Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS REGULAR MEETING

Health District of Northern Larimer County

120 Bristlecone Drive, Fort Collins

Tuesday, September 27, 2022
4:00 p.m.

Health District
OF NORTHERN LARIMER COUNTY

AGENDA

BOARD OF DIRECTORS REGULAR MEETING

September 27, 2022

4:00 pm

4:00 p.m. **Call to Order; Introductions; Approval of Agenda……..Molly Gutilla**

4:05 p.m. **DISCUSSION & ACTIONS**

- Board Retreat Review.....Molly Gutilla
  - Review of priority process, staff input, budget process……Robert Williams
  - Board discussion……..Molly Gutilla
- Employment Policies and Employee Handbook..... Dana Turner
  - FLSA and Employment Types (Employee Handbook § 100.07)
  - Initial Evaluation Period (Employee Handbook § 100.09 and Internal Policy 3-22)
  - Residency Requirement (Employee Handbook § 100.08)
  - Remote Work (Employee Handbook § 100.10 and Internal Policy 3-21)
  - Outside Employment (Employee Handbook § 600.06)
  - Work Schedules (Employee Handbook § 400.06)

4:40 p.m. **PRESENTATION**

- County Health Ranking and Roadmap.....Robert Williams

4:55 p.m. **PUBLIC COMMENT**

Note: If you choose to comment, please follow the "Guidelines for Public Comment" provided on the back of the agenda.

5:00 p.m. **OTHER UPDATES & REPORTS**

- Executive Director Updates.....Robert B. Williams

5:15 p.m. **CONSENT AGENDA**

- Approval of the August 23 and September 19, 2022 Meeting Minutes
- Financials
- Approval of Amendment to Policy 10-01: Financial Accounts Signature Policy
- Approval of Resolutions 2022-23 through 2022-33 updating signature authority

5:20 p.m. **PUBLIC COMMENT (2nd opportunity)** See Note above.

5:25 p.m. **ANNOUNCEMENTS**

- October 27, 4:00 pm – Board of Directors Regular Meeting
- November 14, 4:00 pm – Board of Directors Regular Meeting
- November 16, 4:00 pm – Joint Board Meeting with UCHealth
- December 13, 4:00 pm – Board of Directors Regular Meeting

5:30 p.m. **ADJOURN TO EXECUTIVE SESSION**

Personnel matters regarding an Executive Director Contract review and Executive Director six-month Evaluation Plan per §24-6-402(4)(f) of the C.R.S. Adjourn out of the Executive Session.

GUIDELINES FOR PUBLIC COMMENT

The Health District of Northern Larimer County Board welcomes and invites comments from the public. **Public comments or input are taken only during the time on the agenda listed as 'Public Comment.'** If you choose to make comments about any agenda item or about any other topic not on the agenda, please use the following guidelines.

- **Before you begin your comments please:** Identify yourself – spell your name – state your address. Tell us whether you are addressing an agenda item, or another topic.
- **Limit your comments to five (5) minutes.**

MISSION

The Mission of the Health District of Northern Larimer County is to enhance the health of our community.

VISION

- District residents will live long and well.
- Our community will excel in health assessment, access, promotion and policy development.
  - Our practice of **assessment** will enable individuals and organizations to make informed decisions regarding health practices.
  - All Health District residents will have timely **access** to basic health services.
  - Our community will embrace the **promotion** of responsible, healthy lifestyles, detection of treatable disease, and the **prevention** of injury, disability and early death.
  - Citizens and leaders will be engaged in the creation and implementation of ongoing **systems and health policy development** at local, state, and national levels.
  - Like-minded communities across the country will emulate our successes.

STRATEGY

The Health District will take a leadership role to:

- Provide exceptional health services that address unmet needs and opportunities in our community,
- Systematically assess the health of our community, noting areas of highest priority for improvement,
- Facilitate community-wide planning and implementation of comprehensive programs,
- Educate the community and individuals about health issues,
- Use Health District funds and resources to leverage other funds and resources for prioritized projects, and avoid unnecessary duplication of services,
- Promote health policy and system improvements at the local, state and national level,
- Continuously evaluate its programs and services for quality, value, and impact on the health of the community,
- Share our approaches, strategies, and results, and
- Oversee and maintain the agreements between Poudre Valley Health System, University of Colorado Health and the Health District on behalf of the community.

VALUES

- Dignity and respect for all people
- Emphasis on innovation, prevention and education
- Shared responsibility and focused collaborative action to improve health
- Information-driven and evidence-based decision making
- Fiscal responsibility/stewardship
- An informed community makes better decisions concerning health

Memo

TO: Health District Board of Directors

FROM: Dana Turner, Human Resources Director

DATE: September 27, 2022

RE: Updates to Employment Handbook subsection 100.07 Employment Categories

Attached, please find proposed changes to **subsection 100.07, Employment Categories**. The changes administratively simplify the Health District's employment categories and make it easier for employees to understand Fair Labor Standards Act (FLSA) employment classifications, employment types and benefit eligibility.

An Acting/Interim Appointments category was added to provide employees with the opportunity to obtain additional skills and pay corresponding to additional duties performed during periods of transition, or during extended absences.

Board approval is needed for any changes to the policies contained in the Employment Handbook. Staff recommends consideration and approval of the proposed revisions to subsection 100.07 Employment Categories with an effective date of October 1, 2022.

Change to Existing Policy in the Employment Handbook, clean version (redline version is provided below):

100.07 FLSA CLASSIFICATION AND EMPLOYMENT CATEGORIES

Employees of the Health District are classified as either exempt or nonexempt under federal and applicable state wage and hour laws, and are further classified for administrative purposes so employees understand their employment status and benefit eligibility. These classifications do not guarantee employment for any specified period of time. Accordingly, the right to terminate the employment relationship at any time is retained by both the employee and the Health District.

1. Fair Labor Standards Act (FLSA) Classifications

Exempt Employees: Employees whose job assignments meet specific tests established by the federal Fair Labor Standards Act (FLSA) and applicable state law and who are exempt from minimum wage and/or overtime pay requirements.

Nonexempt Employees: Employees whose job positions do not meet FLSA or applicable state exemption tests, and who are not exempt from minimum wage and/or overtime pay requirements.
The Health District has the ability to classify any position as **nonexempt** even when a position can pass both the salary threshold and duties tests.

2. Employment Types

Full-Time: An employee who is regularly scheduled to work 40 hours per week. They are eligible for the Health District's benefit package, subject to the terms, conditions, and limitations of each benefit program and subject to the Board of Directors' authority to modify or eliminate any such program.

Part-Time: An employee who is scheduled to 39 or less hours per week, but at least 20 hours per week. They are eligible for the Health District's benefit package on a pro-rated basis and subject to the terms, conditions, and limitations of each benefit program, and subject to the Board of Directors' authority to modify or eliminate any such program.

Positions may be further categorized as

Grant-Funded: An employee hired to work in a program or service funded by a grant(s). Such employees may be exempt or non-exempt, part- time or full-time, and are paid utilizing the organization's pay system. Benefits may be available corresponding to the assigned FTE and dependent on length of term and stipulations of the grant contract. Grant-funded employees must be hired through a competitive hiring process and into a classified position. The Health District or

the Grant-Funded Employee may end the employment relationship for any reason at any time.

Limited-Term: An employee hired for a limited period of time for a specific project with a specified time limit. Limited-Term assignments may be intermittent and/or unpredictable in nature. Such employees may be exempt or non-exempt, part-time or full-time, and are paid utilizing the organizations pay system. Benefits may be available corresponding to the assigned FTE and dependent on length of term. Limited Term Employees must be hired through a competitive hiring process. The Health District or the Limited Term Employee may end the employment relationship for any reason at any time.

3. Acting/Interim Appointments

The Executive Leadership may appoint an employee to serve in an "acting" capacity in instances of transition or covering duties for extended absences. The employee may receive a temporary salary increase related to the appointment. Any potential salary increase for the assignment will be determined by Human Resources, based on the additional responsibility. Upon completion of the appointment, the employee will return to their former position and salary. Appointments shall be limited to six (6) months. Extensions may be granted by Human Resources under certain circumstances, but the position must be posted to all Health District employees prior to an extension.

