintain strategic partnerships with local agencies, non-profit organizations, private sector, health care organizations, state agencies and associations to support public health mitigation, preparedness, response, recovery and resilience efforts.
iv. Define roles and responsibilities of public health agencies in establishing short- and long-term community recovery goals.

c. Emergency Response

I. Issue public health orders and coordinate with partner agencies to enforce orders.
II. Maintain ability to provide essential and core public health laboratory testing and reporting functioning as a Laboratory Response Network (LRN). For biological threats, operate as a Biological Reference Laboratory (LRN-B); for chemical threats operate as a Chemical Reference Laboratory (LRN-C) all at levels designated by the CDC.
III. Monitor the burden on the public health and medical system utilizing epidemiology to identify the problem, agent and transmission route, collect data and implement control measures to prevent additional transmission of illness.
i. Implement an emergency communication strategy to inform the community and to activate emergency response personnel in the event of a public health crisis.
ii. Establish and maintain a process for 24/7 access, including coverage and availability, for urgent public health issues.

[67] https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

iii. Maintain an emergency notification system and include all critical public health response and leadership positions, and essential partners as appropriate, as registered users.

iv. Conduct routine staff notification exercises, evaluate results, address issues and make improvements.

v. Maintain procedures for requesting assistance during disasters from the local or state Emergency Operations Center (EOC) and mutual aid partners.

vi. Use the Incident Command System (ICS) to:

- Determine objectives to address the health needs of those affected,
- Develop situational assessments to determine the functionality of critical public health operations, critical health care facilities, critical infrastructure, and the number of ill, injured and deceased,
- Identify and allocate resources to address public health needs,
- Return to routine operations, and
- Write after action reports (AARs) documenting lessons learned from real life activations of plans. Identify corrective actions and track progress in completing those actions.

vii. Maintain and exercise procedures and agreements with health care, private-sector and community partners to request, receive, distribute and dispense medical countermeasures for statewide and community-wide public health incidents.

d. Community Preparedness

I. Establish and promote basic ongoing community preparedness, readiness and resilience by educating, communicating to and encouraging the public to take necessary action before, during and after an incident.

i. Promote community preparedness by communicating steps that can be taken before, during or after an incident.

7. Health Equity and the Social Determinants of Health: Colorado's governmental public health system will intentionally focus on improving systems and institutions that create or perpetuate socioeconomic disadvantage, social exclusion, racism, historical injustice, or other forms of oppression so that all people and communities in Colorado can achieve the highest level of health possible. Governmental public health will have the requisite skills, competencies, and capacities to play an essential role in creating comprehensive strategies needed to address health inequities, and social and environmental determinants of health.[68]

a. Leadership and Workforce Training and Diversity

I. Implement and evaluate training to support the governmental public health workforce in understanding and applying equity principles and inclusionary practices in all aspects of workforce management and workforce culture.

II. Implement and continuously improve staff and volunteer recruitment, retention and promotion practices to ensure that the governmental public health workforce understands the values of the communities served, and has the education, training and experience to address inequitable social and environmental conditions.

III. Develop relationships and partnerships to cultivate a public health workforce and governance that is more representative of communities served.

[68] 6 CCR 1014-7, 3.1 A7

IV. Through use of health equity leadership development strategies, strengthen governmental public health leadership to be competent in addressing health inequities.

V. Cultivate boards of health and elected officials' understanding of equity concepts and the social and environmental determinants of health through orientations and other learning strategies.

VI. Ensure adequate resources are available to support health equity work within the governmental public health system—for example, by devoting staff time or combining efforts and resources across jurisdictions.

b. Health Equity Policy

I. Advocate for population-based, primary prevention policies that improve physical, environmental, social and economic conditions that affect the public's health.

II. Support statutes, regulations, rules, codes, policies and procedures and revisions to those that govern public health to ensure equity in the distribution of public health benefits and interventions across all populations.

III. Ensure that health equity principles are infused across governmental public health programs, initiatives, strategies and investments.

IV. Use performance management and quality improvement principles to continuously improve all policies, processes and programs to advance health equity.

V. Assess the governmental public health system's capacity to act on root causes of health inequities, including organizational structure, policies, processes, culture and historic institutional biases and barriers.

c. Health Equity Data

I. Collect, analyze and report data on the social and environmental determinants of health to better understand health inequities.

d. Health Equity Partnerships

I. Engage and partner with the community and stakeholders to assess social and environmental determinants of health and health inequities.

II. Build strategic public health partnerships to address social, economic, and environmental determinants and health disparities, and recognize root issues for these disparities including, but not limited to, discrimination on the basis of race, ability, age, sexual preference, gender and gender identity.

e. Health Equity Communications

I. Develop, support and inform communication efforts regarding social, economic, and environmental determinants of health disparities and inequities.

II. Ensure that all communications and engagement activities with the public align with federal standards such as Culturally and Linguistically Appropriate Services (CLAS).[69]

B. Foundational Services

1. Communicable Disease Prevention, Investigation and Control: Colorado's governmental public health system will carry out state and locally coordinated surveillance, disease investigation, laboratory testing, and prevention and control strategies to monitor and reduce the incidence and transmission of communicable

[69] https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

diseases. Programs will target illnesses that are vaccine-preventable, zoonotic, vector-borne, respiratory, food- or water-borne, bloodborne, healthcare associated, and sexually transmitted as well as emerging threats. Communicable Disease Control will collaborate with national, state, and local partners to ensure mandates and guidelines are met and timely, actionable information is provided to the public and to health professionals.[70]

a. Communicable Disease Prevention

I. Provide timely, statewide, locally relevant and accurate information to public health partners, health care system partners and the community on communicable disease risks and preventive strategies to reduce those risks.

- **i.** Collect and maintain communicable diseases, other reportable conditions and immunization data according to Colorado Board of Health Rules and Regulations.[71]
- **ii.** Develop and implement protocols for data and information sharing between public health; health care providers; pharmacists and veterinarians, when appropriate, and other local, state and federal agencies and the public to reduce disease transmission and increase immunization rates.
- **iii.** Analyze, interpret and share communicable disease, and other reportable conditions and immunization data pertaining to inequities.
- **iv.** Produce and share periodic/routine reports of communicable diseases, other reportable conditions and immunization rates to support prevention and control strategies.
- **v.** Inform decision makers of potential and actual impacts to public health based on data, immunization for communicable disease and other reportable conditions while complying with statutes related to personal information.
- **vi.** Provide the public, regulated facilities, health care facilities, health care providers and stakeholder organizations effective and timely communication about protection recommendations evidence-based practices.
- **vii.** Gather community input to facilitate the development of public health policy, systems and environmental change initiatives for communicable disease, other reportable conditions and immunization rates, including those designed to promote health equity.
- **viii.** Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and geographic information systems (GIS) to meet user's requests.
- **ix.** Maintain the ability to develop and adapt data systems as needed.

II. Conduct routine surveillance for reportable conditions. Monitor data to prevent and detect outbreaks and maintain awareness of communicable disease trends.

- **i.** Collect and report disease information according to Colorado Board of Health Rules and Regulations.[72]
- **ii.** Develop and maintain up-to-date electronic statewide immunization information system (IIS).
- **iii.** Develop and implement protocols for data and information sharing between public health; health care providers; pharmacists and veterinarians, when appropriate, and other local, state and federal agencies and the public to reduce disease transmission and increase immunization rates. Include protocols for confidentiality as appropriate.

[70] 6 CCR 1014-7, 3.1 B1
[71] 6 CCR 1014-7 4.1 C1
[72] 6 CCR 1014-7 4.1 C1

iv. Ensure that health care providers, pharmacists, school officials and the public are educated about the statewide immunization information system (IIS) and how to enter and access data, as appropriate.

v. Analyze, interpret and share communicable disease and other reportable conditions and immunization data pertaining to inequities.

vi. Measure the impact of communicable disease and other reportable conditions and immunization rates on the health of the public, including priority populations.

vii. Ensure health care facilities, health care providers, veterinarians and laboratories are educated about reportable conditions requirements including the need for timely and accurate reporting and how to report.

viii. Maintain capacity to prioritize and respond to data requests and as appropriate, prepare data files to share and make available to researchers and other stakeholders.

ix. Ability to develop and adapt data systems, as needed.

b. Identify Communicable Disease Prevention, Investigation and Control Assets

I. Identify local community, regional and statewide assets and ensure disease surveillance, investigation and control of communicable diseases, in accordance with local, state and federal mandates and guidelines.

i. Provide subject matter expertise to inform policy, system and environmental change and to inform program design and communications to decision/policy makers, providers, the public and stakeholders about communicable disease and other reportable conditions.

ii. Identify, develop, engage and maintain local strategic partnerships with health care facilities, health care providers, pharmacists, long-term care facility staff, infection control specialists, school officials, the public and others to prevent, control and mitigate risk from communicable disease and other reportable conditions.

iii. Identify, develop, engage and maintain strategic partnerships with statewide organizations, associations and government agencies to prevent, control and mitigate risk from communicable disease and other reportable conditions.

iv. Identify, develop, engage and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovations related to disease prevention, control and mitigation.

v. Work with partners to develop a prioritized control plan(s) addressing important communicable disease and other reportable conditions and immunization rates, as needed.

vi. Work with partners to advocate for high priority policy, system and environmental change and other initiatives regarding communicable diseases and other reportable conditions.

vii. Use data, evidence-informed practices and community input to facilitate the development of public health policy, systems and environmental change initiatives for communicable disease, other reportable conditions and immunization rates, including those designed to promote health equity.

II. Ensure access to communicable disease prevention services through partnerships with community providers or direct service provision.

i. Identify, develop, engage and maintain local strategic partnerships with health care facilities, health care providers, pharmacists, long-term care facility staff, infection control specialists, school officials, the public and others to prevent, control and mitigate risk from communicable disease and other reportable conditions.

ii. Identify, develop, engage and maintain strategic partnerships with statewide organizations, associations and government agencies to prevent, control and mitigate risk from communicable disease and other reportable conditions.

iii. Identify, develop, engage and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovations related to disease prevention, control and mitigation.

iv. Work with partners to develop a prioritized control plan(s) addressing important communicable disease and other reportable conditions, and immunization rates, as needed.

v. Work with partners to advocate for high priority policy, system and environmental change and other initiatives regarding communicable diseases and other reportable conditions.

vi. Use data, evidence-based practices and community input to facilitate the development of public health policy, systems and environmental change initiatives for communicable disease, other reportable conditions and immunization rates, including those designed to promote health equity.

c. Communicable Disease Investigation and Control

I. Investigate case reports, outbreaks, unusual trends and uncommon cases of communicable diseases. Implement disease control measures to prevent communicable disease transmission.

i. Investigate cases of reportable disease and suspected outbreaks according to standard protocols and guidance provided by the Colorado Department of Public Health and Environment (CDPHE) Reportable Condition Investigation Guidance and Communicable Disease Manual.[73]

ii. Work closely with the Colorado Department of Public Health and Environment (CDPHE) in communicable disease investigation and control particularly if an investigation crosses county lines or technical assistance is needed.[74]

iii. Conduct timely investigation of complaints related to communicable disease or other notifiable conditions, including ensuring capacity to identify and respond to rare or previously unidentified infections (conditions for which formal protocols do not yet exist) or novel modes of transmission. Maintain capacity (including a system/process) for prioritization and respond to investigate cases and control disease outbreaks within the jurisdiction, in collaboration with partners.

iv. Maintain a tracking log of all case reports and investigations.

v. Issue public health orders.

vi. Coordinate with partner agencies to conduct public health enforcement activities using legal tools, as appropriate; provide due process and coordinate notification of violations among appropriate agencies.

vii. Provide Directly Observed Therapy (DOT) for active tuberculosis (TB) utilizing qualified local public health agencies (LPHA) personnel.

viii. Provide latent tuberculosis (TB) therapy as a provider of last resort.

ix. Provide recommendations to health care providers for treatment of active and latent tuberculosis (TB).

x. Take appropriate measures to prevent disease transmission using methods specific to: infected persons, contacts to infected persons, and the environment in which communicable disease

[73] 6 CCR 11014-7, 4.1 C2
[74] 6 CCR 1014-7 4.1 C5

occurs (e.g., ensure access to human immunodeficiency virus [HIV] pre- and post-exposure prophylaxis for the purposes of communicable disease control.)[75]

III. Issue public health orders and coordinate with partner agencies to enforce orders.

d. Communicable Disease Laboratory Services

I. Ensure availability of public health laboratory services for disease investigations and response, and for reference and confirmatory testing related to communicable diseases.

i. Provide 24/7 access to laboratory resources to support testing for notifiable conditions and outbreak identification, including biological and chemical agents of weapons of mass destruction.

ii. Maintain a current continuity of operations plan (COOP) in the event of a disruption of laboratory services.

iii. Promote and maintain innovative scientific and technological infrastructure to provide cutting-edge laboratory services to protect and promote the public's health (e.g., next generation sequencing, bioinformatics, and other advanced techniques).

iv. Maintain interdisciplinary collaboration across diverse programs (e.g. epidemiology, preventive health and environmental health) to ensure consistent knowledge and communication on innovation, testing methodologies and results interpretations.

v. Develop and maintain efficient electronic systems that support data collection, analysis and reporting and ability to share confidential lab data within the governmental public health system and clinical laboratories. Include protocols for confidentiality as appropriate.

vi. Maintain protocols and provide training for proper collection, preparation, packaging and shipment of samples of public health importance.

vii. Coordinate with local public health laboratories and federal partners (e.g., Centers for Disease Control and Prevention [CDC], United States Food and Drug Administration [FDA], United States Department of Agriculture [USDA] and United States Environmental Protection Agency [EPA]) in specimen testing, outbreak identification and testing protocols.

viii. Develop and maintain surge capacity agreements with other public health laboratories (regionally and nationally) to ensure testing capacity during emergency events or large outbreaks.

e. Immunization

I. Promote and provide immunization through evidence-informed strategies and in collaboration with schools, health care providers and other community partners to increase vaccination rates.

i. Develop and maintain up-to-date electronic statewide immunization information system (IIS).

ii. Ensure that health care providers, pharmacists, school officials and the public are educated about the statewide immunization information system (IIS) and how to enter and access data, as appropriate.

iii. Provide subject matter expertise to inform policy, systems and environmental change, program design, and communications to decision/policy makers, providers, the public and stakeholders about vaccine preventable disease and immunizations.

iv. Ensure that health care providers, pharmacists, long-term care facility staff, infection control specialists, school officials, the public and others are educated about vaccine-preventable diseases and immunizations.