Redline version

100.07 FLSA CLASSIFICATION AND EMPLOYMENT CATEGORIES

Employees of the Health District are classified as either exempt or nonexempt under federal and applicable state wage and hour laws, and are further classified for administrative purposes~~It is the intent of the Health District to clarify the definitions of employment classifications~~ so employees understand their employment status and benefit eligibility. These classifications do not guarantee employment for any specified period of time. Accordingly, the right to terminate the employment relationship at any time is retained by both the employee and the Health District.

~~**Each employee is designated as either NONEXEMPT (Overtime Eligible) or EXEMPT from federal and state wage and hour laws. See Section 300.04 for further information. NONEXEMPT employees are entitled to compensation under the specific provisions of federal and state laws. EXEMPT employees are excluded from specific provisions of federal and state wage and hour laws. An employee's EXEMPT or NONEXEMPT classification may be changed only upon approval of the Director responsible for Human Resources or their designee. Each employee is designated as either NONEXEMPT (Overtime Eligible) or EXEMPT from federal and state wage and hour laws.**~~

~~An employee's EXEMPT or NONEXEMPT classification may be changed only upon approval of the Director responsible for Human Resources or their designee.~~

~~In addition to the above categories, each employee will belong to one other employment category:~~

4. Fair Labor Standards Act (FLSA) Classifications

Exempt Employees: Employees whose job assignments meet specific tests established by the federal Fair Labor Standards Act (FLSA) and applicable state law and who are exempt from minimum wage and/or overtime pay requirements.

Nonexempt Employees: Employees whose job positions do not meet FLSA or applicable state exemption tests, and who are not exempt from minimum wage and/or overtime pay requirements.
The Health District has the ability to classify any position as **nonexempt** even when a position can pass both the salary threshold and duties tests.

5. Employment Types

~~**REGULAR FULL-TIME**~~**Full-Time:** ~~e~~An ~~mployee~~employee who ~~s are those who are~~is ~~not in a temporary status and who are~~ regularly scheduled to work ~~34~~0 ~~or more~~ hours per week. They are eligible for the Health District's benefit package, subject to the terms, conditions, and limitations of each benefit program and subject to the Board of Directors' authority to modify or eliminate any such program.

~~**REGULAR PART-TIME**~~**Part-Time:** ~~e~~An employees ~~are those who are~~who is ~~not assigned to a temporary status and who are regularly~~ scheduled to 39 or less ~~work less than 30~~ hours per week, but at least 20 hours per week. They are eligible for the Health District's benefit package on a pro-rated basis and~~,~~ subject to the terms, conditions, and limitations of each benefit program, and ~~and~~ subject to the Board of Directors' authority to modify or eliminate any such program.

Positions may be further categorized as

~~**TIME-LIMITED FULL-TIME**~~ **Grant-~~f~~Funded:** An employee hired to work in a program or service funded by a grant(s). Such employees may be exempt or non-exempt, part- time or full-time, and are paid utilizing the organization's pay system. Benefits may be available corresponding to the assigned FTE and dependent on length of term and stipulations of the grant contract. Grant-funded

employees must be hired through a competitive hiring process and into a classified position. The Health District or the ~~Limited Term~~Grant-Funded Employee may end the employment relationship for any reason at any time. ~~employees are those who are not in a temporary status and who are regularly scheduled to work 30 or more hours per week. In addition, they must be hired under a project or funding source with a defined ending date or a soft money source (for example, a special project or outside funding source) or are an interim replacement expected to last more than five months. They are eligible for the Health District's benefit package subject to the terms, conditions, and limitations of each benefit program and subject to the Board of Directors' authority to modify or eliminate any such program.~~

~~**TIME-LIMITED PART-TIME**~~**Limited-Term:** An employee hired for a limited period of time for a specific project with a specified time limit. Limited-Term assignments may be intermittent and/or unpredictable in nature. Such employees may be exempt or non-exempt, part-time or full-time, and are paid utilizing the organization's pay system. Benefits may be available corresponding to the assigned FTE and dependent on length of term. Limited Term Employees must be hired through a competitive hiring process. The Health District or the Limited Term Employee may end the employment relationship for any reason at any time.
~~employees are those who are not in a temporary status and who are regularly scheduled to work less than 30 hours per week, but at least 20 hours a week. In addition, they must be hired under a special project or funding source with a defined ending date, or are an interim replacement expected to last more than five months. They are eligible for the Health District's benefit package subject to the terms, conditions, and limitations of each benefit program and subject to the Board of Directors' authority to modify or eliminate any such program.~~

~~**PART-TIME** employees are those who are not assigned to a temporary status and who are regularly scheduled to work less than 20 hours per week. While they do receive all legally mandated benefits (such as Social Security, workers' compensation), they are ineligible for any of the Health District's other benefit programs.~~

~~**TEMPORARY** employees are those who are hired as interim replacements, to temporarily supplement the work force, or to assist in the completion of a specific project and do not fit the requirements for a time-limited employee. Employment assignments in this category are of a limited duration either by time or event, which will be defined at the time of hire. If a temporary employee remains to the end of this period and is still needed, the temporary appointment will be reevaluated for consideration of a move to the appropriate status. Employment beyond any initially stated period does not in any way imply a change in employment status. Temporary employees retain that status unless and until notified of a change by their supervisor. While temporary employees receive all legally mandated benefits (such as Social Security, workers' compensation), they~~

~~are ineligible for any of the Health District's other benefit programs. Individuals hired through temporary agencies are not employees of the Health District.~~

6. Acting/Interim Appointments

The Executive Leadership may appoint an employee to serve in an "acting" capacity in instances of transition or covering duties for extended absences. The employee may receive a temporary salary increase related to the appointment. Any potential salary increase for the assignment will be determined by Human Resources, based on the additional responsibility. Upon completion of the appointment, the employee will return to their former position and salary. Appointments shall be limited to six (6) months. Extensions may be granted by Human Resources under certain circumstances, but the position must be posted to all Health District employees prior to an extension.

Memo

TO: Health District Board of Directors

FROM: Dana Turner, Human Resources Director

DATE: September 27, 2022

RE: New subsection to the Employment Handbook and new internal policy: Initial Evaluation Period

Attached, please find the following for your consideration and approval:

1. A new proposed subsection to the employee handbook (100.09 Initial Evaluation Period), and
2. The respective new internal policy (3-22 Initial Evaluation Period).

The Initial Evaluation Period policy defines a period of time in which a new employee, or an employee who has moved into a new position, receives close guidance and frequent feedback, and the supervisor closely observes the employee's work in a new position. This period of time allows the employee and the Health District to evaluate whether the position is a fit for both parties.

This policy is intended to benefit both the employee in a new position, and the Health District. Prior to the completion of the evaluation period, a meeting will be scheduled with the employee and immediate supervisor in which a written evaluation discussing overall performance, organizational fit, and recommendation of regular status will be provided.

Board approval is needed for any changes to the policies contained in the Employment Handbook. Staff recommends approval of the addition of the new subsection 100.09 Initial Evaluation Period, and adoption of 3-22 Initial Evaluation Period Policy with an effective date of October 1, 2022.

New subsection for the Employment Handbook

100.09 INITIAL EVALUATION PERIOD

The initial evaluation period is intended to give new employees (or existing employees in a new position) the opportunity to demonstrate their ability to achieve a satisfactory level of performance and is used to determine whether their position with the Health District meets the expectations of both parties. The initial evaluation for new employees or existing employees in a new position is six (6) months from the effective date of hire.

The Health District uses this period to evaluate employee capabilities, work habits, and overall performance. **Either the employee or the Health District may end the employment relationship at any time during or after the initial evaluation period, with or without good cause shown or advance notice to the employee. The Health District maintains an "at will" status in relation to all employment matters.**

The initial evaluation period is a final step in the selection process to closely observe an employee's work in a new position. The period is used to assist with the effective adjustment of a new employee and may result in dismissal if an employee is determined not to be suited for or appropriate in a new position. Furthermore, if the employee does not feel comfortable in their job assignment, the employee may choose to terminate employment with the Health District.

An employee must complete their initial evaluation period before they will be eligible for any competitive promotion. An employee promoted who does not successfully complete the initial evaluation period may be offered (but is not guaranteed) their previously held position, if available, or any other open position for which the employee is qualified.