[75] 6 CCR 1014-7, 4.1

v. Develop, implement, and enforce laws, rules, policies and procedures related to immunizations per local, state and federal mandates and guidelines (e.g., school/work exclusion, isolation and quarantine).

vi. Identify, develop, engage and maintain local strategic partnerships with health care providers, pharmacists, long-term care facility staff, infection control specialists, school officials, the public and others to use evidence-based strategies that are culturally and linguistically appropriate to increase immunization rates in children and adults, and in communities that are disproportionately impacted by low immunization rates.

vii. Identify, develop, engage and maintain strategic partnerships with statewide organizations, associations and government agencies to use evidence-based strategies that are culturally and linguistically appropriate to increase immunization rates in children and adults and in communities that are disproportionately impacted by low immunization rates.

viii. Identify, develop, engage, and maintain relationships with academic institutions and/or research centers to advance evidence-based practice and innovation regarding immunizations.

ix. Work with partners to develop a prioritized plan addressing important immunization issues.

x. Work with partners to advocate for high priority policy, system and environmental change initiatives regarding immunizations.

f. Coordination of Other Communicable Disease Services with Foundational Capabilities and Services

I. When other public health services are delivered regarding prevention and control of communicable disease, ensure they are well coordinated with foundational capabilities and services.

i. Identify and support relationships, interdependencies and coordination needs between the foundational service and related public health services.

ii. Leverage foundational activities and funding to support identification and implementation of related public health services and vice versa.

2. Environmental Public Health: Colorado's governmental public health system will use evidence-informed practices to understand the cause and effect relationships between environmental changes and ecological and human health impacts, to protect, promote, and enhance the health of the community and environment. Agencies will participate in the protection and improvement of air quality, water, land, and food safety by identifying, investigating, and responding to community environmental health concerns, reducing current and emerging environmental health risks, preventing communicable diseases, and sustaining the environment in a coordinated manner with agencies at the federal, state, and local levels as well as industry stakeholders and the public.[76]

a. Environmental Health Data

I. Use available community specific environmental and health data to ensure protection of public health, assess health impacts, reduce risk and communicate risk information to the community.

i. Provide subject matter expertise to inform policy, system and environmental change, and program design.

ii. Evaluate implementation of environmental public health regulations, inspections, investigations, enforcement and other response, and use findings to improve processes and procedures.

b. Identify Environmental Health Assets

[76] 6 CCR 1014-7, 3.1 B2

I. Identify local community, regional and statewide assets to perform environmental health assessments, inspections, investigations and monitoring programs in accordance with local, state and federal mandates and guidelines.

c. Environmental Health Investigations, Inspections, Sampling, Lab Analysis and Oversight

I. Implement public health laws, policies and procedures to ensure the safety of food provided to the public from all parts of the local food system.
- **i.** Conduct regulatory inspections of food facilities based on jurisdictional authority
- **ii.** Conduct investigations of food facilities related to outbreaks, complaints, recalls, etc. based on jurisdictional authority.
- **iii.** Provide or ensure access to laboratory services that are certified and supported by the FDA for milk and food testing, and that participate in the Food Emergency Response Network.

II. Take appropriate steps to support the protection of surface water and groundwater, including recreational waters and drinking water sources; collect and use community specific water quality data to assure community health and assure appropriate local regulatory oversight of onsite wastewater treatment systems.
- **i.** Provide and/or ensure access to laboratory services that are United States Environmental Protection Agency (EPA)-certified for testing water.
- **ii.** Ensure that appropriate permitting, inspection and enforcement of regulated facilities and treatment plant operators is conducted based on jurisdictional authority.
- **iii.** Ensure implementation of local Onsite Wastewater Treatment Systems programs in accordance with the Onsite Wastewater Act and Water Quality Control Commission Regulation 43.[77]

III. Implement public health laws, policies and procedures to ensure the sanitation of institutional facilities (e.g., child care facilities, local correctional facilities and schools).
- **i.** Conduct regulatory inspections of facilities based on jurisdictional authority.
- **ii.** Conduct investigations of facilities related to outbreaks, complaints, recalls, etc. based on jurisdictional authority.

IV. Collect and analyze air quality data throughout the state to better understand the sources of air pollution and develop mitigation strategies.
- **i.** Collect and analyze statewide ambient air quality data.
- **ii.** Provide daily air quality advisories during the summer ozone season and the winter high pollution season.
- **iii.** Perform complex modeling analysis to determine impacts of air pollution sources on air quality.
- **iv.** Provide forecasting and meteorology information related to air pollution.
- **v.** Maintain emission inventory data to track quantity and sources of various pollutants.
- **vi.** Regulate the use of controlled burns and prescribed fire through a smoke management program.
- **vii.** Conduct air visibility research and analysis.
- **viii.** Ensure that appropriate permitting, inspection and enforcement of regulated facilities and other regulated emissions is conducted based on jurisdictional authority.

V. Ensure proper management of solid and hazardous waste, maximizing waste diversion and ensuring safe storage, collection, treatment and disposal of solid and hazardous waste.
- **i.** Ensure that appropriate permitting, inspection and enforcement of regulated waste facilities and waste handlers is conducted based on jurisdictional authority.

[77] 5 CCR 1002-43

ii. Collaborate with community partners to advance waste diversion programs and activities.

VI. Issue public health orders related to environmental health, and coordinate with partner agencies to enforce orders.

d. Zoonotic Conditions

I. Identify and mitigate zoonotic and vector-borne (e.g., insects, rodents), air-borne, water-borne, foodborne and other public health threats related to environmental hazards and consumer-oriented facilities (e.g., body art facilities, swimming pools, and marijuana-related facilities).
   i. Conduct surveillance for zoonotic and vector borne diseases of concern in Colorado.
   ii. Establish and implement appropriate policies and response systems to prevent the spread of zoonotic, vector borne and other consumer-related communicable diseases and reduce environmental toxics exposures.
   iii. Provide and/or ensure access to laboratory services that are EPA-certified for zoonotic disease specimens.

e. Land Use Planning and Climate Change

I. Use community-specific data to decrease vulnerability to and mitigate risks related to climate impacts.
   i. Conduct vulnerability assessments to identify populations most likely to be impacted by climate impacts.
   ii. Utilize vulnerability assessments to develop and implement risk reduction strategies.

II. Participate in land use and sustainable development decision making processes to encourage practices that promote positive public health outcomes (e.g., consideration of housing, development approaches, recreational facilities and transportation systems), and that protect and improve air and water quality, promote water conservation, effectively manage solid and hazardous waste and promote energy efficiency and clean energy resources.

f. Coordination of Other Environmental Health Services with Foundational Capabilities and Services

I. When public health services are delivered regarding environmental health, ensure they are coordinated with foundational capabilities and services.

3. **Maternal, Child, Adolescent, and Family Health:** Colorado's governmental public health system will develop, implement and evaluate state-wide, regional and local strategies related to maternal, child, adolescent and family health to increase health and wellbeing, reduce adverse health outcomes and advance health equity across the life course. Strategies may include but are not limited to identifying and providing information, promoting evidence-informed and multi-generational approaches, identifying community assets, advocating for needed initiatives, and convening partners.[78]

a. Maternal, Child, Adolescent and Family Health Information

I. Provide timely and relevant federal, state and local evidence-informed information on maternal, child, adolescent and family health using health equity and life course frameworks.
   i. Maintain and enhance reporting systems.
   ii. Provide information on topics such as accessing care and community resources.

[78] 6 CCR 1014-7, 3.1 B3

iii. Share data and performance metrics relevant to maternal, child, adolescent and family programs.
iv. Collect, analyze, interpret and share maternal, child, adolescent and family health data pertaining to inequities.
v. Provide reports as appropriate that measure the impact of maternal, child, adolescent and family health activities.
vi. Provide communities and stakeholders with timely communications and recommendations.

b. Identify Maternal, Child, Adolescent and Family Health Assets

I. Identify local community, regional and statewide assets to improve maternal, child, adolescent, and family health in accordance with local, state and federal mandates and guidelines.

c. Collaborative Efforts around Maternal, Child, Adolescent, and Family Health

I. Lead systems improvements and coordinate efforts across sectors to ensure access to services such as primary care, oral health care, specialty care, mental health prevention and treatment, social services and early intervention for development.
i. Coordinate and/or participate in cross-sector partnerships.
ii. Identify key partners and stakeholders with expertise in maternal, child, adolescent and family program areas.
iii. Identify strategies and action plans to overcome barriers and increase the number of children and families receiving services.
iv. Develop consultants to work in communities, especially with affected populations.
v. Provide subject matter expertise and education on legislation and policies.
vi. Provide subject matter expertise and education to boards of health, school boards, community agencies and other organizations.

II. Collaborate with cross sector partners, including community members, to promote and build will for policies, practices and strategies that improve maternal, child, adolescent and family health.
i. Provide subject matter expertise and education to cross-sector partners and community members.
ii. Share data and performance metrics relevant to maternal, child, adolescent and family programs.
iii. Provide technical assistance on community-specific data including identification, interpretation and dissemination.
iv. Identify policy and/or system change to improve maternal, child, adolescent and family programs and services.
v. Identify strategies and action plans to overcome barriers and increase the number of children and families receiving services.
vi. Engage families in the development and implementation of activities to improve services.
vii. Implement policies and systems that support collaboration between programs.

d. Maternal, Child, Adolescent and Family Health Improvement

I. Improve the health status of infants, children, adolescents, youth, women and their families, and protect critical stages of a child's physical and mental development during pregnancy and early childhood.
i. Deliver community level services in settings that meet community needs.

ii. Ensure maternal, child, adolescent and family health is addressed in community health assessments (CHAs).
iii. Engage in state and local coalitions to increase awareness of maternal, child, adolescent and family health programs and needs.
iv. Build and support infrastructure to facilitate community-based resources.
v. Make appropriate referrals to meet needs.
vi. Provide staff development and training relevant to skills needed to address maternal, child, adolescent and family health needs.
vii. Develop consultants to work in communities, especially with affected populations.
viii. Provide developmental screenings when necessary.
ix. Ensure children and their families with special needs get resources they need filling the gap around care coordination.
x. Provide child care nurse consultation.
xi. Educate health care providers about evidence-informed screenings, patient education, and community resources.

II. Identify and develop maternal, child, adolescent and family health prevention approaches, using life course expertise to advance equity, and advocate and seek resources for related initiatives.
i. Use data and evidence-informed practices to identify and develop public health policies, systems, programs and initiatives to address maternal, child, adolescent and family health.
ii. Utilize community health assessments (CHAs) to develop strategies, policies, programs and initiatives related to maternal, child, adolescent and family health.
iii. Identify strategies and action plans to overcome barriers and increase the number of children and families receiving services.
iv. Assess community assets and evaluate needed resources and unmet needs related to maternal, child, adolescent and family health.
v. Provide technical assistance and coaching to promote best practices such as breastfeeding practices or early child care setting practices.
vi. Provide education on risk factors such as smoking and secondhand smoke.

e. Mandated Newborn Screening (State Role Only)

I. Ensure mandated newborn screening to test every infant born in Colorado to detect and prevent developmental impairments and life-threatening illnesses associated with congenital disorders that are specified by the State Board of Health.

Bloodspot Screening

i. Determine which conditions are on Colorado's newborn bloodspot screening panel.
ii. Provide the collection and analysis of newborn bloodspot screening specimens.
iii. Communicate the results of the newborn bloodspot analysis to the provider/entity that submitted the specimen.
iv. Provide repeat or confirmatory testing, when needed.
v. Provide referrals to specialists occur when needed.
vi. Assure quality control and education necessary to support quality standards is provided.

Hearing

vii. Collect newborn hearing screening statewide data.
viii. Report statewide screening rates for newborn hearing.
ix. Maintain an advisory committee to develop recommendations to support the implementation of newborn hearing screening throughout the state.

Critical congenital heart disease (CCHD)

x. Promulgate rules for critical congenital heart disease (CCHD) screening protocol.
xi. Collect critical congenital heart disease (CCHD) screening data from birthing facilities.
xii. Report statewide screening rates for critical congenital heart disease (CCHD).

f. Coordination of Other Maternal, Child, Adolescent and Family Health Services with Foundational Capabilities and Services

I. Coordinate and align categorically-funded maternal, child, adolescent and family health programs and services to work in synergy toward improved health outcomes.
i. Identify and support relationships and coordination need between public health foundational capabilities and services.
ii. Leverage foundational capabilities and services as appropriate to increase health and wellbeing and reduce adverse health outcomes related to maternal, child, adolescent and family health.

4. Chronic Disease, Injury Prevention, and Behavioral Health Promotion: Colorado's governmental public health system focuses on common risk and protective factors that affect social, emotional and physical health and safety. To prevent chronic disease and injuries and promote behavioral health, Colorado's governmental public health system will use policy, systems and environmental change strategies to comprehensively address the root causes of poor health outcomes and advance health equity. Priority areas include, but are not limited to, nutrition, physical activity, oral health, access to care and disease management, injury prevention, violence prevention, suicide prevention, mental health and substance use (including tobacco, alcohol and other substances).[79]

a. Chronic Disease, Injury Prevention, and Behavioral Health Promotion Data

I. Provide timely, relevant and accurate information statewide and to communities on chronic disease prevention and management, injury and violence prevention and behavioral health promotion.
i. Collect, analyze, interpret and share chronic disease prevention and management, injury and violence prevention and behavioral health promotion data pertaining to inequities.
ii. Collect and maintain data (such as risk factors, demographic information, surveillance, and fatality review data) on chronic disease prevention and management to support public health functions.
iii. Collect and maintain data (such as risk factors, demographic information, surveillance and fatality review data) on injury and violence prevention to support public health functions.
iv. Collect and maintain data (such as risk factors, demographic information, surveillance, and fatality review data) on behavioral health promotion to support public health functions.
v. Analyze, interpret and share data regarding chronic diseases with appropriate public health workforce, decision makers, governmental entities, partners, community members, stakeholders and others.
vi. Analyze, interpret and share data regarding injury and violence prevention with appropriate public health workforce, decision makers, governmental entities, partners, community members, stakeholders and others.
vii. Analyze, interpret and share data regarding behavioral health promotion with appropriate public health workforce, decision makers, governmental entities, partners, community members, stakeholders and others.