Newly hired employees attain regular status upon completion of the initial evaluation period and when notified by Human Resources. A written evaluation by the immediate supervisor will be placed in the employee's personnel file at the end of the initial evaluation period.

For further information, please refer to Internal Policy ***3-22 Initial Evaluation Period Policy***.

3-22 Initial Evaluation Period Policy

PURPOSE

The initial evaluation period is intended to give new employees (or existing employees in a new position) the opportunity to demonstrate their ability to achieve a satisfactory level of performance and is used to determine whether their position with the Health District meets the expectations of both parties.

The Health District uses this period to evaluate employee capabilities, work habits, and overall performance. **Either the employee or the Health District may end the employment relationship at any time during or after the initial evaluation period, with or without good cause shown or advance notice to the employee. The Health District maintains an "at will" status in relation to all employment matters.**

The initial evaluation period is a final step in the selection process to closely observe an employee's work in a new position. The period is used to assist with the effective adjustment of a new employee and may result in dismissal if an employee is determined not to be suited for or appropriate in a new position.

If there is doubt about a newly hired employee's appropriateness or suitability for a position or their ability to perform the work or meet Health District standards, the employee in question may be dismissed. Newly hired employees are subject to termination at any time during the initial evaluation period. Furthermore, if the employee does not feel comfortable in their job assignment, the employee may choose to terminate employment with the Health District.

POLICY

The initial evaluation period for new employees or existing employees in a new position is six (6) months from the effective date of hire. The initial evaluation period may be extended for up to a maximum of an additional ninety (90) days upon written request of the immediate supervisor and concurrence of the Executive Director or designee. Reasons for extending the evaluation period may include, without limitation, below standard job performance, non-adjustment to the work environment, additional training requirements, or inability on the part of the supervisor to adequately assess the employee's suitability for the position. Any significant absence, as may be granted by the employee's supervisor, may extend the introductory period by the length of any approved absence.

Newly hired employees attain regular status upon completion of the initial evaluation period and when notified by Human Resources. A written evaluation by the immediate supervisor will be placed in the employee's personnel file at the end of the initial evaluation period.

Prior to the completion of the evaluation period, the immediate supervisor will schedule an evaluation conference with the employee. The purpose of this conference is to inform the employee whether regular status is recommended and to discuss the employee's performance. The conference is also used to encourage the employee regarding any satisfactory or superior

performance and to discuss any objectives that the employee should achieve. Action taken by management with respect to one individual case does not establish a precedent in another circumstance.

The Health District does not intend to create any expectation that an employee will be assured of a specific form of corrective action or discipline. **It is the Health District's discretion to impose any corrective action or discipline it may deem appropriate, including, without limitation, dismissal during or after the initial evaluation period with or without good cause shown or advance notice to the employee.**

An employee must complete their initial evaluation period and be elevated to regular status before they will be eligible for any competitive promotion. An employee promoted who does not successfully complete the initial evaluation period may be offered (but is not guaranteed) their previously held position, if available, or any other open position for which the employee is qualified.

DEFINITIONS

Introductory Employee

An employee in the first six (6) months of continuous Health District employment, or the first six (6) months following transfer through a competitive recruitment process.

REVIEW AND REVISION HISTORY

Developed/Reviewed	Approval	Recorded	Published	Notes
[09/16/2022 – Dana Turner, Human Resources Director	[MM/DD/YYYY – Name]	[MM/DD/YYYY – Name/Title]	[MM/DD/YYYY – Name/Title]	

Memo

TO: Health District Board of Directors

FROM: Dana Turner, Human Resources Director

DATE: September 27, 2022

RE: New subsection to the Employment Handbook: 100.08 Residency Requirement

Attached you will find the proposed subsection: **100.08, Residency Requirement**. This new subsection was developed to address and recognize previous Board discussions related to concerns regarding ongoing out of state employment; specifically regarding legal business and employment law requirements which differ from state to state and can contribute to personnel time costs and administrative burdens.

The section outlines that employees will be subject to a residency requirement. The requirement includes both Colorado and Wyoming (with limitations) as we wanted to remain somewhat flexible to address equity related to the high cost of living in areas closer to, or within the district.

Board approval is needed for any changes to the policies contained in the Employment Handbook. Staff recommends that the Board of Directors approve the addition of Subsection 100.08: Residency Requirements with an effective date of October 1, 2022. This effective date would allow notification and necessary planning time for affected employees.

100.08 RESIDENCY REQUIREMENT

The Health District of Northern Larimer County requires employees to maintain their residence in Colorado or Wyoming throughout their employment. Time-limited exceptions may be granted with approval from the Executive Director or their designee.

Employees are not required to reside within the Health District's service boundaries; however, they are required to have the ability to commute to Health District offices during normal business hours throughout their employment.

The Health District reserves the right to place additional maximum distance requirements or response time requirements on key employees whose positions include duties that clearly demonstrate a need for them to be close to their place of employment to ensure timely response to Health District offices.

New employees must establish residency as required by this policy on or before their employment start date. Specific and limited exceptions to meet the needs of the organization or the employee may be granted on a case by case basis.

To prove residency an employee must be able to provide two forms of identification showing name and address dated within the last 12 month period, such as:

- A driver's license or state-issued ID card;
- Utility bill (such as gas, electric, phone); or
- A lease agreement, mortgage statement or rental receipt

Memo

TO: Health District Board of Directors

FROM: Dana Turner, Human Resources Director

DATE: September 27, 2022

RE: New subsection to the Employment Handbook and new internal policy: Remote Work

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For your consideration and approval, please find attached:

1. A new subsection for inclusion in the employee handbook: **100.10 Remote Work.**
2. The respective full internal policy 3-21 Remote Work Policy.

The remote work policy allows employees who have been approved to work some portion of their schedule remotely. Health District leadership will continually assess and review remote work arrangements to ensure service delivery and collaboration are prioritized. No position will be fully remote.

Board approval is needed for any changes to the policies contained in the Employment Handbook. Therefore, staff is seeking approval of the new subsection 100.10 Remote Work for inclusion in the employee handbook, and adoption of the supporting 3-21 Remote Work Policy with an effective date of October 1, 2022.

New subsection for the Employee Handbook

100.10 REMOTE WORK

The Health District values collaborative teamwork and wants to provide significant opportunities for in-person interaction. The Health District of Northern Larimer County recognizes that remote work may be beneficial to the organization and its employees at times. Remote work is a voluntary arrangement and must meet the outlined criteria. No employee is entitled or guaranteed a remote work arrangement. Remote work is considered when both the employee and the job are suited to such an arrangement. Remote work is not an option for every position or employee. Employees must be approved for remote work, and no position is eligible for a 100% remote work arrangement.

The option for an employee to work remotely is dependent on:

- Specific job duties;
- Ability to provide service to the public;
- The necessity to interact with the public or other employees in person; and
- The ability of the employee to meet schedule and technical requirements, including review of the employee's past and present levels of performance.

Remote work requires leadership evaluation and approval. Executive Leadership will review remote work requests and determine if a specific position or program meets the required criteria. Approved requests require a remote work agreement. Executive Leadership may refuse remote work requests and may terminate a remote work arrangement at any time. Remote work agreements will be assessed on a regular basis to ensure service delivery and collaboration are prioritized. Employees are not required to work remotely except in cases of emergency.

For additional information see ***3-21 Remote Work Policy***

3-21 Remote Work Policy

1 PURPOSE

The Health District values collaborative teamwork and wants to provide significant opportunities for in-person interaction. The Health District of Northern Larimer County recognizes that remote work may be beneficial to the organization and its employees at times. Remote work is a voluntary arrangement and must meet the outlined criteria. No employee is entitled or guaranteed a remote work arrangement. The purpose of this policy is to provide an understanding of remote work at the Health District and define the criteria and procedures for remote work arrangements.

2 CROSS REFERENCES

- Employee Handbook, Section 500.02 Alcohol and Drugs
- Employee Handbook, Section 600.06: Outside Employment
- Employee Handbook, Section 900.03: Disciplinary/Dismissal Procedures

3 POLICY

Remote work is a cooperative arrangement between Executive Leadership (or their designee), an employee, and the Health District, is not an entitlement or benefit. Remote work is considered when both the employee and the job are suited to such an arrangement. Remote work is not an option for every position or employee. Employees must be approved for remote work, and no position is eligible for a 100% remote work arrangement.

The option for an employee to work remotely is dependent on:

- Specific job duties;
- Ability to provide service to the public from a remote location;
- The necessity to interact with the public or other employees in person; and
- The ability of the employee to meet schedule and technical requirements, including review of the employee's past and present levels of performance.

Executive Leadership will determine if a specific position, program, or employee meets the criteria for remote work. Executive Leadership may refuse remote work requests and may terminate a remote work arrangement at any time. Employees are not required to work remotely except in cases of emergency.

Executive Leadership will review requests, and:

1. Determine the level of in-person interaction necessary to provide reasonable opportunity for in-person collaboration**,** relationship development and team building;
2. Ensure that any required business with the public continues to meet the needs of the public;
3. May adapt remote work schedules to address concerns about service availability or

changes in business needs; and

4. May authorize remote work on a temporary basis only due to extenuating circumstances the employee is facing.

Conditions of Remote Work Arrangements:

1. Remote work does not change the basic terms and conditions of employment as a Health District employee.
2. Approval for remote work may be terminated at any time.
3. Remote work must be conducted on Health District computer equipment and other IT equipment. This equipment must be returned upon termination or resignation.
4. The Health District will not purchase or provide telephone lines, high-speed internet, or office furniture for an offsite work location. The Health District is not responsible for any loss, damage or wear to employee-owned equipment used for remote work.
5. Remote workers must remain accessible by phone, email, and other communication platforms during their regularly scheduled work hours. The remote worker must have a reliable, high-speed internet connection.
6. Confidential and personal information (Social Security numbers, credit information, patient health information) must not be removed from the office or accessed through the Health District's network unless approved in advance by Executive Leadership or their designees.
7. Employees shall not reproduce confidential or personal material while working remotely and must take precautions to ensure that confidential and personal information remains confidential.
8. No original program or service records may be removed from Health District sites without prior written approval of Executive Leadership or their designee.
9. Any changes to an employee's remote work schedule must be reviewed and approved by the supervisor and manager in advance.
10. Employee's salary, job responsibilities, benefits, and Health District sponsored insurance coverage do not change as a result of remote work.
11. Remote work is subject to the same policies as work done on Health District premises, including, without limitation, timesheet recording, section 500.01 Alcohol and Drugs of the employee handbook, federal regulations such as the Fair Labor Standards Act, and cyber-security policies.
12. Remote workers will be evaluated based on their ability to manage work performance in the remote environment to ensure they are fully meeting their job responsibilities.
13. Remote work must be performed in an environment free of distractions and generally cannot be done while caring for a dependent. Employees working remotely should not expect to be available for personal business during regularly scheduled work hours.
14. An employee may not engage in other employment during working hours, in accordance with section 600.06 Outside Employment of the employee handbook.
15. Violation of this policy may result in the end oF remote work for the employee, disciplinary action, or both as described in the employee handbook section 900.03 Disciplinary/Dismissal Procedures.

4 DEFINITIONS

1. Remote Work

Some portion of work away from a Health District work site.

5 REVIEW AND REVISION HISTORY

Developed/Reviewed	Approval	Recorded	Published	Notes
09/16/22 – Dana Turner, Human Resources Director	[MM/DD/YYYY – Name]	[MM/DD/YYYY – Name/Title]	[MM/DD/YYYY – Name/Title]	

Memo

TO: Health District Board of Directors

FROM: Dana Turner, Human Resources Director

DATE: September 27, 2022

RE: Updates to Employment Handbook subsection 600.06 Outside Employment

The addition of the Remote Work Policy prompted the review and/or updates of the policies it cross-references. Attached you will find changes to subsection **600.06, Outside Employment**. The updated language in this policy is intended to provide employees with additional clarity regarding the parameters in which secondary employment is acceptable. As well, it adds additional context to align with the new Remote Work Policy.

Board approval is needed for any changes to the policies contained in the Employment Handbook. Staff recommends consideration and approval of the proposed revisions to subsection 600.06 Outside Employment with an effective date of October 1, 2022.

Change to Existing Policy in the Employment Handbook, clean version (redline version is provided below):

600.06 OUTSIDE EMPLOYMENT

Employees are permitted to work a second job as long as it does not interfere with their Health District job performance. Employees with a second job are expected to work their assigned Health District schedules. Secondary work may not be performed during an employee's assigned Health District work schedule. A second job will not be considered an excuse for poor job performance, absenteeism, tardiness, leaving early, refusal to travel, or refusal to work overtime or different hours.

If secondary employment could represent a conflict of interest as defined in section 600.01, it may not be permissible.

If secondary work activity causes or contributes to job-related problems, it must be discontinued, or the employee may be subject to disciplinary action, up to and including termination.

Employees are not permitted to use any of the Health District's equipment for any purposes related to secondary employment.

Redline version

600.06 OUTSIDE EMPLOYMENT

Employees are permitted to work a second job as long as it does not interfere with their Health District job performance. Employees with a second job are expected to work their assigned Health District schedules. Secondary work may not be performed during an employee's assigned Health District work schedule. A second job will not be considered an excuse for poor job performance, absenteeism, tardiness, leaving early, refusal to travel, or refusal to work overtime or different hours.

If ~~outside~~ secondary employment could represent a conflict of interest as defined in section 600.01, it may not be permissible.

If ~~outside~~ secondary work activity causes or contributes to job-related problems, it must be discontinued, or the employee may be subject to disciplinary action, up to and including termination.

Employees are not permitted to use any of the Health District's equipment for any purposes related to secondary employment.

Memo

TO: Health District Board of Directors

FROM: Dana Turner, Human Resources Director

DATE: September 27, 2022

RE: Updates to Employment Handbook subsection 400.06 Work Schedules

Attached, please find proposed changes to subsection **400.06, Work Schedules**. The changes to this policy remove language referencing an older policy (3-12 Telework Policy) that will be retired. This language will no longer be applicable with the addition of the 3-21 Remote Work Policy.

Board approval is needed for any changes to the policies contained in the Employment Handbook. Staff recommends consideration and approval of the updated language to Section 400.06 Work Schedules with an effective date of October 1, 2022.

Change to subsection in the Employment Handbook, clean version (redline version is provided below):

400.06 WORK SCHEDULES

Work schedules for employees vary throughout our organization. Supervisors will assign employees their individual work schedules. Staffing needs and operational demands may necessitate variations in starting and ending times, as well as variations in the total hours that may be scheduled each day and week. Supervisors must approve changes to an individual's normal work schedule.

Flexible scheduling is available in some cases to allow employees to vary their starting and ending times each day within established limits. Employees should consult their supervisors to determine if their position is eligible.

Redline version

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Work schedules for employees vary throughout our organization. Supervisors will assign employees their individual work schedules. Staffing needs and operational demands may necessitate variations in starting and ending times, as well as variations in the total hours that may be scheduled each day and week. Supervisors must approve changes to an individual's normal work schedule.

Flexible scheduling is available in some cases to allow employees to vary their starting and ending times each day within established limits. Employees should consult their supervisors to determine if their position is eligible.

~~The Health District believes that working in teams is the preferred way to accomplish tasks, recognizing that at times working from remote locations can be an employee's more efficient way of completing certain assignments. In no case will an employee's job be entirely telework. The Telework Policy provides a criteria and procedure for employees working from home or other remote locations. Telework is intended only for regular, recurring work done from a remote location on an ongoing basis.~~

~~*For further information see Internal Policy 3-12: Telework Policy.*~~

KEY FINDINGS REPORT

2019 Community Health Survey

Throughout the Fall of 2019 the Health District of Northern Larimer County conducted a population health survey of adults living in the Health District and the southern part of Larimer County. Of twelve-thousand addresses randomly selected to participate in the survey, the survey yielded 1,682 responses from the Health District and 850 responses from South County. These responses were weighted to represent the true known populations of these regions. Data presented in this notebook are limited to the Health District, unless otherwise noted.

The following is a compilation of key findings from the Health District's 2019 Community Health Survey. It is organized by areas in which our community is doing well, followed by areas of potential concern for our community.