[79] 6 CCR 1014-7, 3.1 B4

viii. Provide reports that measure the impact of chronic disease prevention and management, injury and violence prevention and behavioral health promotion activities.
ix. As appropriate, prepare data to share and make available to stakeholders.
x. Provide communities and stakeholders with timely communications and recommendations to prevent and manage chronic disease, prevent injuries and violence, and promote behavioral health.
xi. Fulfill future data needs using multiple methods and sources for data collection, analysis and presentation using evolving technology with near real-time data displayed using visualization tools and GIS to meet user's requests.
xii. Develop new and/or adapt existing data systems as needed.

b. Chronic Disease, Injury Prevention and Behavioral Health Promotion Assets

I. Work with partners to identify community assets and develop state and local plans to prevent and manage chronic disease, prevent injury and violence, and promote behavioral health.
  i. Identify, develop, engage and maintain local and statewide strategic partnerships to advance evidence-informed practices and initiatives related to chronic disease prevention and management, injury and violence prevention, and behavioral health promotion.
  ii. Utilize strategic and improvement plans to inform policies, programs and strategies related to chronic disease prevention and management, injury and violence prevention and behavioral health promotion.
  iii. Work with partners to advocate for policies, systems and initiatives to support chronic disease prevention and management, injury and violence prevention and behavioral health promotion.
II. Work with partners to identify community assets and needs related to chronic disease prevention and management, injury and violence prevention and behavioral health promotion. Seek resources for policies, programs and strategies that support the prevention and management of chronic disease, prevention of injuries and violence and promotion of behavioral health.
  i. Assess community assets and evaluate needed resources for appropriate chronic disease prevention and management, injury and violence prevention, and behavioral health promotion policies, systems and programs.
  ii. Seek funding as necessary to implement evidence-informed prevention and promotion policies, systems and initiatives.

c. Chronic Disease, Injury Prevention and Behavioral Health Promotion Policies

I. Develop, implement and evaluate evidence-informed strategies, policies and programs that aim to prevent, delay or detect the onset of chronic diseases and injuries, and promote behavioral health to protect and enhance the health and wellbeing of communities.
  i. Use data and evidence-informed practices to facilitate the development of public health policies, systems and initiatives for preventing and managing chronic disease, preventing injuries and violence and promoting behavioral health.
  ii. Utilize community health assessments (CHAs) to develop strategies, policies and programs related to chronic disease prevention and management, injury and violence prevention and behavioral health promotion.
  iii. In conjunction with partners, community members and stakeholders develop and implement strategies and/or plans for assuring the development and implementation of appropriate policies, systems and initiatives for preventing and managing chronic diseases, preventing injuries and violence and promoting behavioral health.

iv. Provide subject matter expertise to inform policies, systems and environmental changes, interventions and program designs related to chronic disease, injuries and violence and promoting behavioral health.

II. Advocate for policies, programs and strategies that support the prevention and management of chronic disease, prevention of injuries and violence and promotion of behavioral health.

i. Provide subject matter expertise and advocate for policy, systems and environmental change, interventions and programs that support chronic disease prevention and management, injury and violence prevention and behavioral health promotion.

d. Coordination of Other Chronic Disease, Injury Prevention, and Behavioral Health Promotion Services with Foundational Capabilities and Services

I. When public health services are delivered regarding chronic disease and injury prevention and behavioral health promotion, ensure they are coordinated with foundational capabilities and services.

i. Identify and support relationships and coordination needed between public health foundational capabilities and services.

ii. Leverage foundational capabilities and services, as appropriate, to provide chronic disease prevention and management, injury and violence prevention and behavioral health promotion activities.

5. Access to and Linkage with Health Care: All Coloradans should be connected with and have access to needed personal health care services that include primary care, maternal and child health care, oral health care, specialty care, and mental health care. Colorado's governmental public health system will coordinate governmental and community partners to link individuals to and ensure the provision of health care within their jurisdictions.[80]

a. Collaborative Efforts Around Access to Clinical Care

I. Participate actively in state, regional and local level collaborative efforts regarding primary, maternal/child, oral, behavioral, and specialty health care systems planning to improve health care quality and effectiveness, reduce health care costs and improve population health

i. Assess health care service capacity and access to health care services.[81]

b. Access to Clinical Care Data

I. Provide data and information to health care providers, coalitions, decision-makers, legislators and other stakeholders to support health care planning.

c. Health Facility Inspection and Licensure (State Role Only)

I. Conduct timely inspection and review of regulated health facilities and ensure compliance with all licensing rules and minimum standards.

d. Linkage to Clinical Care

I. Link people to needed personal health care services and ensure the provision of health care.[82]

[80] 6 CCR 1014-7, 3.1 B5
[81] 6 CCR 1014-9, 3.1 G1
[82] 6 CCR 1014-7, 2.1 E7

i. Identify, implement and promote strategies that improve access to health care services.[83]

ii. Coordinate efforts with governmental and community partners to link individuals to health services.[84]

[83] 6 CCR 1014-9, 3.1 G1 and G2
[84] 6 CCR 1014-7, 4.1 D7

Appendix A: Acknowledgements

The Colorado State Board of Health adopted Colorado's CPHS framework April 17, 2019 into CCR (6 CCR 1014-7 Core Public Health Services), the official publication of Colorado's state administrative rules. This framework goes into effect January 1, 2020. The framework, as enacted into administrative rule, describes the seven foundational capabilities and 5 services that should be available to residents in Colorado.

However, for the governmental public health system to successfully and consistently implement CPHS, more detail was needed to describe what implementation of each foundational capability and service should include. In 2019, the Colorado Public Health System Transformation Steering Committee oversaw the development of operational definitions that:

- Describe "what" CPHS provides for Colorado's communities, but not "how" the governmental public health system should provide it,
- Are agnostic to which governmental public health provider should provide it,
- Are reduced to discreet activities (define as few actions as possible per statement) and begin with a verb identifying the action to be taken and,
- Align with existing statutes, rules, regulations and guidelines.

These operational definitions add detail by adding functions, definitions, and operational definitions that define the functions, elements, and activities that the governmental public health system must deliver for residents for CPHS to be fully implemented. They definitions are published in this document, the *Foundational Public Health Services Functional Definitions Manual.*

While the Colorado Public Health System Transformation Steering Committee oversaw the development of the definitions, the actual work of "writing" them was done by subgroups in a three-step iterative process. The subgroups were comprised of governmental public health system subject matter experts who developed the definitions for their specific foundational capability or service, or in the case of the foundational capability Organizational Competencies, function.

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Subject Matter Expert Subgroups

Assessment and Planning Subgroup

Communications Subgroup

Policy Development and Support Subgroup

Partnerships Subgroup

Accountability, Performance Management, and Quality Improvement Subgroup

Financial Management, Contract and Procurement Services, and Facilities Management Subgroup

Human Resources Subgroup

Information Technology and Informatics Subgroup

Leadership and Governance Subgroup

Legal Services and Analysis Subgroup

Emergency Preparedness and Support Subgroup

Health Equity and Social Determinants of Health Subgroup

Communicable Disease Prevention, Investigation and Control Subgroup

Environmental Public Health Subgroup

Maternal, Child, Adolescent and Family Health Subgroup

Chronic Disease, Injury Prevention and Behavioral Health Promotion Subgroup

Access to and Linkage with Health Care Subgroup

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Appendix B: Acronyms

24/7 access	Twenty-four/seven access
AAR	After Action Reports
ACE	Adverse Childhood Events
BRFSS	Behavioral Risk Factor Surveillance System
CALPHO	Colorado Association of Local Public Health Officials
CBO	Community-based Organizations
CCHD	Critical Congenital Heart Disease
CCR	Code of Colorado Regulations
CDC	Centers for Disease Control and Prevention
CDOH	Social Determinants of Health
CDPHE	Colorado Department of Public Health and Environment
CEMP	Comprehensive Emergency Management Program
CHA	Community Health Assessment
CHIP	Community Health Improvement Plan
CLAS	Culturally and Linguistically Appropriate Services, as defined by the United States Department of Health and Human Services, Office of Minority Health standards
C-MIST	Communications, Medical Care, Independence, Self Determination and Safety Support Services, and Transportation
COOP	Continuity of Operations Plan
CPHS	Core Public Health Services
CRS	Colorado Revised Statutes
EOC	Emergency Operations Center
EPA	United States Environmental Protection Agency
ESF8	Emergency Support Function 8 - Public Health & Medical
FDA	United States Food and Drug Administration
FPHS	Foundational Public Health Services
FTE	Full Time Equivalents
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles

GASB	Governmental Accounting Standards Board
GFOA	Government Finance Officers Association
GIS	Geographic Information System
HHS	United States Department of Health and Human Services
HIPPA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HKCS	Healthy Kids Colorado Survey
ICS	Incident Command System
IIS	Immunization Information System
IOM	Institute of Medicine
IT	Information Technology
LPHA	Local Public Health Agency
LRN	Laboratory Response Network
LRN-B	Biological Reference Laboratory
LRN-C	Chemical Reference Library
MOU	Memorandum of Understanding
OMB	United States Office of Management and Budget
PHAB	Public Health Accreditation Board
PHIP	Public Health Improvement Plan
PHNCI	Public Health National Center for Innovations
TB	Tuberculosis
USDA	United States Department of Agriculture

Appendix C: Glossary

24/7 Access: Each governmental public health authority as well as a few specific CDPHE programs must be reachable by phone 24/7 for urgent or emergency issues. It is expected that use of the 24/7 agency or program contact numbers will reach, within 15 minutes, a knowledgeable public health professional capable of assessing an event or urgent public health consequence and initiating an appropriate response.

Ability to: Capacity and expertise to implement an activity, element, function and/or foundational capability or service, as needed.

Activities: The discreet (defining only one action per statement) public health work described by operational definitions.

Assure[85]: The dictionary definitions implies the removal of doubt and suspense from a person's mind. In the context of Colorado's CPHS definitions, this means that it is foundational for the governmental public health system to invest time and resources as needed to make sure that the service is available to the community, generally as provided by partner organizations. The service may already be provided by a partner organization or governmental public health may coordinate with partners to get them to provide the service. If no other organization is willing or able to provide the service, governmental public health may decide to become the provider of the services and seek the necessary funds for the service.

Capacity to: Staff or resources with the necessary expertise and associated materials and supplies to provide the activity, element, function and/or foundational capability or service.

Core Public Health Services (CPHS): Colorado's framework for describing the limited statewide set of core public health services that include foundational capabilities and services that (1) must be available to all people in Colorado, and (2) meet one or more of the following criteria:

- Services that are mandated by federal or state laws.
- Services for which the governmental public health system is the only or primary provider of the service, statewide.
- Population-based services (versus individual services) that are focused on disease prevention and protection and promotion of health.

Definition: Definitional components that organize the different activities (described by operational definitions) of CPHS to detail the work being done. In some cases where a definition is discreet (defining only one action per statement) it will not organize activities, and will instead standalone in detailing the work to be done.

Element: The public health work described by definitions.

Emergency Support Function (ESF8) Public Health and Medical Services Annex: Provides the mechanism for coordinated federal assistance to supplement local, state, and Tribal Nations' resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated federal response, and/or during a developing potential health and medical emergency.

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[85] PHAB definition of "Assurance": "The process of determining that "services necessary to achieve agreed upon goals are provided, either by encouraging actions by other entities (public or private sector), by requiring such action through regulation, or by providing services directly." (Institute of Medicine, The Future of Public Health. Washington, DC: National Academy Press; 1988.)" http://www.phaboard.org/wp-content/uploads/FINAL_PHAB-Acronyms-and-Glossary-of-Terms-Version-1.5.pdf.

Ensure: The dictionary definition implies a virtual guarantee. In the context of Colorado's CPHS definitions, this means that the governmental public health system provides the service to the community.

Expertise: The appropriate knowledge and skills necessary to provide the activity, element and/or foundational capability or program.

Foundational Capabilities: The crosscutting capacity and expertise needed to support public health programs.

Foundational Services: The subset of services in each public health program area that are defined as foundational.

Foundational Public Health Services (FPHS): A national framework for describing the limited statewide set of core public health services that include foundational capabilities and programs that (1) must be available to all people served by the governmental public health system, and (2) meet one or more of the following criteria:

- Services that are mandated by federal or state laws.
- Services for which the governmental public health system is the only or primary provider of the service, statewide.
- Population-based services (versus individual services) that are focused on disease prevention and protection and promotion of health.

Function: Definitional components that organize the different elements (described by definitions) and activities (described by operational definitions) of CPHS to detail the work being done.

Operational Definitions: Definitions that describe "what" CPHS provides for Colorado's communities, but not "how" governmental public health should provide it,

- Are agnostic to which governmental public health provider should provide it,
- Are reduced to discreet activities (define as few actions as possible per statement) and begin with a verb identifying the action to be taken, and
- Align with existing guidelines and regulations.

A singular operational definition describes a single public health activity.

Public Health Accreditation Standards: A set of standards defined by the Public Health Accreditation Board (PHAB) to support assessment of the quality and performance of all public health agencies in the United States. Agencies that meet these standards through a vetting process with PHAB can become accredited.

Reportable Conditions: Selected diseases and conditions for which Colorado health care providers, health care facilities, laboratories, veterinarians, food service establishments, child day care facilities and schools are legally required to notify local public health agencies of suspected or confirmed cases. The full current list of reportable conditions is available here:
https://www.colorado.gov/pacific/cdphe/communicable-disease-manual.

Surge Capacity: The staffing and resources necessary to provide the implement the activity, element, function and/or foundational capability or program in annually-expected (one year) events that lead to demand increases.

Colorado Governmental Public Health System: All governmental public health agencies, which currently include the Colorado Department of Public Health and Environment (CDPHE), Colorado State Board of Health (SBOH), and 53 local public health agencies (LPHA).

Appendix D: Sources and Resources

Centers for Disease Control and Prevention, Center for Preparedness and Response, *Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health,* October 2018: https://www.cdc.gov/cpr/readiness/00_docs/CDC_PreparednesResponseCapabilities_October2018_Final_508.pdf

Institute of Medicine. "For the Public's Health: Investing in a Healthier Future." April 10, 2012.

Public Health Accreditation Board, Standards and Measures, Version 1.5, Accessed May 10, 2019: https://www.phaboard.org/wp-content/uploads/2019/01/PHABSM_WEB_LR1.pdf

Public Health National Center for Innovations (PHNCI), FPHS Fact Sheet: http://phnci.org/uploads/resource-files/PHNCI-FPHS-Factsheet_FINAL-1.pdf.

United States Department of Health and Human Services, Office of Minority health, National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Accessed May 10, 2019: https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

United States Department of Homeland Security, Federal Emergency Management Agency, *A Whole Community Approach to Emergency Management: Principles, Themes, and Pathways for Action, FDOC 104-008-1,* December 2011: https://www.fema.gov/media-library-data/20130726-1813-25045-3330/whole_community_dec2011__2_.pdf

Washington State Department of Health, *Foundational Public Health Services (FPHS) Functional Definitions Manual, Definitions Version 1.3*, November 2017: https://www.doh.wa.gov/Portals/1/Documents/1200/FPHSp-2016definitions.pdf.

CHAPS

Colorado Health & Assessment Planning System

Office of Planning, Partnerships & Improvement
Colorado Department of Public Health & Environment

CHAPS Outline

Phase I: Plan the Process

1. Coordinate with the Office of Planning, Partnerships and Improvement.
2. Familiarize yourself with background materials.
3. Communicate with county/regional leadership and staff.
4. Formalize relationships as necessary.
5. Develop a timeline and work plan.
6. Create a project team and designate a project manager.
7. Identify and review existing local needs assessments.
8. Determine resource needs and develop a budget.

Phase II: Identify and Engage Stakeholders

1. Clarify your goals for engaging stakeholders.
2. Design an organizational structure to manage stakeholders.
3. Link with other community initiatives.
4. Identify individual stakeholders and determine their roles.
5. Recruit stakeholders.
6. Engage new stakeholders as the process evolves.
7. Celebrate stakeholder contributions and successes.