Issues with Positive Indicators and/or Positive Progress

1.

Reports of cigarette smoking has declined in every triennial survey since the first survey assessment in 1995.

Those who report any use of cigarettes has decreased since 2016 from 7.2% to 4.0%. It is also reported that fewer people have someone in their household that smokes cigarettes indoors. Cigarette smoking has declined in every triennial survey since the first survey assessment in 1995 Additionally, only 3.5% of Medicaid clients reports smoking in the household.

2.

Seatbelt use in the Health District is the highest reported since the question has been asked on the survey.

93.1% of respondents stated that they **always** wear seatbelts when driving or riding in a vehicle. This rate is better than the Healthy People 2020 goal of 92% and also higher than Larimer County (86%), Colorado (88%) and the US (86%).

3.

Obesity rates are remaining stable.

Obesity, while not improving, remains stable at 16% (up from 9% in 1995), better than Colorado (23%) and the US (31%).

4.

Health District residents can find places to go for care.

There have been decreased reports of having no place to go for care except emergency rooms or urgent care, from 21.7% in 2016 to 16.7% in 2019.

5.

Those with Medicaid understand their dental benefits.

80.3% of Medicaid insured individuals reported that they had insurance coverage for dental services, which suggests an increased awareness that their insurance covers dental care. Similarly, 50% of Medicare clients have insurance that covers dental.

6.

Those who needed and *used* mental health services increased.

In 2016, 17% of respondents reported needed and using mental health services in the past year, while that proportion increased to 24% in 2019.

Issues of Potential Concern:

Mental Health

1. Lower income residents report more days with poor mental health.

Those with income <185%FPL reported 3 times higher mean number of days with poor mental health than >285%FPL (8.29 vs 3.43). Residents with income <185%FPL had an average of 4.33 days that poor mental health kept them from doing usual activities, compared to 1.41 days of those with income >185%FPL. The highest mean days that poor mental health kept them from doing usual activities was for those with income between 186-250% FPL, with a mean of 5.6 days.

2. Health District Residents are reporting an average increase of poor mental health days.

In 2016, 65% of HD residents reported no days with poor mental health (past month). In 2019 this percentage significantly dropped to 47%. The mean number of days when mental health was not good increased from 2.77 to 3.95 days.

3. Reports of general and diagnosed mental health issues have increased.

Overall, those reporting now having depression, anxiety, or other mental health issues increased from 21% in 2016 to 33% in 2019. 45% of those aged 18-34, 49% of those on Medicaid and 45% of those with income <250% FPL currently have depression, anxiety, or other mental health problems at the time of the survey.

Those who reported that a health care provider has told them they have a mental health issue other than depression increased significantly from 4.5% to 9.1%.

4. Suicide ideation is increasing.

The 2019 CHS showed the highest suicide ideation report yet, with 8.8% of HD residents reporting considering suicide in the past year compared with 6.6% in 2016.

5. Medicare clients are unsure of their mental health benefits.

27% of residents with Medicare responded “I don’t know” to the question, “Do you currently have insurance that covers at least part of the cost for mental health services?”, higher than all other health insurance groups

6. Residents, particularly low income residents, are putting off mental health care due to cost

The percentage of those who reported putting off a visit to a mental health care provider due to cost in the past two years rose from 17% in 2016 to 24% in 2019. Among those with income 186-250% FPL, 52% reported putting off mental health care due to cost.

Issues of Potential Concern:

Substance Use

1.

Alcohol use remains a concern.

Alcohol use continues to be higher than Colorado and the US. 25% of respondents reported binge drinking (compared to 19% in Colorado and 16% (in the US.), while 11% can be classified as heavy drinkers (compared to 7% in CO and 6.5% in US). Higher income groups are more likely to be heavy drinkers (14% compared to 11% overall).

2.

Residents are drinking and driving more than in the past.

Drinking and driving has significantly increased from 4.2% in 2016 to 9.6% in 2019. Men are more likely to have 2+ drinks in an hour and drive than women (13.2% vs 6.2%). Those with income >185% FPL reported higher rates of drinking and driving than those <185% FPL (11.4% vs 6.1%). Respondents in the income category 186-250% FPL, reported the highest rates of drinking and driving at, 17%.

3.

The proportion of residents who have used marijuana is increasing.

The percentage of those who have never used marijuana has decreased from 50% to 37% between 2013 and 2019. The percentage who have used marijuana in the past year has increased from 17% to 35%. Groups most likely to have used marijuana in the past 30 days include those ages 18 to 34 (49% used in the past 30 days), those on Medicaid (45% had used in the past 30 days), and those with incomes between 186 and 250% FPL (46% had used in the past 30 days).

4.

Those with income 186-250% FPL are using marijuana more frequently than others.

Those with income 186-250% FPL reported the highest marijuana utilization rate, both recreational and medical, of all income groups. Among the 35% who reported using marijuana at least once in the past 30 days, this income group reported a mean 17.7 days of use. Of those who reported using marijuana in the last 30 days, 25.3% of this income group reported using marijuana daily. The second highest utilizers by income group were those <100% FPL, with 12% reporting they used marijuana daily.

5.

About a quarter of those who use marijuana drive after using it.

26% of those who reported using marijuana at least once in the past 30 days use marijuana and drive within 2-3 hours of using it.

Issues of Potential Concern

Access To/Concerns About Care

1.

Uninsured rates have increased since 2016, especially among those with low income.

8.7% of HD residents ages 18 to 64 reported having no health insurance, up from 4.6% in 2016. Across Larimer County, the uninsured rate for ages 18 to 64 was 8.0%. In 2016, across Larimer County, 5.0% of those with income <138% FPL (ages 18-64) reported having no health insurance. This number rose to 19.1% in 2019, a 2.8 fold increase.

2.

Fewer residents are self-purchasing plans through the marketplace.

Among all ages within the Health District, between 2016 to 2019, there was a significant decrease (22.6% in 2016 to 12.6% in 2019) in those who report having self-purchased commercial plan or marketplace insurance.

3.

Those with low income are using the ER for conditions that could be treated elsewhere.

Residents with low income (<185% FPL) reported visiting the ER 2 times more than those with comes > 185% FPL (31% vs 14%). 33% of this low-income group reported their condition could be treated elsewhere.

4.

A quarter of Medicaid clients cannot pay their medical bills.

25.3% of those on Medicaid reported being contacted by collections for medical bills in the past year.

Other

1.

Decline in self-reported health status.

There has been a statistically significant decline in the percentage of people self-reporting excellent or very good overall health status, from 67% in 2016 to 60% in 2019.

2.

Finding childcare is difficult.

53% of those who had tried to find child care in the past year reported a lot of difficulty or some difficulty in finding the type of child care they wanted for their child. An additional 16% were unable to find the child care program they wanted. 43% of those who had difficulty indicated cost as the primary reason for the difficulty.

TOP 10 THEMES

EMERGING FROM OPEN-ENDED RESPONSES ON THE 2019 COMMUNITY HEALTH SURVEY

The 2019 Community Health Survey featured one open-ended question at the end of the survey:

What do you feel are the greatest local concerns or issues impacting the health of the people of Larimer County?

In total, 1,859 respondents out of 2,532 residents in Larimer County answered this question with their concerns about local health issues. 1,123 of those responses were within Health District boundaries. After applying thematic codes and tabulating frequency of mentions, ten themes emerged as the top concerns for Northern Larimer County. In order of most frequently mentioned, the top concerns voiced by survey participants in the Health District were:

1. Mental Health
2. High Cost of Health Care
3. Pollution & Evironment
4. Homelessness
5. Affordable Housing & Cost of Living
6. Traffic
7. Alcohol & Substance Use
8. Population Growth
9. Tobacco & Vaping
10. High Cost of Health Insurance

Some other common topics mentioned in the open-ended responses include (in no specific order):

- **Healthy eating and active living:** concerns about food sources, access to affordable healthy options, and lack of physical activity.
- **Transportation:** responses included concerns about driving safety (accidents, traffic laws), improving public transportation access, and quality sidewalks and bike paths.
- **Dangerous driving:** cell phone use, driving under the influence, not following road rules or speed limits.
- **Political discontent:** mix of respondents expressing concern about government from both political directions, criticisms of free services, and disapproval of taxes in Larimer County.
- **Growing inequities**: mentions about access/affordability of healthcare for those who are living in poverty or people of color.
- **Older adults:** lack of affordable housing options, concern for income limitations, access to transportation options, confusion about Medicare.

MENTAL HEALTH

186 mentions

Overwhelmingly, mental health came up in comments regarding access to services, resources, and support. Many commented on the lack of available options for adolescents who are struggling with mental health issues. Mental health concerns were also mentioned in connection to homelessness, substance use, and isolation.

Selected comments regarding mental health:

"Mental health and addiction services are critical in this area. In-patient services are needed."

"Mental health issues that aren't getting addressed aggressively enough / not enough $ to support more mental health issues locally."

"I believe mental health, especially in our homeless population, poses the greatest local concern for health. People who want to be healthy in our community can - the opportunities and options are limitless, but until we normalize getting help + recognizing mental health it will always be the hardest thing to overcome."

"More mental health care is needed. Especially with the jail nearby and homeless population."

"We need more inpatient mental health facility capacity with enough beds for the community's population dealing with alcohol and drug addiction. Detox + treatment."

"I am concerned with mental health of our preteens and teens, including anxiety, depression, thoughts of suicide, etc."

"Affordability and access ... Especially in regards to mental health and specifically for Spanish speaking community members."

"The stigma against mental health, especially addictions, that sometimes keep people from getting the support they need."

"Mental health services for homeless people"

"Oh and suicide is pretty high in Larimer County. Let's amp up the prevention side of things. I went looking for a parent support group for an adult friend who has a 10 year old with suicide ideation. I couldn't find anything. It's out there -- let's talk about it!"

HIGH COST OF HEALTH CARE

165 mentions

The rising cost of health care was mentioned second most frequently. Comments were often connected to cost of prescriptions, medical procedures, and dental care. Participants also mentioned spending money on housing, healthy food, and other costs instead of their health.

Selected comments regarding the high cost of health care:

"Not having the money to afford healthcare needs. Even people with insurance put off going to the doctor or hospital because of the expense."

"Access to affordable health care (health INSURANCE IS NOT health care)."

"Lack of accessible, affordable health care in rural areas."

"COST. Also, the free/low cost clinics are sub-par. I don't want to take my kids to that trash, so I avoid it for their sake."

"Access to health care for middle income families with no savings. Access and ability to pay for medication for seniors and those on Medicare and those whose insurance does not cover a MAJOR part of the cost."

"Cost of Health Care, especially the high deductibles. Basically paying full price on care until the large deductible is paid keeps many people from getting the care they need early in order to address the problem while it is minor. "

"Dental care that is inexpensive."

"Cost and the transparency of fees. It is extremely unclear how much health care services in general cost whether an individual has insurance (and type of) or not."

"Access to specialists and general providers for low income. High cost of prescription drugs."

"Affordability and easy access - lots of people I know put off medical appointments and treatment due to cost even if they have insurance."

"Cost - in general, I think we could do a better job helping those that aren't poor enough for federal assistance but aren't rich enough to easily afford various healthcare services. Our family falls in this trap all the time and we often have to prioritize who and what services our family can [get]"

POLLUTION & ENVIRONMENT

147 mentions

Air quality, pollution, fracking concerns, and water quality were frequently mentioned issues regarding the environment. Comments were both about climate change specifically as well as how population growth in the area has had an effect on pollution.

Selected comments regarding pollution and environment:

"I think air quality is also a concern, particularly for people who live in eastern Larimer County near oil and gas development in the DJ Basin."

"Air pollution - need more regulation for those “rolling coal" and oil + gas emissions settling in foothills."

"Too many people on the road - so too much pollution. Don't know how clean our drinking water is."

"Poor air quality"

"Automobile congestion/pollution, human population growth/sprawl, resource extraction: oil and gas, gravel, rock quarries prioritized over the human/natural environment."

"Oil exploration & fracking."

"Pollution from oil and gas drilling, and pollution from coal fired power plants."

"I think that having water storage is important that with our rapid growth it will become increasing necessary to have adequate water."

"Fracking and oil industry. Known carcinogens and practices are causing high rates of cancer and sickness to the whole population that lives within a range of 10-20 miles of fracking, refinery and transportation sites. Profit should not trump public health in regards to oil and fracking."

"Climate change (including all related health issues: increasing disease transmission rates, especially tick- and mosquito-transmitted; heat morbidity; increased wildfire frequency and intensity; flooding; drought; etc.)"

HOMELESSNESS

143 mentions

Concerns regarding the growing homeless population were a mix between those who wanted to provide more resources and support and others who had a more negative perception of homeless as violent or dangerous. Homelessness was often mentioned in conjunction with substance use, mental health issues, or panhandling.

Selected comments regarding homelessness:

"Low income housing for homeless and affordable health care for all including dental and vision etc."

"There are many people facing homelessness, money is being wasted on harassing them with police or arresting them for minor 'offenses' rather than provide housing."

"Homelessness, it is very sad seeing people who live this way."

"The amount of homeless/transient people living in town without access to clean restrooms and places to reside (take up space) to be/live...

"I think there are too many homeless. I am not sure if it impacts our health but I am concerned about their health. And I wonder if it is their choice or that they may not have a choice."

"Homelessness + all the related problems but mostly lack of affordable housing"

"Mental health, drug addiction, affordable health care. I realize this is not impacting health but- Please make our parking lots and corners free from panhandling!!!! There are other resources for them. Focus should be on those resources. There is no incentive for them to get a job!"

"increasing # of panhandlers in Fort Collins who probably don't have health insurance"

"Mental health and self-soothing with marijuana or alcohol or meth abuse that leads to homelessness, begging and reluctance to find employment."

"Homeless folks on the streets. They leave trash, beg for food, money, etc. Disrupt businesses so clients don't feel safe. Walk around intoxicated."

"Low income people not being able to afford insurance and homeless people needing all kinds of services. A number of cities have almost solved the homeless problem by providing semi-permanent living spaces."

AFFORDABLE HOUSING & COST OF LIVING

129 mentions

Responses included concern for the lack of affordable housing in the area as well as the increased cost of living. The inability to afford health care and/or healthy food options due to the cost of housing was a connection several individuals made.

Selected comments regarding affordable housing and cost of living:

"Affordable housing is a real problem here in Larimer County. Families are not able to even think about setting their kids and selves up with services, when bigger needs are present such as transportation and housing "

"There's a strong need for low income housing and affordable or free child care."

"Housing prices are too high and wages are too low to pay housing costs. People don't have enough money to eat let alone pay for health care."

"High cost of living, not enough affordable housing for those of lower paying jobs and therefore they aren't able to afford basic things like healthcare and healthy food."

"Cost of living is also a major issue in Larimer, especially Fort Collins. This increases stress of residents and leaves less income to spend on health care, recreation, and nutritious meals."

"Unaffordable housing that puts stress on the ability of afford health care"

"Cost of living is so high and it is difficult for people to find affordable housing."

"Affordability of housing and health care"

"Affordable housing – "you + 2" rule for students & young adults in Fort Collins - this is a great economic burden - rent is nearly unaffordable which impacts my ability to purchase healthy foods pay expensive (even with insurance) medical bills & so on."

"Cost of living is obscene. Can't afford to buy housing, stuck with renting at ridiculous prices. Can't save money to buy a house because it all goes to rent, food, and utilities. This is becoming a county for the rich. Those of us in the "new" Larimer County need to make quadruple the average wage just to scrape by... "

TRAFFIC

120 mentions

Traffic was a major concern mentioned in relation to the growing population and lack of infrastructure to support it. Often, the participants commented on how traffic has had an effect on the air quality, the number of accidents, and related stress from driving.

Selected comments regarding traffic:

"The number of people choosing to move to Colorado and settle along the front range causes increased cars on the roads, adding to air pollution, longer travel times, and more stress getting around town."

"TRAFFIC. Lack of adequate roads and effective alternate transportation is negatively affecting our quality of life."

Traffic issues and pollution; sky high population growth and no apparent planning from county and city officials."

"Too much car and truck traffic which is dangerous for pedestrians, bicyclists, makes for bad air quality and causes stress from noise pollution."