Phase III: Conduct a Community Health Assessment

1. Review background materials.
2. Determine the scope of your community health assessment.
3. Develop a community health assessment data gathering outline.
4. Gather quantitative data.
5. Gather qualitative data.
6. Interpret the data and information.
7. Report the results.

Phase IV: Conduct a Capacity Assessment

1. Review available resources and background materials.
2. Determine the scope of your capacity assessment.
3. Gather data and information.
4. Interpret your findings.
5. Report the results.

Phase V: Prioritize Issues

1. Use assessment results to identify issues for consideration.
2. Identify potential strategies to address each issue.
3. Develop a summary presentation of each issue.
4. Identify and engage stakeholders.
5. Plan the prioritization process.
6. Facilitate prioritization meeting(s) to determine PHIP focus areas.

Phase VI: Develop a Public Health Improvement Plan

1. Review your community health assessment, current priorities, past PHIPs and the state PHIP and priorities.
2. Determine the purpose(s) and audience of your PHIP.
3. Develop a planning process that includes key stakeholders.
4. Hold facilitated planning meetings.
5. Develop action plans for each priority issue.
6. Draft the local PHIP.
7. Submit the local PHIP.
8. Disseminate the PHIP.

Phase VII: Implement, Promote and Monitor the Plan

1. Determine organizational structure and process for implementing, evaluating, and communicating the work.
2. Review and refine your action plan(s).
3. Prepare for implementation.
4. Prepare for evaluation.
5. Make mid-course corrections based on evaluation results.
6. Develop a plan to communicate about implementation and evaluation.

Phase VIII: Inform and Participate in Statewide Public Health Improvement Planning

1. Share local/regional PHIP content with statewide partners (though plan submission, reporting, and collaboration).
2. Participate in statewide planning opportunities.
3. Communicate with stakeholders about the statewide plan.

Getting Started: Frequently Asked Questions

Introduction

In 2008, the Colorado Public Health Act was signed into law, calling for major reforms to the state's governmental public health system. The purpose of the Act is to assure that core public health services are available to every person in Colorado, regardless of where they live, with a consistent standard of quality. Toward that end, the Act requires the use of assessments to determine both population health and system-wide capacity issues and to then develop five-year state and local public health improvement plans (sometimes called a community health improvement plan or CHIP) that engage communities in health improvement, increase the availability and quality of public health services, and ultimately improve health outcomes.

In response to the Act, the Office of Planning and Partnerships (the Office) was created at the Colorado Department of Public Health and Environment (CDPHE). The purpose of the Office is to coordinate the implementation of the Act, facilitate the development of a standard public health improvement planning system, provide technical assistance, and act as liaison between state and local public health agencies (LPHAs). The Office is guided by the Public Health Improvement Steering Committee, comprised of stakeholders with representation from around the state.

Figure 1: How Does a Public Health Improvement Plan Make a Difference?

- It provides a baseline by which to monitor change, by answering the question: "What are the recent trends and current conditions?"
- It identifies emerging issues by answering the questions: "What has changed since the last assessment?" "What new concerns do community members have?"
- It helps the community set health priorities and focus resources by answering the questions: "What are the leading causes of disease, disability and death?" "Who is most impacted?" and "What are the best ways to address these issues?"
- It provides facts upon which to base programmatic or organizational decisions by answering the question: "What are the current service levels and where are the unmet needs?"
- It helps partners to plan effective, collaborative interventions by answering the questions: "What's the best strategy to address this issue?" "Who should be leading this effort?" and "How can we support them?"
- It increases the ability to secure new funding by answering the questions: "What are our greatest public health needs?" "How do we best to address these?" and "What is the level of community support?"
- It supports advocacy for policy changes because it communicates: "Here are the facts. We need things to be different."

What is the value of a local public health improvement process?

The public health system is larger than the local public health agency, since many community businesses and organizations have the capacity to impact health. When a public health agency convenes a community-wide process that considers health and environmental data, service capacity, and how to best address an issue, and then uses

that information to develop a plan, the community alignment of health priorities and directed resources is the result. This type of strategic and inclusive process ultimately promotes health improvement.

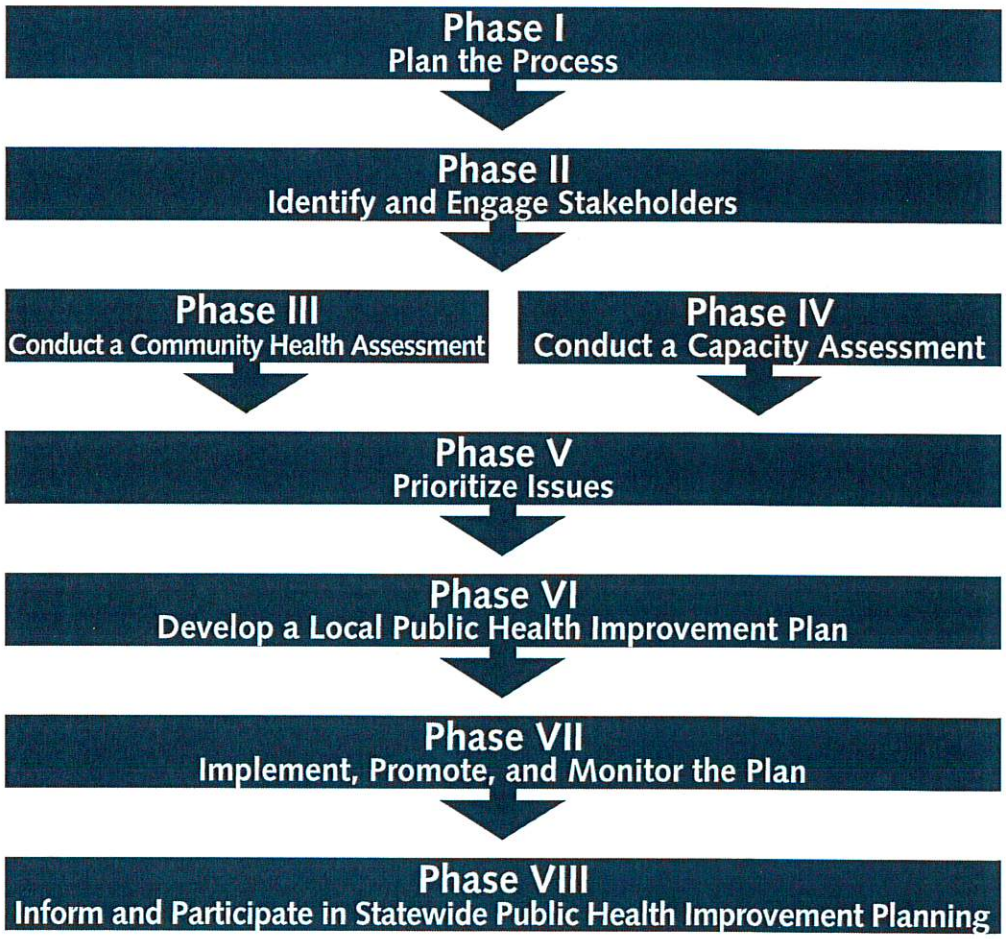
Public health improvement planning has become a standard practice within the public health field, recommended by the National Association of City and County Health Officials (NACCHO), mandated by Colorado's Public Health Act, required for voluntary accreditation by the national Public Health Accreditation Board (PHAB), and linked to federal funding from the Centers for Disease Control and Prevention (CDC). Figure 1 illustrates how a local public health improvement plan (PHIP) can make a difference to a community's health.

What is CHAPS?

CHAPS stands for Colorado Health Assessment and Planning System, which provides a standard mechanism for assisting local public health agencies and CDPHE in meeting assessment and planning requirements of the Public Health Act of 2008 (C.R.S. 25-1-501 et seq.). CHAPS will also assist agencies in preparing for voluntary accreditation by the national Public Health Accreditation Board since many of its processes meet national standards. The public health improvement process of Assessing, Prioritizing, Planning, Implementing and Evaluating is laid out in CHAPS as "Phases," with stakeholders being utilized in nearly every step.

The Act requires that state and local public health improvement plans (PHIP) be developed based on a community health assessment and capacity assessment every five years. These processes are included in CHAPS, each with its own Phase. This CHAPS system is illustrated in Figure 2.

Figure 2: CHAPS System Flowchart



How does CHAPS fit nationally with other public health improvement efforts?

Mobilizing Action for Planning and Partnerships (MAPP):

MAPP was developed by the National Association of City and County Health Officials (NACCHO), and is widely recognized as a model practice in public health improvement planning. CHAPS is closely aligned with the MAPP process; therefore, LPHAs may use MAPP as long as they also meet the other requirements of CHAPS, including utilizing Colorado's standard prioritization criteria and following the criteria for developing the local public health improvement plan. For more information, visit the MAPP website (www.naccho.org/topics/infrastructure/mapp/index.cfm).

Public Health Accreditation Board (PHAB):

Advancing public health performance

PHAB is the national body that oversees the voluntary public health accreditation process for state, local, territorial and tribal public health agencies. This public health accreditation system uses common standards to measure performance and assist agencies in continuously improving their services, and ultimately the community's health. Many steps within CHAPS meet the standards necessary for voluntary accreditation including the following:

- Engage with the community to identify and address health problems
- Conduct and disseminate assessments focused on population health status and public health issues facing the community
- Conduct a Community Health Improvement Planning Process
- Develop and implement a health department strategic plan
- Evaluate and continuously improve processes, programs, and interventions For more information, visit the PHAB website: www.phaboard.org.

Healthy People 2020:

CHAPS promotes the alignment of local health data and strategies with the Healthy People 2020 framework, including the use of national health objectives as benchmarks. Healthy People initiatives provide science-based, 10-year national objectives for improving the health of all Americans. Healthy People also encourages collaboration across sectors in order to enhance the impact of prevention activities. Visit the Healthy People 2020 website: www.healthypeople.gov/2020.

How does CHAPS meet the requirements of the Public Health Act?

CHAPS is built upon requirements of the 2008 Public Health Act, with optional processes, tools, templates with an order that is logical but not required. We expect variability in how CHAPS is implemented and hope that you will continually share your experiences to help improve the Colorado Health Assessment and Planning System. There are only a few required aspects of CHAPS, which are listed below.

1. Stakeholder Engagement: The involvement of community stakeholders to inform the process, plan and implementation of public health improvement activities is a best practice in the public health field. Colorado's Public Health Act recognizes this and requires that representatives of the local community develop and implement the local plan. Although the Act does not specify a process, CHAPS Phase II provides guidelines.
2. Community Health Assessment: According to the Act, the local public health improvement plan should examine data about health status and risk factors specific to the local community. Although the Act doesn't specify a process, CHAPS Phase III provides guidelines.

3. **Capacity Assessment:** The Act requires that the local public health improvement plan include an assessment of the capacity and performance of the county or district public health system. Guidance is provided in CHAPS Phase IV.
4. **CHAPS Prioritization Process:** The Act requires the comprehensive statewide public health improvement plan to incorporate local public health goals and priorities. Standard criteria have been developed for use at the local level to ensure consistency in setting priorities for Colorado's public health system. The criteria and a proposed process are described in CHAPS Phase V.
5. **CHAPS Local Public Health Improvement Plan:** The Act states that the local public health plan shall not be inconsistent with the statewide public health improvement plan and that at a minimum, each local plan shall:
    - Examine data about health status and risk factors in the local community;
    - Assess the capacity and performance of the county or district public health system;
    - Identify goals and strategies for improving the health of the local community;
    - Describe how representatives of the local community develop and implement the local plan;
    - Address how county or district public health agencies coordinate with the state department and others within the public health system to accomplish goals and priorities identified in the comprehensive, statewide public health improvement plan; and
    - Identify financial resources available to meet identified public health needs and requirements for the provision of core public health services.

According to the Act, the local public health plan shall be submitted to the local board of health for review. A summary of each local public health plan will then be reported to the Colorado Board of Health by the Office of Planning, Partnerships and Improvement. Guidance is provided in CHAPS Phase VI.

6. **Inform and Participate in the Comprehensive Statewide Public Health Improvement Plan:** The Public Health Act requires the development and implementation of a comprehensive statewide improvement plan every five years in consultation with the State Board of Health, the Colorado Department of Public Health and Environment, local public health agencies and their partners in the public health system. CHAPS Phase VIII describes the components of the comprehensive statewide plan, which includes incorporating goals and priorities of public health plans developed by local public health agencies.

What are the components of a local public health improvement plan?

The public health improvement plan is a systematic road map that illustrates county or regional public health needs, describes priorities for health improvement, names the partners to be involved, documents the steps to get there, and provides a method for evaluating progress. The plan is for the entire community, including leaders, system partners, public health staff and boards of health. It can help generate excitement about community health improvement activities, as well as provide an easy-to-use point of reference for monitoring and communicating health improvement activities. Developing a public health plan is a best practice in the field of public health and a prerequisite for applying for accreditation by PHAB. CHAPS Phase VI offers further information, guidance and resources.

How is a local public health improvement plan different from my agency's strategic plan?

Both types of plans usually include goals, strategies, evaluation measures and timeframes; however, the local public health improvement plan involves the entire public health system, including organizations and individuals outside of the public health agency. By contrast, the local public health agency's strategic plan is specific to agency staff and resources. It is a good practice for a local public health agency (LPHA) to incorporate

relevant parts of the local PHIP into its strategic plan, in order to hold itself accountable for implementation and to measure progress. The agency-level strategic plan, like the public health improvement plan, meets a PHAB standard and is a requirement for voluntary national accreditation.

Can CHAPS be conducted across a region?

Counties may consider taking a regional approach to CHAPS. This is especially true for agencies that are not yet able to assure all of the core public health services and may want to determine how to share services with other LPHAs. Not only will this be a better use of scarce resources for assessment and planning activities, it will also help build core public health service capacity in the region and throughout the state. The Office of Planning, Partnerships and Improvement can help counties with the design of a regional approach. Any combination of the phases and steps can be done together or separately. At minimum, it will be helpful to embark on this process during the same time frame as neighboring counties to facilitate information sharing, plus technical assistance will be more efficient if offered at the same time regionally.

Who should be involved in our local CHAPS process?

The local public health agency is the perfect leader of a public health improvement process, by assuming the tasks of convening participants, facilitating the process, providing expertise, overseeing plan implementation and monitoring progress. According to the Act, the LPHA shall carry out the development of public health improvement plan, under the direction of the County or District board of health. Public health staff members with direct program responsibility (i.e., "front-line" staff) should be included in order to garner expertise and gain buy-in. Additionally, individuals with information about the community or specific populations are also valuable, as are other agencies and organizations that are providing core public health services or that can impact leading health outcomes.

A good first step in stakeholder recruitment is to contact any nonprofit hospitals serving your area, as these entities are mandated to conduct a community health assessment under the federal the Patient Protection and Affordable Care Act (i.e. Healthcare Reform Act). Other potential community participants might include local law enforcement that can enforce smoking bans and conduct DUI checkpoints, or city and county planners that determine the walkability/bikeability of a community. Also, a neighboring county may desire to determine how core public health services could be shared. By strategically selecting stakeholders and assuring the diversity of input, the assessment will be more accurate and the plan more likely to garner the resources and support needed to fully implement it. A guide to selecting community stakeholders is provided in CHAPS Phase II.

How does the Environmental Health field fit into CHAPS?

Within the Public Health Act, the field of Environmental Health is included under the broad definition of Public Health. Local public health agencies have specific duties with regard to environmental health, such as enforcing environmental laws, abating nuisances, conducting inspections, controlling hazards, carrying out programs that protect the environment, and coordinating with the environmental commissions at CDPHE. In addition, Environmental Health is defined in rule as a "Core Service" by the Colorado Board of Health, to be provided or assured by all local public health agencies. Therefore, environmental health service capacity, indicators, and resulting health outcomes should be documented during local assessment processes, and if determined to be a focus area for improvement, addressed in the public health improvement plan.

How does CHAPS take advantage of other needs assessments?

The Public Health Act requires LPHAs to complete a community health assessment and create a local public health improvement plan at least once every five years. Other organizations may complete assessments more frequently. For example, the Patient Protection and Affordable Care Act requires nonprofit hospitals to complete a community health needs assessment every three years in order to maintain their preferred tax-exempt status. Other funders, including CDPHE programs, may also require an assessment to meet contractual requirements. It is recommended that LPHAs take advantage of other processes in terms of timing (collaborating with other entities) or using the information collected in one assessment to inform another. Using assessments and data already collected within your agency or among your partners can reduce the amount of resources needed.

What resources are needed for the local CHAPS process?

The financial resources needed to complete assessment and planning activities will depend on: **1)** the size of the community, **2)** the amount of "in-kind" resources (e.g., donated time, money, supplies, space, etc.), and **3)** how extensive the assessment and planning processes needs to be. A budget should be developed and other necessary resources identified before starting the process.

One strategy to promote fundraising with public and private resources is to determine how the goals of the plan may align with the goals of potential resource contributors. During your initial meeting with the Office of Planning, Partnerships and Improvement, we will discuss resource needs and our ability to provide monetary support for assessment and planning activities. Funding may be made available on a county or regional level, depending on population size.

Costs associated with assessment and planning activities may include personnel and consultants, office supplies and equipment, space, communication, and travel. In order to staff the project, the following positions would be helpful: a project manager to lead the project and assure its completion; a health planner with technical expertise to gather and interpret data and report findings; a facilitator to organize and manage meetings and assure decisions are made and documented; and administrative support. Note that one person can fill more than one position. Also, a consultant can provide expertise on a temporary basis to fill personnel gaps.

Will technical assistance be available?

The Office of Planning, Partnerships and Improvement will provide technical assistance to local public health agencies (LPHAs) throughout the CHAPS process and advise on key areas such as data gathering and interpretation, issue prioritization, identification of strategies to address priorities, plan development, implementation and evaluation support. In addition, a data specialist is available through the Colorado Department of Public Health and Environment's Health Statistics Section to assist with needs regarding data gathering, analysis, and presentation, which is addressed in CHAPS Phase III. Each phase of CHAPS has a section describing the technical assistance available related to that phase.

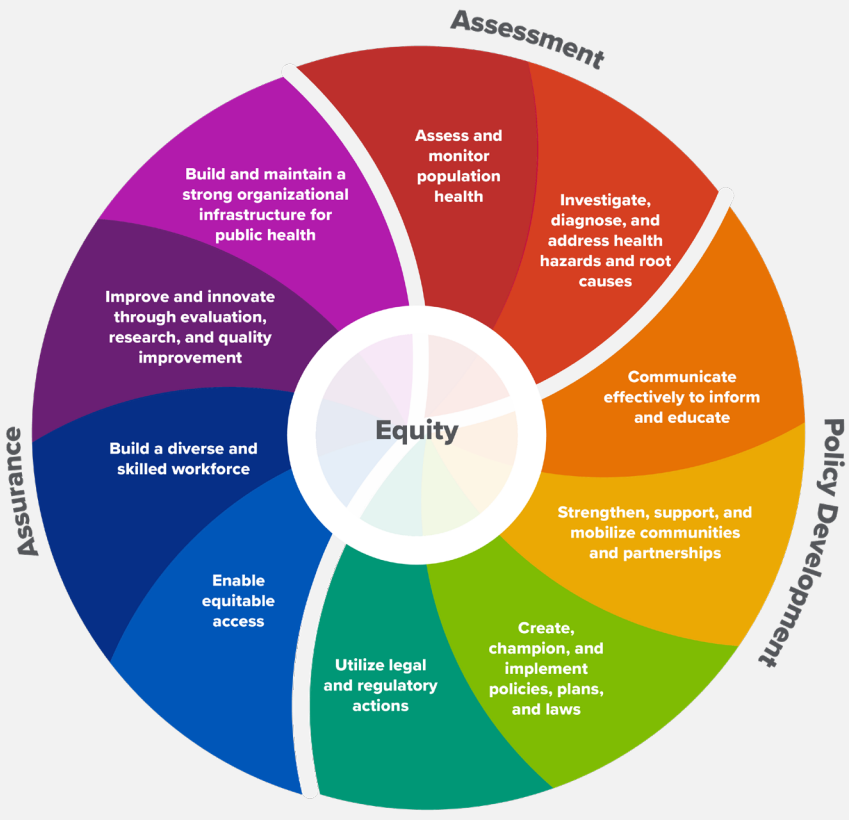
When does the Public Health Improvement Plan need to be completed?

The Act requires that the comprehensive statewide public health improvement plan be developed every five years with local public health improvement plans to follow. The first plan was due in 2009 with subsequent plans due every five years thereafter. It is recommended that localplans be submitted prior to each statewide plan in order to inform the development of the state plan. Therefore, the next local public health improvement plans are due in 2018 and the state plan is due in 2019.

THE 10 ESSENTIAL PUBLIC HEALTH SERVICES

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve equity, the Essential Public Health Services actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. Everyone should have a fair and just opportunity to achieve optimal health and well-being.



ESSENTIAL PUBLIC HEALTH SERVICE #1
Assess and monitor population health status, factors that influence health, and community needs and assets

ESSENTIAL PUBLIC HEALTH SERVICE #2
Investigate, diagnose, and address health problems and hazards affecting the population

ESSENTIAL PUBLIC HEALTH SERVICE #3
Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it

ESSENTIAL PUBLIC HEALTH SERVICE #4
Strengthen, support, and mobilize communities and partnerships to improve health

ESSENTIAL PUBLIC HEALTH SERVICE #5
Create, champion, and implement policies, plans, and laws that impact health

ESSENTIAL PUBLIC HEALTH SERVICE #6
Utilize legal and regulatory actions designed to improve and protect the public's health

ESSENTIAL PUBLIC HEALTH SERVICE #7
Assure an effective system that enables equitable access to the individual services and care needed to be healthy

ESSENTIAL PUBLIC HEALTH SERVICE #8
Build and support a diverse and skilled public health workforce

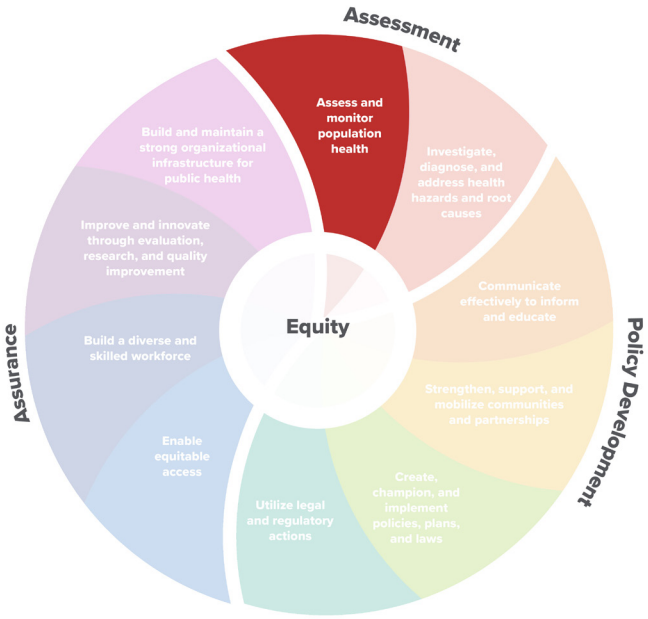
ESSENTIAL PUBLIC HEALTH SERVICE #9
Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement

ESSENTIAL PUBLIC HEALTH SERVICE #10
Build and maintain a strong organizational infrastructure for public health

Created 2020

ESSENTIAL PUBLIC HEALTH SERVICE #1

Assess and monitor population health status, factors that influence health, and community needs and assets

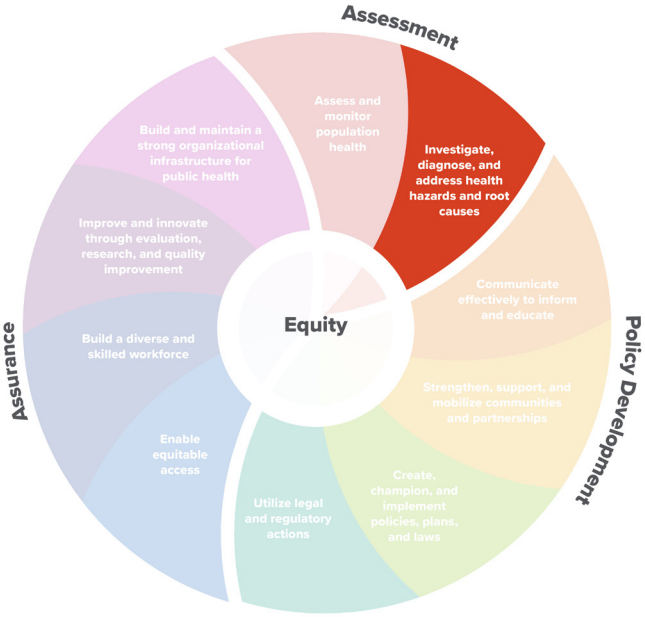


THIS SERVICE INCLUDES:

- **Maintaining an ongoing understanding of health** in the jurisdiction by collecting, monitoring, and analyzing data on health and factors that influence health to identify threats, patterns, and emerging issues, with a particular emphasis on disproportionately affected populations
- **Using data and information** to determine the root causes of health disparities and inequities
- **Working with the community** to understand health status, needs, assets, key influences, and narrative
- **Collaborating and facilitating data sharing** with partners, including multi-sector partners
- **Using innovative technologies**, data collection methods, and data sets
- **Utilizing various methods and technology** to interpret and communicate data to diverse audiences
- **Analyzing and using disaggregated data** (e.g., by race) to track issues and inform equitable action
- **Engaging community members** as experts and key partners

ESSENTIAL PUBLIC HEALTH SERVICE #2

Investigate, diagnose, and address health problems and hazards affecting the population

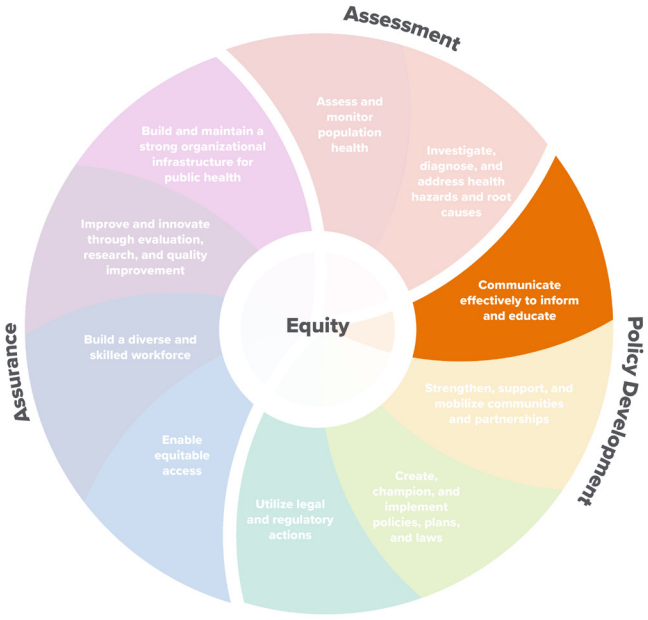


THIS SERVICE INCLUDES:

- **Anticipating, preventing, and mitigating emerging health threats** through epidemiologic identification
- **Monitoring real-time health status and identifying patterns** to develop strategies to address chronic diseases and injuries
- **Using real-time data** to identify and respond to acute outbreaks, emergencies, and other health hazards
- **Using public health laboratory capabilities and modern technology** to conduct rapid screening and high-volume testing
- **Analyzing and utilizing inputs** from multiple sectors and sources to consider social, economic, and environmental root causes of health status
- **Identifying, analyzing, and distributing information** from new, big, and real-time data sources

ESSENTIAL PUBLIC HEALTH SERVICE #3

Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it

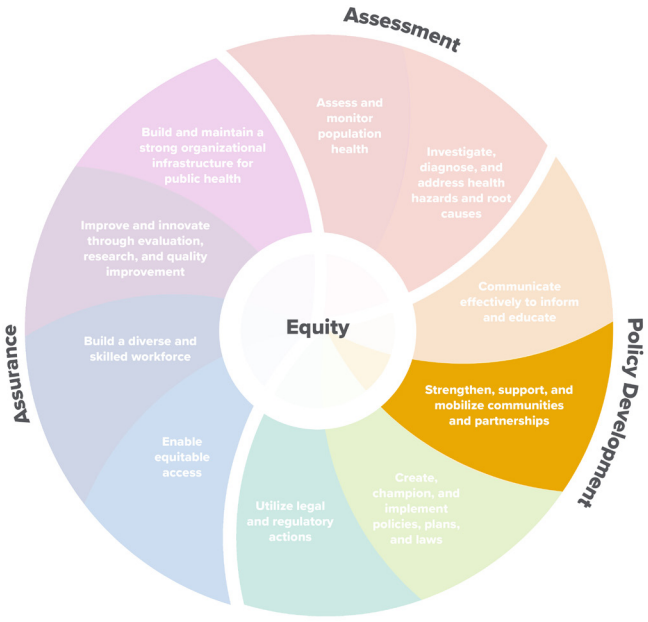


THIS SERVICE INCLUDES:

- **Developing and disseminating accessible health information** and resources, including through collaboration with multi-sector partners
- **Communicating with accuracy and necessary speed**
- **Using appropriate communications channels** (e.g., social media, peer-to-peer networks, mass media, and other channels) to effectively reach the intended populations
- **Developing and deploying culturally and linguistically appropriate and relevant communications** and educational resources, which includes working with stakeholders and influencers in the community to create effective and culturally resonant materials
- **Employing the principles of risk communication, health literacy, and health education** to inform the public, when appropriate
- **Actively engaging in two-way communication** to build trust with populations served and ensure accuracy and effectiveness of prevention and health promotion strategies
- **Ensuring public health communications and education efforts are asset-based** when appropriate and do not reinforce narratives that are damaging to disproportionately affected populations