"Transportation issues: high traffic density and availability of public transportation."

"Stress from a growing population and crowded roads/highways."

"Congested traffic, Our roads are very dangerous. Fort Collins desperately needs to find real solutions to this issue. Possibly crosstown freeways or byways."

"Increased traffic -- air pollution, road congestion, distracted driving."

"Increasing injury from vehicle accident due to population growth (increasing number of cars on roads) with little improvements to or expansion of roadways."

"Not enough ways to access/ get around Fort Collins, so jammed roads causing additional vehicle pollution along with dangerous conditions for bikers/ pedestrians."

ALCOHOL & SUBSTANCE USE

116 mentions

Issues about substance use came up frequently in the open-ended responses. Of the 116 comments, 33 of them specifically mentioned marijuana as a concern. Responses included topics related to treatment options, youth substance use, and the cultural acceptance of marijuana use and alcohol in the community.

Selected comments regarding alcohol and substance use:

"Alcohol + substance abuse. Marijuana + tobacco smoking"

"Addressing all mental health issues including depression, excessive stress, and those that lead to destructive tobacco, drug, and alcohol usage."

"Our young being attracted to the use of drugs, cigarettes and other products which are harmful to their health."

"Legalized marijuana and it's prolific usage by age and location."

"Too many alcohol sponsored festivals/activities"

"We need more inpatient mental health facility capacity with enough beds for the communities population dealing with alcohol and drug addiction Detox + treatment"

"High substance use (marijuana and alcohol), increase in methamphetamine use"

"Too much beer emphasis and drunk people. Such as: after race parties held at breweries!!"

"Illegal drug use, legal drug abuse, mental illness, alcohol/nicotine use."

"Excessive marijuana use and increased incidence of homelessness and transients due to that. Pro-alcohol and drinking environment. Use of substances is socially acceptable and promoted in many community events."

POPULATION GROWTH

97 mentions

Comments about population growth were often linked to the traffic issue mentioned above as well as the strain on local resources, infrastructure, cost of living, and the current housing crisis. Some responses expressed negative views of population growth as it relates to taxes and free services.

Selected comments regarding population growth:

"Population growth and affordable housing"

"How to deal with raising population as folks move to Colorado."

"Town is growing faster than the infrastructure"

"Growing population in the US. Shortage of doctors/services"

"I feel overpopulation is a huge concern. Too many people are being allowed into our beautiful county. Problems such as water needs, pollution, disease and such are only going to get worse."

"Increased growth and associated health impacts like air & water quality."

"Population explosion causing unaffordable housing"

"Larimer County's growth is my largest concern. Limited resources such as water don't seem to limit the uncontrolled development. More people, more cars, more issues."

"My concerns are population growth and the determination in quality of life associated with it."

"The population boom in this area is also a huge concern and causes stress due to increased traffic and all that goes with that such as crowding, crime etc. Local government seems to be intent on building more and also raising taxes but not seeking to help those families that are unable to make ends meet with the cost of living rising so rapidly. This affects quality of life for all and definitely impacts health."

TOBACCO & VAPING

80 mentions

Respondents had concerns about smoking, tobacco use, and vaping in the community, and often mentioned a specific concern about youth tobacco/vaping rates.

Selected comments regarding tobacco and vaping:

"Smoking and cancers of all kind"

"Work on getting a better control of vaping devices being sold to our young people."

"Cigarette smoke, "juuling", and vaping smell are the most common concerns."

"The ease by which teens can obtain tobacco, vaping, alcohol and illegal drugs, including marijuana. It's far too prevalent!"

"Vaping is horrible, ban it!"

"Personally, I get annoyed by how many smokers live around me...having to open my windows to cool down the house during the Summertime (and having Asthma), I get frustrated that my health is somewhat out of my control."

"Vaping (people not recognizing the newly recognized health hazards)"

"People disregarding the "no smoking ban" in Old Town. It only seems to be enforced against our residents that are homeless."

"Our young being attracted to the use of drugs, cigarettes and other products which are harmful to their health."

"Vaping and pot are huge issues in our schools and teenagers! Education does not seem to decrease the trend, maybe stricter laws could? These kids can get anything they want."

HIGH COST OF HEALTH INSURANCE

67 mentions

Many participants expressed concerns with the high cost of insurance (including premiums and deductibles), often mentioned in conjunction with the cost of health care services. Some commented on the affordability for those who do not qualify for Medicaid but still have limited income.

Selected comments regarding the high cost of health insurance:

"Cost of health insurance for those having to purchase it on the open market privately"

"Health Insurance Options & Affordability - Retirement is postponed because people can't risk losing health insurance. A catastrophic medical issue can bankrupt you!"

"Insurance for low income people/homelessness"

"Cost of care which goes hand in hand with cost of insurance"

"I cannot afford health insurance on my social security but am still looking into finding something to help if a catastrophe should happen."

"No affordable access to health insurance. Those who make "too much" don't have access to reduced cost services."

"Health insurance options are too confusing and often not sufficiently affordable."

"Cost of health insurance and healthcare, especially for seniors"

"Insurance is too expensive. Health Care is too expensive"

"Cost of health care + doctors' visits + dental work costs, of which all have increased dramatically. Health ins. hardly covers these charges. Premiums too high, considering how high the deductibles are now, Cost of dental work very expensive; dental ins. not paying for the cost"

YOUTH DATA SUMMARY

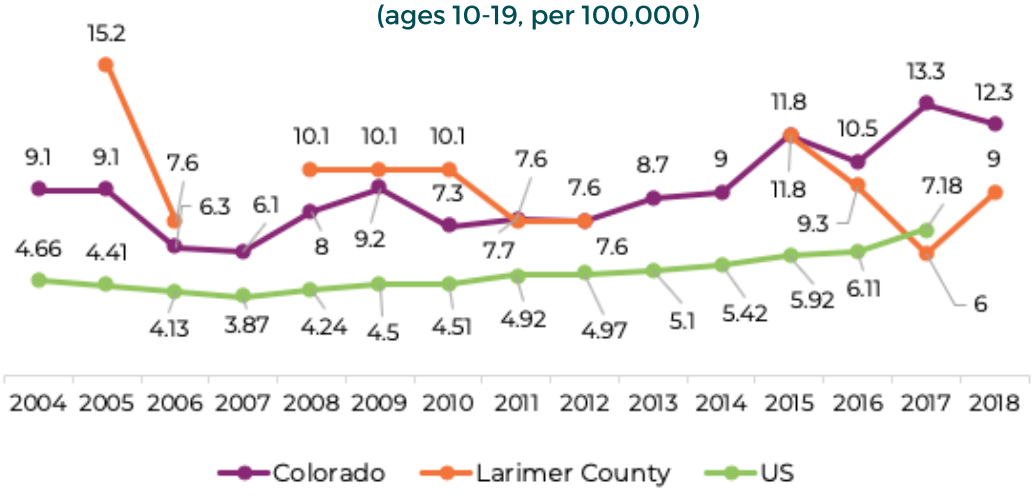
The following data summary includes information about the current health status of youth in Larimer County and across the state of Colorado. Topics covered in this report include suicide and mental health, sexual health, tobacco/e-cigarette use, substance use, healthy lifestyles, and vaccinations.

Data presented in this report comes from the Colorado Healthy Kids Survey of middle and high school students unless otherwise noted.

YOUTH SUICIDE RATES CONTINUE TO BE AN ISSUE.

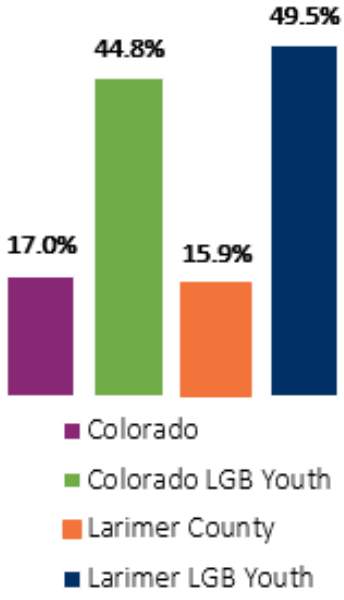
Suicide continues to be a leading cause of death for US teens. In the state of Colorado, the number of suicides per year is increasing over time for ages 10 to 19. From 2004 to 2018, the age-adjusted rate of suicide has increased from 17.0 suicides to 21.2 suicides per 100,000 population (25%).