ESSENTIAL PUBLIC HEALTH SERVICE #4

Strengthen, support, and mobilize communities and partnerships to improve health

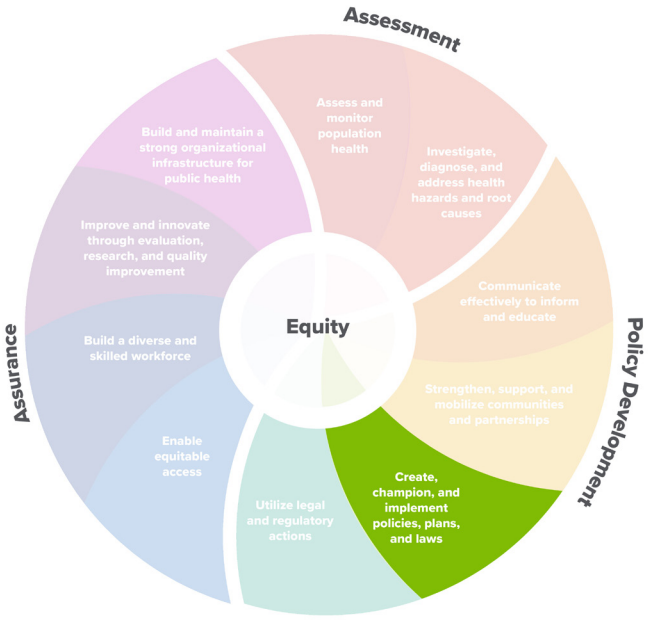


THIS SERVICE INCLUDES:

- **Convening and facilitating multi-sector partnerships** and coalitions that include sectors that influence health (e.g., planning, transportation, housing, education, etc.)
- **Fostering and building genuine, strengths-based relationships** with a diverse group of partners that reflect the community and the population
- **Authentically engaging with community members** and organizations to develop public health solutions
- **Learning from, and supporting, existing community partnerships** and contributing public health expertise

ESSENTIAL PUBLIC HEALTH SERVICE #5

Create, champion, and implement policies, plans, and laws that impact health

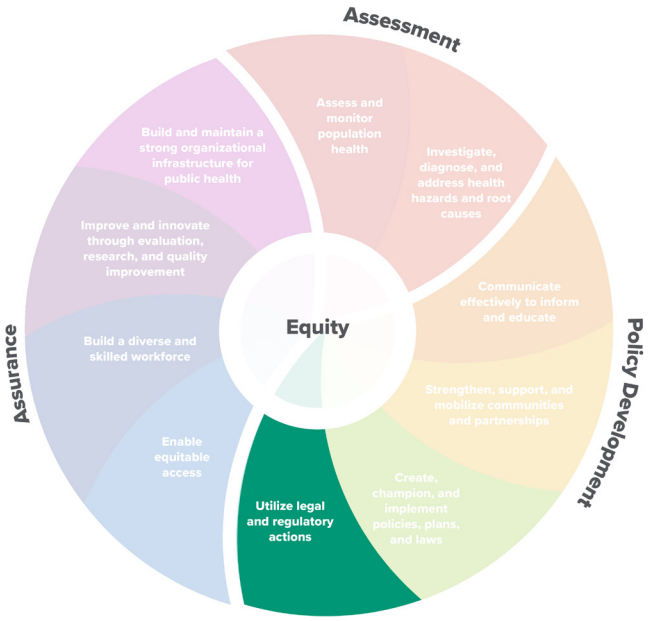


THIS SERVICE INCLUDES:

- **Developing and championing policies, plans, and laws** that guide the practice of public health
- **Examining and improving existing policies, plans, and laws** to correct historical injustices
- **Ensuring that policies, plans, and laws provide a fair and just opportunity for all** to achieve optimal health
- **Providing input into policies, plans, and laws** to ensure that health impact is considered
- **Continuously monitoring and developing policies, plans, and laws** that improve public health and preparedness and strengthen community resilience
- **Collaborating with all partners**, including multi-sector partners, to develop and support policies, plans, and laws
- **Working across partners and with the community** to systematically and continuously develop and implement health improvement strategies and plans, and evaluate and improve those plans

ESSENTIAL PUBLIC HEALTH SERVICE #6

Utilize legal and regulatory actions designed to improve and protect the public's health

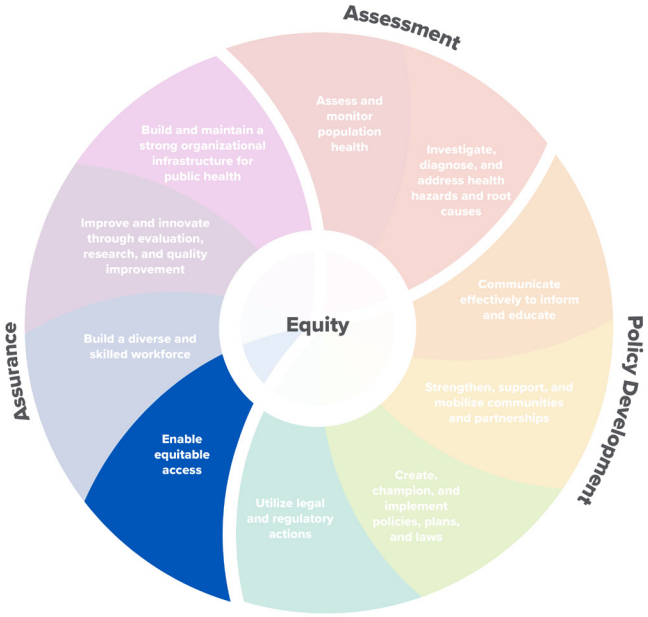


THIS SERVICE INCLUDES:

- **Ensuring that applicable laws are equitably applied** to protect the public's health
- **Conducting enforcement activities** that may include, but are not limited to sanitary codes, especially in the food industry; full protection of drinking water supplies; and timely follow-up on hazards, preventable injuries, and exposure-related diseases identified in occupational and community settings
- **Licensing and monitoring the quality of healthcare services** (e.g., laboratory, nursing homes, and home healthcare)
- **Reviewing new drug, biologic, and medical device applications**
- **Licensing and credentialing the healthcare workforce**
- **Including health considerations in laws from other sectors** (e.g., zoning)

ESSENTIAL PUBLIC HEALTH SERVICE #7

Assure an effective system that enables equitable access to the individual services and care needed to be healthy

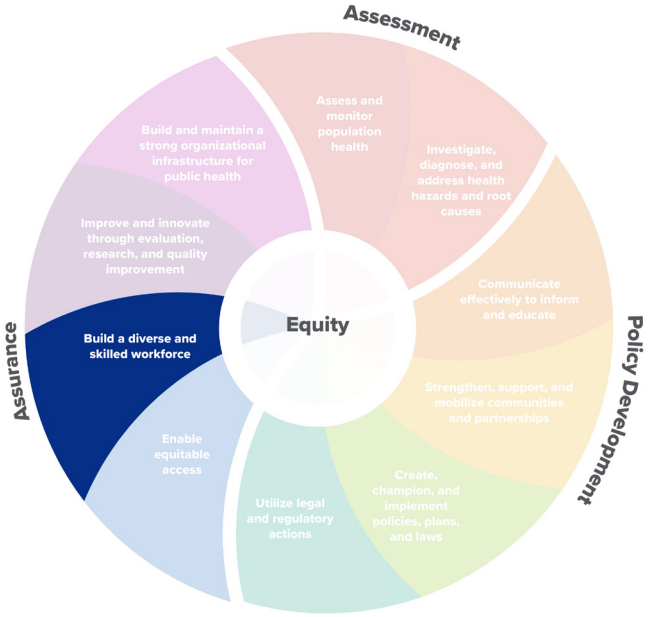


THIS SERVICE INCLUDES:

- **Connecting the population to needed health and social services** that support the whole person, including preventive services
- **Ensuring access to high-quality and cost-effective healthcare and social services**, including behavioral and mental health services, that are culturally and linguistically appropriate
- **Engaging health delivery systems** to assess and address gaps and barriers in accessing needed health services, including behavioral and mental health
- **Addressing and removing barriers to care**
- **Building relationships with payers and healthcare providers**, including the sharing of data across partners to foster health and well-being
- **Contributing to the development of a competent healthcare workforce**

ESSENTIAL PUBLIC HEALTH SERVICE #8

Build and support a diverse and skilled public health workforce

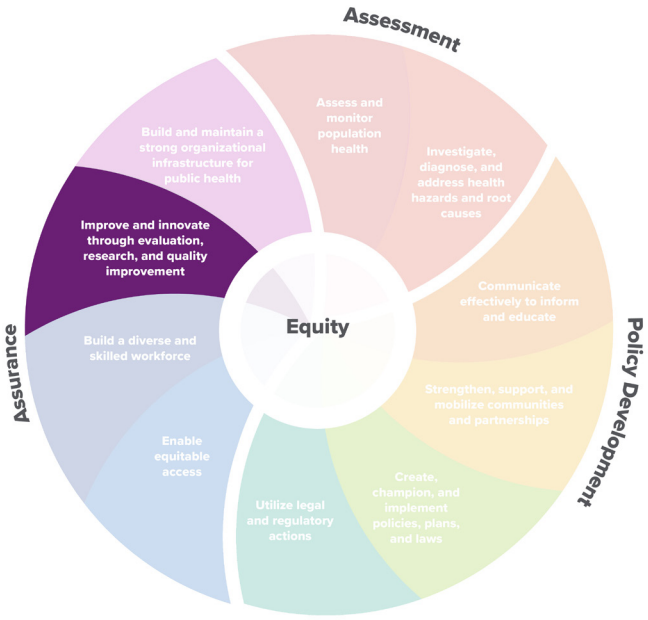


THIS SERVICE INCLUDES:

- **Providing education and training** that encompasses a spectrum of public health competencies, including technical, strategic, and leadership skills
- **Ensuring that the public health workforce is the appropriate size** to meet the public's needs
- **Building a culturally competent public health workforce and leadership** that reflects the community and practices cultural humility
- **Incorporating public health principles in non-public health curricula**
- **Cultivating and building active partnerships with academia and other professional training programs** and schools to assure community-relevant learning experiences for all learners
- **Promoting a culture of lifelong learning in public health**
- **Building a pipeline of future public health practitioners**
- **Fostering leadership skills at all levels**

ESSENTIAL PUBLIC HEALTH SERVICE #9

Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement

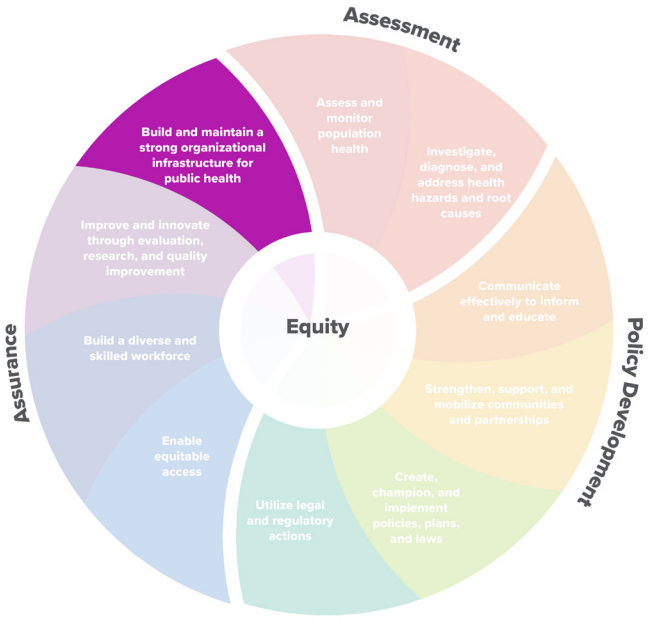


THIS SERVICE INCLUDES:

- **Building and fostering a culture of quality** in public health organizations and activities
- **Linking public health research with public health practice**
- **Using research, evidence, practice-based insights, and other forms of information to inform decision-making**
- **Contributing to the evidence base** of effective public health practice
- **Evaluating services, policies, plans, and laws continuously** to ensure they are contributing to health and not creating undue harm
- **Establishing and using engagement and decision-making structures** to work with the community in all stages of research
- **Valuing and using qualitative, quantitative, and lived experience as data and information** to inform decision-making

ESSENTIAL PUBLIC HEALTH SERVICE #10

Build and maintain a strong organizational infrastructure for public health



THIS SERVICE INCLUDES:

- **Developing an understanding of the broader organizational infrastructures and roles** that support the entire public health system in a jurisdiction (e.g., government agencies, elected officials, and non-governmental organizations)
- **Ensuring that appropriate, needed resources are allocated equitably** for the public's health
- **Exhibiting effective and ethical leadership, decision-making, and governance**
- **Managing financial and human resources effectively**
- **Employing communications and strategic planning capacities and skills**
- **Having robust information technology services** that are current and meet privacy and security standards
- **Being accountable, transparent, and inclusive** with all partners and the community in all aspects of practice

The 10 Essential Public Health Services
Glossary

Community is a group of people who have common characteristics; communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other similar common bonds. Ideally, there would be available assets and resources, as well as collective discussion, decision-making and action. (Turnock, BJ. *Public Health: What It Is and How It Works.* Jones and Bartlett, 2009)

Equity is defined as a fair and just opportunity for all to achieve good health and well-being. This requires removing obstacles to health such as poverty and discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare. It also requires attention to health inequities, which are differences in population health status and mortality rates that are systemic, patterned, unjust, and actionable, as opposed to random or caused by those who become ill.

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The bibliographic citation for this definition is: Preamble to the Constitution of WHO as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

Healthcare sector is defined as entities that provide clinical services, mental health services, oral health services, provide or pay for services for individuals, or facilitate the provision of services to individuals. Entities in this sector may include hospitals, health systems, health plans, health centers, behavioral health providers, oral health providers, etc.**Law(s)** refer to the aggregate of statutes, ordinances, regulations, rules, judicial decisions, and accepted legal principles that the courts of a particular jurisdiction apply in deciding controversies brought before them. The law consists of all legal rights, duties, and obligations that can be enforced by the government (or one of its agencies) and the means and procedures for enforcing them. *(Garner, B.A. editor. Black's Law Dictionary. 8th ed. West Group; 2004)*

Law(s) refer to the aggregate of statutes, ordinances, regulations, rules, judicial decisions, and accepted legal principles that the courts of a particular jurisdiction apply in deciding controversies brought before them. The law consists of all legal rights, duties, and obligations that can be enforced by the government (or one of its agencies) and the means and procedures for enforcing them. *(Garner, B.A. editor. Black's Law Dictionary. 8th ed. West Group; 2004)*

Population health is the health outcomes of a group of individuals, including the distribution of such outcomes within the group. The field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link these two. Population health approaches are community or policy non-clinical approaches that aim to improve health and wellbeing of a group of individuals. This differs from population health management which refers to improving clinical health outcomes of individuals through improved care coordination and patient engagement supported by appropriate financial and care models. *(Adapted from Kindig and Stoddart).*

Created 2020

The 10 Essential Public Health Services Glossary

Public health is defined as the science of protecting the safety and improving the health of communities through education, policy making and research for disease and injury prevention. (CDC Foundation).

Research is a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge. (United States Department of Health and Human Services. *Healthy People 2020*. Washington, DC)

- Community-based Participatory Research (CBPR) is a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community, has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities. (W. K. Kellogg Foundation, Community Health Scholars Program, 2001 quotes from Minkler M, and Wallerstein N, editors. *Community-Based Participatory Research for Health*. San Francisco, CA: Jossey-Bass Inc.; 2003)

To view the complete 10 Essential Public Health Services, visit https://phnci.org/uploads/resource-files/EPHS-English.pdf.



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NEWS • News

L.A. County cities face a tough task if serious about own public health departments

Some envision their own such agency, akin to what Long Beach, Pasadena, Berkeley and Vernon have. Others have been flirting with pooling resources among two or three other cities.



ORG XMIT: CALOS103 A nurse prepares a dose of H1N1 vaccine at the Balboa Park Community Center in Encino, Calif., Friday, Oct. 23, 2009. At the time, Los Angeles County officials opened the first public health clinic there for patients in the high priority group with special health needs. (AP Photo/Mark Boster, Pool)

By **RYAN CARTER** | rcarter@scng.com | Daily News

PUBLISHED: December 4, 2020 at 5:53 p.m. | UPDATED: December 4, 2020 at 7:15 p.m.

Just as the pandemic is at its worst, a handful of cities in Los Angeles County are seeking to break away from the county's massive Public Health Department, seeking to create their own.

On Thursday, the city of Lancaster approved a city report on how to do it. That came on the heels of the city of Beverly Hills' resolution to do the same earlier. Whittier, West Covina, Santa Clarita and Palmdale are all exploring the idea.

The county has initiated waves of restrictions aimed at battling the virus' relentless recent surge, but the tipping point was the decision to shut down outdoor dining at the county's 31,000 restaurants.

Add that to frustration city leaders expressed over physically distant downtown policymakers and the cities' own independent streaks.

Some envision their own such agency, akin to departments operated by Long Beach, Pasadena, Berkeley and Vernon — the only other city-run health departments in the state.

Others have flirted with pooling together smaller mutlicity health departments or contracting for services with a neighboring city — or county.

Whatever the breakaway strategy, it won't be easy.



Carlos Jarillo gets a flu shot from a Long Beach Health Department employee at The Port of Long Beach COVID-19 testing site, 2100 W. Anaheim St. in Long Beach on Monday, November 16, 2020. The flu shots were provided for one day only by the Long Beach Department of Health and Human Services. (Photo by Brittany Murray, Press-Telegram/SCNG)

Cities face substantial legal requirements in the state's Health & Safety Code, to be approved by the state's health department. Health officers and staff also face rigorous vetting. Assembling teams of trained professionals also isn't cheap.

Experts caution that if you're going to do it, make sure you're ready — and aren't doing it for the wrong reasons, like making a political point.

The scope of such an agency, even for a smaller city, is immense, they say. The expectations range well beyond restaurant inspections and immunizations for these departments, that were invisible to many until the current crisis thrust them into the spotlight.

"If you are going to form one, you better be prepared to provide the types and level of program and service the community needs across many many different areas," said Lori Tremmel Freeman, chief executive officer of the National Association of County and City Health Officials.

"I just don't think anything can happen very quickly," said Freeman, who noted that gathering the expertise, mounting the needed certifications and scaling up the diversity of services provided by a health department is not an easy in normal times, let alone during a pandemic.



Leland Craig receives his flu shot from public health nurse Daniel Evans during a morning of vaccinations administered by the Manhattan Beach Parks and Recreation Department, in tandem with the Los Angeles County Department of Public Health, at the Joslyn Community Center in Manhattan Beach on Wednesday, October 24, 2018.(Photo by Axel Koester, Contributing Photographer)

If cities were successful in their breakaway, they'd still be losing the scope and resources of the county, which legally has jurisdiction over public health functions in the county, save Long Beach and Pasadena, which report their own numbers and can choose not to adhere to the county's health orders.

The county's Department of Public Health is one of the largest such departments in the nation and is nationally accredited by the Public Health Accreditation Board.

With an annual budget over $940 million and a staff of more than 4,000, the L.A. County department has legal jurisdiction over a region of 10 million residents. Not all of those thousands are public figures, but such folks as Health Director Barbara Ferrer and Health Officer Muntu Davis have become the faces and voices of the county's drive to beat back the deadly outbreak.

Before the COVID-era, the department was well known for its restaurant grading inspections. But its range of responsibilities go way beyond that.

It's services are vast, including work in HIV and STD screenings; tuberculosis control; immunization; acute communicable disease control; community health services; maternal, child and adolescent health; women's health; environmental health; emergency preparedness and response; children's medical services; and health assessment and epidemiology.

It also works on broader environmental health issues, such as fostering health studies in such areas as Porter Ranch, in the San Fernando Valley, where the nation's largest natural gas leak made headlines five years ago. And the debate in that community is arguably just as fierce today.

Lisa Derderian, spokeswoman in the city of Pasadena, said starting a health department is a "major undertaking." Pasadena established its health department in 1892 according to the city's website.

Derderian said it's an advantage of an independent, smaller jurisdiction, where for decades the agency has forged ties with with local businesses. When a major event happens, enforcement teams are nimble and the agency's focus is on a singular city.

Many of the responsibilities are the same as the county — from maternal care to child health to monitoring the public health at congregate settings, Derderian said.

Lancaster is a city that sees that kind of local touch as motivation to create an agency.

But there's also a huge legal process involved to get certified by the state, local and national officials said. Even Lancaster Mayor Rex Parris said that a local agency in his city would need the force of the state to function properly.

The state assesses economic and geographic factors, establishes standards of education and experience for professional and technical personnel employed in local health departments and for the organization and operation of the local health departments. There are standards for the maintenance of records of services, finances and expenditures.

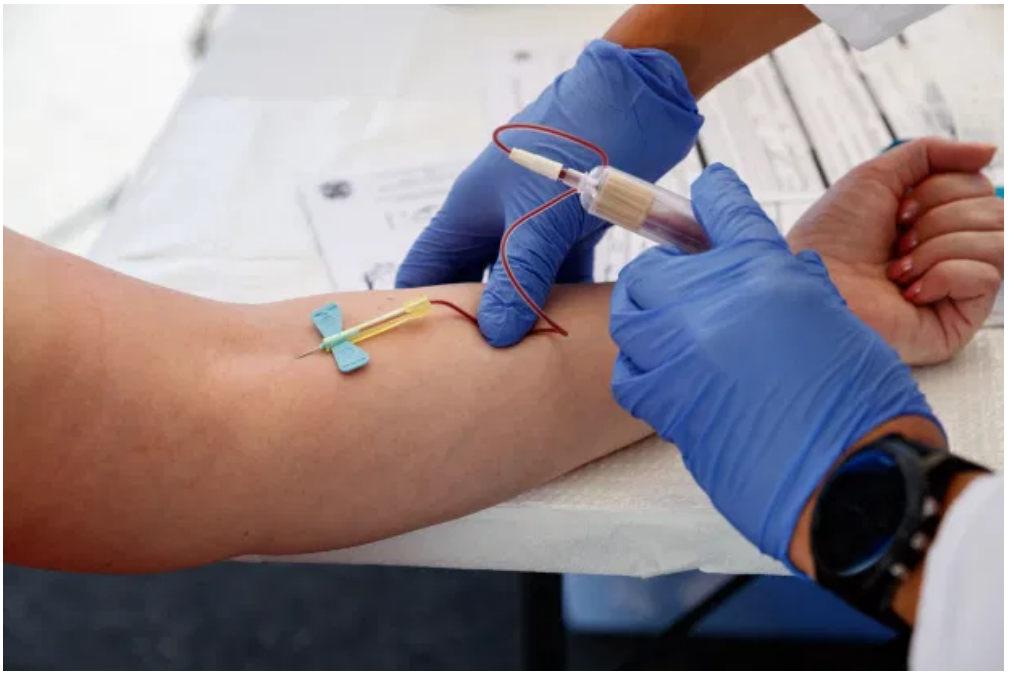
Much of the state's code speaks to county's authority to establish a health department.

On the county level, each board of supervisors "shall appoint a health officer who is a county officer," for instance.

"The county health officer shall be a graduate of a medical college of good standing and repute," according to the statutes. "His or her compensation shall be determined by the board of supervisors."

All of which is set up now, in L.A. County.

"Existing county health departments have both specialized personnel and hospital and clinical facilities which a city would have trouble duplicating in short order. These include epidemiologists, inspectors, sanitarians, engineers, lab technicians, patient care professionals, and on and on," said Howard Greenwald, a professor at USC's Sol Price School of Public Policy.



Hacienda Heights resident Tina Letellier, left, has her blood taken for lead testing by County of Los Angeles Department of Public Health nurse Lorenzo Hernandez, right during the Community Resource Fair & Free Blood Lead Testing event at Hacienda Heights Community Center in Hacienda Heights, Calif. on Saturday September 21, 2019. (Photo by Raul Romero Jr., Contributing Photographer)

Greenwald pointed to other barriers, including obtaining the funding to establish a health department.

“I’d guess that there would be fierce battles over funding, as cities competed with counties for resources,” he said.

Also, accreditation is a “tedious process and success depends on demonstrating capability and resources,” he noted.

“It is a lot, in terms of thinking about what’s needed and staffing, and Title 17 requirements,” said Davis, L.A. County’s health officer. “Those are things that are needed to be incorporated into what the health department does.”

Local officials stress they are not naive about the process — wary that they may be on the verge of creating a whole new layer of government that could prompt more difficult funding choices.

“The reason we want our own public health department goes beyond COVID,” said Parris. “It’s a plethora of programs that if we had local control of we could target those funds to areas where we need them. If you do it on a countywide basis it makes little sense for outlying areas.”

But they also added this is not something thought up in a day and don’t expect it to come overnight.

In Santa Clarita and Palmdale, tensions have been brewing for a while over the connection between local leaders and county policymakers downtown, some said.

“While we have traditionally valued the partnership with the county, that relationship is being increasingly strained,” said Palmdale Mayor Steve Hofbauer. “There has been an ongoing dialogue surrounding the actual fiscal value in allowing/contracting for some of the county services to our cities. There seems to be an effort by some to balance the county’s budget on our backs. We’ve seen that in the outrageous increase proposed for animal control services. Then there are comments made by some supervisors that their law enforcement pricing needs to be dramatically increased.”

Santa Clarita Mayor Cameron Smyth reached back in to history to note that his city has always had an independent strain in dealing with the county.

In Beverly Hills, Mayor Lester Friedman emphasized that it’s still early, but worth exploration, noting that his city on Tuesday voted a probe into the feasibility of a health department.

"I don't think it's something that something any city official wants to do, to create a whole new bureaucracy," he said. "But if they are not getting the (necessary) response from the county department of health it really leaves us no other option."

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Ryan Carter | Reporter

Ryan Carter, a reporter and editor, is part of team covering COVID-19 in L.A. County and lead election and politics coverage in L.A. County.Ryan started his career writing obituaries at the Glendale News-Press, before working as assistant city editor for Times Community News (Division of the L.A. Times) and city editorfor the Glendale News-Press, San Bernardino Sun and L.A. Daily News. Ryan earned a BA degree in Political Science from UCLA and is working toward his Master's of Legal Studies at UCLA.

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NEWS

La Puente is latest city to explore breaking away from LA County to create own health department

Suggested by Councilman David Argudo, the city will look at the logistics and cost of creating its own health department, but has not yet decided to make the leap



La Puente Mayor Pro Tem Valerie Muñoz (File photo by Ed

Crisostomo, Contributing Photographer)

By **PIERCE SINGGIH** | psinggih@scng.com | San Gabriel Valley Tribune

PUBLISHED: May 12, 2021 at 8:11 p.m. | UPDATED: May 12, 2021 at 8:14 p.m.

La Puente city staff will explore what it would look like to break away from the Los Angeles County Department of Health and create its own health department, the City Council decided at its meeting Tuesday night.

Suggested by Councilman David Argudo, the city will look at the logistics and cost of creating its own health department, but has not yet decided to do so.

“I think we could create a cost-savings measure and create an opportunity for us to regionalize and react and move a little faster than we do with our county contract as it is today,” Argudo said at the meeting.

The councilman also brought up West Covina, which recently decided to break away from the county and create its own health department. That city, of about 100,000, is moving quickly and is already establishing a public health director position.

During the height of the pandemic, many residents and business owners in the county became frustrated with government mandates intended to stem the further spread of the coronavirus, particularly county rules that were at times stricter than statewide guidelines. As the months passed, and shutdown orders remained, some cities began to wonder: If Long Beach and Pasadena have their own health departments, why can’t we?

Besides Beverly Hills and West Covina, the cities of Azusa, Claremont, Diamond Bar, Lancaster, Palmdale, San Dimas, Santa Clarita, Walnut and Whittier have all expressed interest in breaking from the LA County Department of Public Health in recent months.

Most of those, however, have opted not to rush in. It would take, they acknowledge, at least another year — and likely even longer — before they could get their own health departments up and running.

The West Covina City Council, however, had moved quickly since voting in February to terminate services with the L.A. County Department of Public Health, a result of what some council members called a poor response to the coronavirus pandemic. Since then, it has created the outline for how the department will be structured, approved the pay scale and job description for a public health officer and health codes are modeled after those used by the county public health department.

West Covina has until July 1 to submit its plan to the state for approval.

Like most of its peer cities, La Puente will take its time to make any big decisions.

“I would just want to make sure we are thoroughly doing our due diligence and homework to ensure we are going to make a decision based on facts and specific information,” said Mayor Pro Tem Valerie Muñoz.

The City Council’s discussion on the issue was brief, but many said the idea of local control was appealing to councilmembers. Even if the city doesn’t create its own health department, Argudo suggested city staff explore what it would look like to regionalize a health department with other cities.

City Manager Bob Lindsey said there are a lot of quirks and issues to work out if the city goes ahead with its own health department, but was optimistic and said the city could do it.

"I believe in local control," he said at the meeting. "I don't think the county has our best interests in mind, or at least not in the same way the city has its interests in mind."

Two L.A. County cities, Pasadena and Long Beach, already have their own health departments. But those two cities created its health departments long before the county health department was established in 2006. At around 150,000 and 500,000, respectively, those two cities also have much greater populations than La Puente has, at around 40,000.

"All of us that are business owners naturally sympathize with a lot of the restaurants and others during this virus," said Mayor Charlie Klinakis at the meeting. "We know that the health department (bore) the brunt of the bad news to the businesses and others. I'm definitely in favor of exploring."

Hayley Munguia and Tim Haddock contributed to this report

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Pierce Singgih

Pierce Singgih is a reporter for the San Gabriel Valley Tribune, covering Azusa, West Covina, El Monte and everything in between. Previously, he interned for the Los Angeles Daily News. He graduated with a B.A. in Journalism in 2019 from Biola University, where he served as the Editor-in-Chief of the Chimes Newspaper. Outside of journalism, Pierce is an avid street photographer and enjoys supporting local coffee shops.

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Amid frustrations over pandemic response, two Virginia counties want their own health departments

https://www.washingtonpost.com/local/virginia-politics/prince-william-loudoun-health-departments/2021/03/20/d54e2e92-88be-11eb-bfdf-4d36dab83a6d_story.html

By Antonio Olivo

March 20, 2021 at 9:30 a.m. MDT

Two of Virginia's fastest-growing local jurisdictions are working to create their own health departments, a step that could move most of Northern Virginia out of the state system on key aspects of public health, including coronavirus vaccinations.

Both Loudoun and Prince William counties say they've been hampered in their ability to address the health needs of their communities under the system of state-run health districts that governs most of Virginia.

Some crucial jobs have been left vacant, while a lack of resources and too much bureaucracy have stalled efforts to open vaccination clinics in underserved areas, officials in those counties say.

"If anything good came out of the pandemic, I would say it exposed the soft underbelly of our public health department," said Ann Wheeler (D), chair of the county board in Prince William, where the state health district also covers the cities of Manassas and Manassas Park.

Legislation awaiting Gov. Ralph Northam's (D) signature would grant Prince William and Loudoun administrative control of their health departments, allowing them to join Fairfax and Arlington counties as the only localities in the state with such authority. A law is required before the move, under Virginia's 125-year-old status as a Dillon Rule state, under which the commonwealth retains legal authority that is not explicitly granted to a local government.

Fairfax County, which won control of its health department in 1995, broke away from the state on vaccination registration last month, declining to participate in Virginia's initially troubled centralized registration system. Arlington, which gained local control in 1988, is using the state program.

State Sen. Barbara A. Favola, who sponsored the legislation, said it makes sense for local governments with enough money for local health programs to have that freedom, particularly during a pandemic.

"Local government is much closer to the constituents," said Favola (D-Arlington), who sits on the Senate's committee for local government. "They have the people who know exactly what to do when there is a public health emergency."

Alena Yarmosky, Northam's spokesperson, said the governor is still reviewing the legislation but is supportive of efforts that will improve the public health infrastructure in the state.

Yarmosky said the governor recently signed a law aimed at steering more state money into state health districts.

“One of the major challenges has been an outdated funding formula for local health districts that hasn’t been changed in a generation,” Yarmosky said.

The bill before Northam originated in Loudoun. Phyllis J. Randall, chair of Loudoun’s board, said discussions about local control began several years ago, when a discrepancy in the health district’s pay structure made it harder to retain workers on the state health department payroll.

The districts’ staffs are a mix of state and local employees who, besides responding to the pandemic, run locally funded programs such as mental health services and restaurant inspections. Health district directors manage both sets of workers in a two-tiered operation that includes separate health benefits.

The workers paid by the state tend to make less than those on the county’s payroll, even when they have the same titles and job functions, making it harder to retain them, Randall (D) said.

For example, the average annual salary for a registered nurse employed by the state is about $74,000, while a county-employed nurse would make an average $87,000 per year, according to data provided by Loudoun officials.

“Because they can get paid more someplace else, we would lose the state employees,” Randall said.

The pandemic added another complication.

Each time Loudoun’s health district director David Goodfriend wanted to set up a coronavirus testing site or make vaccinations more widely available, he was required to get state approval, which could take a long time.

“It delayed things more than it needed to be,” Randall said.

Prince William officials have been aggravated by the health district system, prompting them to ask Favola to include their county in the Loudoun bill.

Supervisors in the county, where people of color make up 58 percent of the population, have been frustrated over the vaccination rates in lower-income communities, with just 36 percent of doses administered so far given to African American, Latino or Asian residents.

“Our health district was offered opportunities to hold vaccination sites in different locations, but if you don’t have the manpower to even manage it, how do you address that?” Wheeler said.

State officials said they have been pouring more resources into Prince William, including a federally funded mass vaccination site near the Potomac Mills shopping center that is scheduled to open next this week. Yarmosky noted that site will be able to administer as many as 6,000 doses per day.

But the district has 23 unfilled positions, including six public health nurses and two nurse supervisors.

The vacancies in the health district have made it harder to respond to the pandemic, said Alison Ansher, the district's director.

Some nurses have recently been hired, she said. But, she added, "this has also impacted our pandemic response as they are still orienting."

With anxious constituents pleading for more vaccinations in their communities, frustrated county supervisors have repeatedly pressed Ansher to do more.

"If those numbers are the same next month, people need to be fired," Supervisor Pete Candland (R-Gainesville) said to Ansher during a board meeting this month about the lower vaccination rates in communities of color. Ansher, a state employee, did not respond.

Supervisor Margaret A. Franklin, who launched the county's effort to gain local control, said that kind of oversight would make it easier to develop a targeted response to health emergencies.

"That's the biggest challenge: We're the Board of County Supervisors, but we're not actually in charge," Franklin (D-Woodbridge) said. "It's left us vulnerable during the unforeseen case of having a pandemic."

Local government advocacy groups in the state say other jurisdictions have not sought similar control, though Virginia Beach has entertained the idea amid problems with vaccinations that city officials blame on having to share a local state health district director with the city of Norfolk, 20 miles away.

Virginia Beach Mayor Bobby Dyer asked Northam to allow the city to run its own vaccination program but was turned down. In response, Yarmosky pointed to the bill Northam recently signed that would put more state resources into the system.

Dyer said that even with more resources from the state, the city is pushing the state to hire a state health district director for Virginia Beach, adding that the question of seeking local authority is on the table.

"If we can eliminate the bureaucracy, that's optimal," he said. "The more autonomy we have as a city, the better."

NEWS

West Covina approves pay scale, job description for public health officer

The next step for the City Council is to decide if the manager and the services his department provides would be outsourced, a move Mayor Letty Lopez-Viado said is aimed at privatizing health services.



The West Covina City Council meets on Tuesday, Feb. 23, to vote on terminating services with the Los Angeles County Department of Public Health. The council voted 4-1 to terminate services. (Tim Haddock/SCNG)

By **TIM HADDOCK** | thaddockscng@gmail.com |
PUBLISHED: April 27, 2021 at 9:50 p.m. | UPDATED: April 28, 2021 at 7:20 p.m.

Continuing its effort to establish an independent health department, the West Covina City Council approved the pay scale and job description for a public health officer .

The next step for the City Council is to decide if the manager and the services his department provides would be outsourced, a move Mayor Letty Lopez-Viado said is aimed at privatizing health services.

“We are still planning to move toward the private model,” Lopez-Viado said. “Some people think it’s new, but it’s been operational for years with different types of cities.”

West Covina contracts with private sector companies for a variety of services, she said, including a privately owned sanitation company to collect trash in its parks. Neighboring cities contract with private companies for similar services.

Lopez-Viado added that the plan to create a health department does not include using revenue from the general fund, a point of concern for some members of the community.

“We are moving forward,” Lopez-Viado said. “We are expecting whatever legal matters there are. It is moving forward.”

The council is expected to develop a fee resolution plan and professional service agreements for health department services, and present it at its meeting on May 18.

The City Council voted 4-1 to approve the pay scale and job description for the public health officer position at its Tuesday, April 20 meeting. The salary range will be between $154,368 and $187,644 annually.

The health director, if employed by the city, will report to the city manager and would be responsible for overall planning, administration and operation of the public health department. The public health officer will also assist in establishing the city's public health department.

Councilmember Brian Tabatabai voted against the resolution.

"We're going to have a completely outsourced health department to, I don't know how many different for-profit companies, to provide those services to West Covina," Tabatabai said. "This has never been done."

Cities with their own health departments do outsource some services. Pasadena, one of three cities in California with its own health department, contracts for services where expertise is needed, said Manuel Carmona, Deputy Director of the Pasadena Public Health Department, in an email.

For example, Pasadena contracts with Los Angeles County for public health laboratory services. The Pasadena Humane Society serves as poundmaster for animal control. Pasadena's clinical programs, such as the Tuberculosis Clinic and Substance Use Disorder Program, receive physician support that are not full-time positions to meet medical expertise requirements for the programs.

Pasadena is also part of the San Gabriel Valley Mosquito and Vector Control District, which provides public health related, support and education services.

The West Covina City Council voted in February to terminate services with the L.A. County Department of Public Health, a result of what some council members called a poor response to the coronavirus pandemic. The city has until July 1 to submit its plan to the state for approval.

“The question about state approval, there’s no guarantee that this kind of model would be approved by the state,” Tabatabai said. “There’s a lot of complications.”

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West Covina votes to terminate services with LA County Public Health



The West Covina City Council meets on Tuesday, Feb. 23, to vote on terminating services with the Los Angeles County Department of Public Health. The council voted 4-1 to terminate services. (Tim Haddock/SCNG)

By **TIM HADDOCK** | thaddockscng@gmail.com |

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Frustrated by the Los Angeles County Department of Public Health's oversight during the pandemic, the West Covina City Council voted, 4-1, to terminate health officer services with the agency during a lengthy, sometimes contentious meeting on Tuesday, Feb. 23.

City Councilmember Brian Tabatabai was the lone dissenter during Tuesday's vote. He questioned the timing of the decision — with the coronavirus outbreak seemingly far from over — as well as the cost and time it would take to create an independent health department.

In a letter prepared to LACDPH, council members explained that it adopted a resolution and urgency ordinance to conclude consenting to health officers' services relating to enforcement of orders and quarantine regulations issued by the state and county. The resolution and ordinance will be sent to the county by March 1 and will go into effect July 1, they said.

"Establishing a city health department will take time, planning and coordination through a process that has not been accomplished in decades," the letter said. "The city does not anticipate having a health department at the level of Pasadena or Long Beach by the 1st of July, but intends to provide services that are responsive to the community's needs. The city's desire to provide better health services and dedication to the community's safety will guide us through this uncharted process."

During the pandemic, other communities — Diamond Bar, San Dimas and Walnut among them — have considering breaking away from county Public Health, but West Covina is the first to make such a move.

More than 40 people made comments during the five-hour special meeting. Some business and restaurant owners expressed frustration with county and state health orders, especially moves to close down indoor dining and limiting access to some other businesses. Some said they felt bullied by the county, whom they called consistently unresponsive.

The meeting included a presentation from Dr. Basil Vassantachart, who has been serving as a health advisor to the city as its weighed its options in recent weeks. His advice to city leaders: “Plan ahead. Don’t be reactive. Be proactive.”

Vassantachart offered some options for the city after it terminates county health:

- Create a full service health department, similar to ones established in Pasadena, Long Beach and Berkeley; or
- Install a limited service health department, similar to one in Vernon, which has a “health and environmental control department”that oversees environmental health programs, including issuing permits to non-food vehicles; or
- Negotiate services with the county so that the city can have some independence in making decisions for businesses and community-based organizations, but sti use the county Public Health for selected services.

The deadline to terminate services with the county is March 1, when each year public health officials accept requests from cities to renew or terminate health department services. The county would continue to provide health department services until July 1.

The county collects 1% of property taxes from West Covina to pay for services provided to the city by the county. A third of that 1% is used for Public Health services. Those funds would continue to be collected by the county even if West Covina terminates services.

“Although it is well within a city’s jurisdiction to create its own public health department, the Los Angeles County Department of Public Health (Public Health) is not aware of any planning or coordination with the city for this drastic change.” wrote Muntu Davis, health officer for the County of Los Angeles Public Health Department, in a letter in response to the vote.

“Public Health is concerned that even if the city has made plans to create and operationalize the infrastructure necessary to run an effective public health department,” Davis wrote, “there are significant hurdles to ensuring to protection of the health of the city’s residents.”

One of the reasons West Covina wants to terminate services with the county is because “response has been ponderously slow,” said City Manager David Carmany.

Neither Carmany nor Vassantachart provided financial details about start-up or operational costs for creating and maintaining an independent health department.

Tabatabai provided a report from San Dimas, which estimated it would cost $60-$90 million to start a health department and $10-$15 million to maintain operations each year.

It was unclear how the city would fund the department, though city officials discussed some options Tuesday. “The initial start up will have to be a model that operates like an enterprise fund,” said Carmany. The city could collect fees on a service basis. For example, collecting fees for inspections. “We don’t know yet how many of those inspections will be done and how much inspectors cost and what that math is.”

“This vote signals the Council’s intention to create a full-functioning city public health department that is recognized by the State, like those in Long Beach and Pasadena,” a statement from LADPH read. “All local public health jurisdictions must be able to provide the following basic public health services to their residents: Public Health Statistics (recording of birth and death certificates); Communicable disease control; medical and nursing services to promote maternal and child health; environmental health and sanitation services; laboratory services, as well as nutrition, chronic disease, social factors affecting health, and occupational health services. The LA County Public Health provides these services to all of its contracted city partners at no cost.”

County officials vowed to work with the city until its new approach was in place, but "until West Covina has a state recognized city public health department, LA County Public Health will continue to serve the residents of West Covina in its current capacity. All public health orders issued by the State and County Health Officer regarding COVID-19 remain in effect and Public Health will continue to enforce those infection control measures within the City of West Covina."

West Covina Unified schools Superintendent Charles D. Hinman sent a letter opposing the move. Hinman cited several services the county provides to the school district, including collection, tabulation and analysis of all public health statistics, health-education programs, communicable-disease control, and medical, nursing, education and other services to promote maternal and child health.

"These services are integral to the operation of the district and are expertly provided by LACDPH," Hinman wrote. "If the city terminates its relationship with LACDPH, the district fears that the city's proposed health department will not be able to provide the district with the services needed to protect the health and service of district students, families and staff."

"It's my hope that even if the state approves West Covina's ability to move forward with establishing its own health department, the City will recognize that it needs to partner with surrounding cities and communities to address current and future public health crises," County Supervisor Hilda L. Solis said in a statement.

Solis cited the services that the county has provided West Covina during the pandemic, including helping to set up a COVID-19 testing site at Cameron Park, providing COVID-19 vaccines for residents at the Bridgecreek retirement community and providing vaccines for educators and staff in the West Covina Unified School District.

“I want to be clear: I will continue to ensure support and services for the residents of West Covina even if some members of the City Council do not want to be part of this network of resources,” Solis said. “That extends to environmental justice issues that West Covina residents endure.”

Editor’s note: This version of the story corrects errors in the estimates from San Dimas for starting and maintaining the health department.

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