Crude Rate of Youth Suicides Per Year
(ages 10-19, per 100,000)



Counts of less than three are suppressed

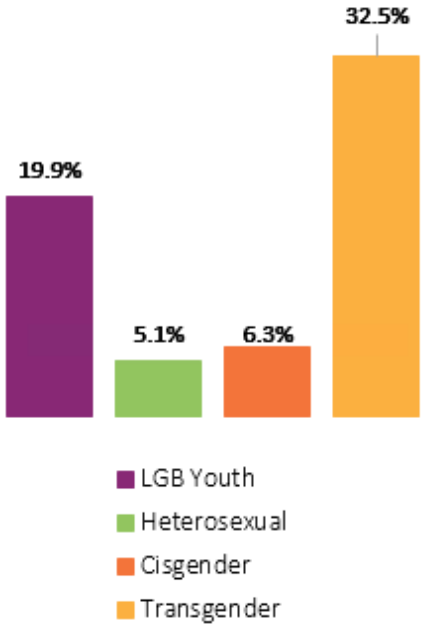
Youth who Seriously Considered Attempting Suicide in the Past 12 Months (2017)



In Colorado, LGB* youth are more than twice as likely to report that they considered suicide in the past 12 months. Among transgender youth, 58.9% had seriously considered suicide in the past 12 months. 32.5% of transgender youth reported attempting suicide in the past year compared to 6.3% of cisgender students.

From 2004 to 2018, the Larimer County crude suicide rate for youth aged 10-14 years was 4.3 and 10.9 for youth aged 15-19 years, Although the number of suicides per year is increasing for the state of Colorado, suicides in Larimer County are not increasing at the same rate.

Colorado Youth who Attempted Suicide in the Past 12 Months (2017)



*Healthy Kids Colorado Survey asks to self-identify as gay, lesbian, bisexual, or heterosexual. They also ask students to self-identify as transgender or cisgender. 97.5% identified as cisgender and 1.1% identified as transgender

RATES OF SEXUALLY TRANSMITTED INFECTIONS ARE RISING.

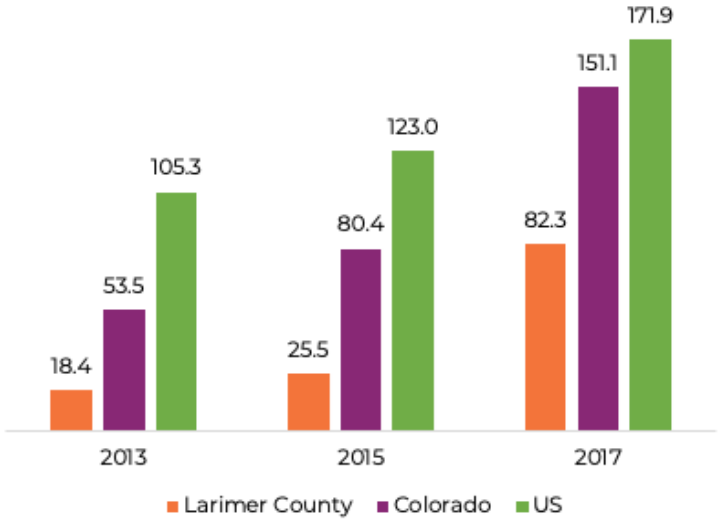
Rates of STIs are increasing across all age groups in both the United States and in Colorado. In the US, from 2017 to 2018, there has been a 32.5% increase in syphilis (all stages), 6.4% increase in chlamydia, and a 3.3% increase in gonorrhea.STI data comes from the Colorado Department of Health and Environment (CDPHE).

The 2017 Healthy Kids Colorado Survey found that students are less likely to be having sex compared to previous years, but most sexually active teens use condoms, however that rate has decreased from 64% to 59% of high schoolers using a condom. The use of long-acting reversible contraception (intrauterine devices, subdermal implants, and injections) is increasing which is helpful for preventing pregnancy, but does not protect from STIs.

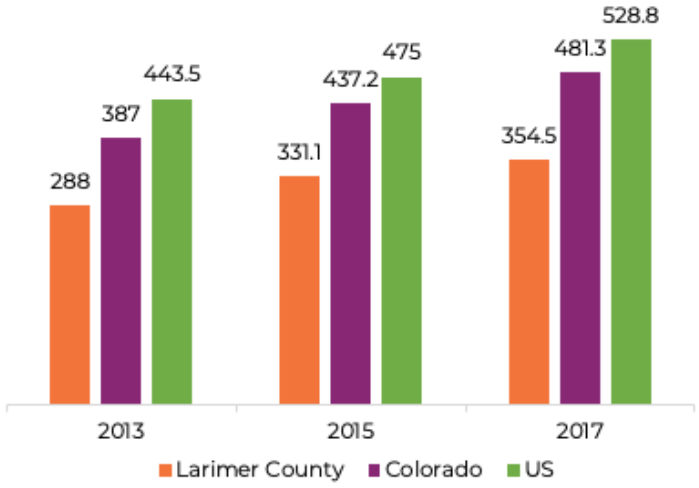
LGBT teens report much higher rates of abuse by a partner (18.5% for LGB students, 8% for heterosexual).

Federal Art Project, S. The enemy is syphilis Enlist employees in a campaign against it. Chicago Illinois, None. [Chicago: illinois wpa art project, between 1936 and 1940] [Photograph] Retrieved from the Library of Congress, https://www.loc.gov/item/98507183/.

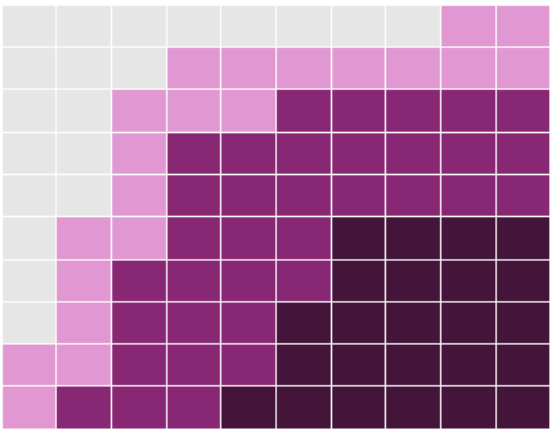
Rates of Gonorrhea (All Ages) per 100,000



Rates of Chlamydia (All Ages) per 100,000



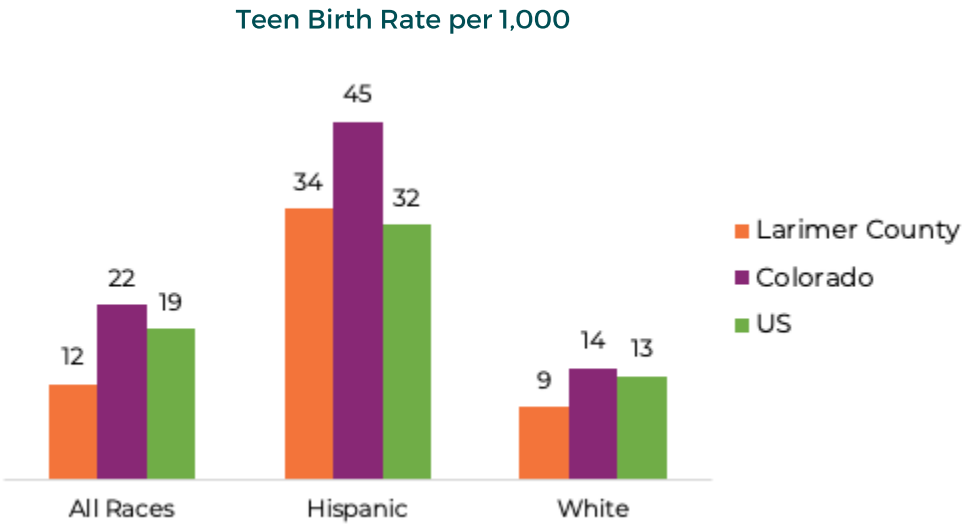
Of the Reported 26,995 Chlamydia Cases in Colorado in 2017:



20%
of cases ages 25 - 29

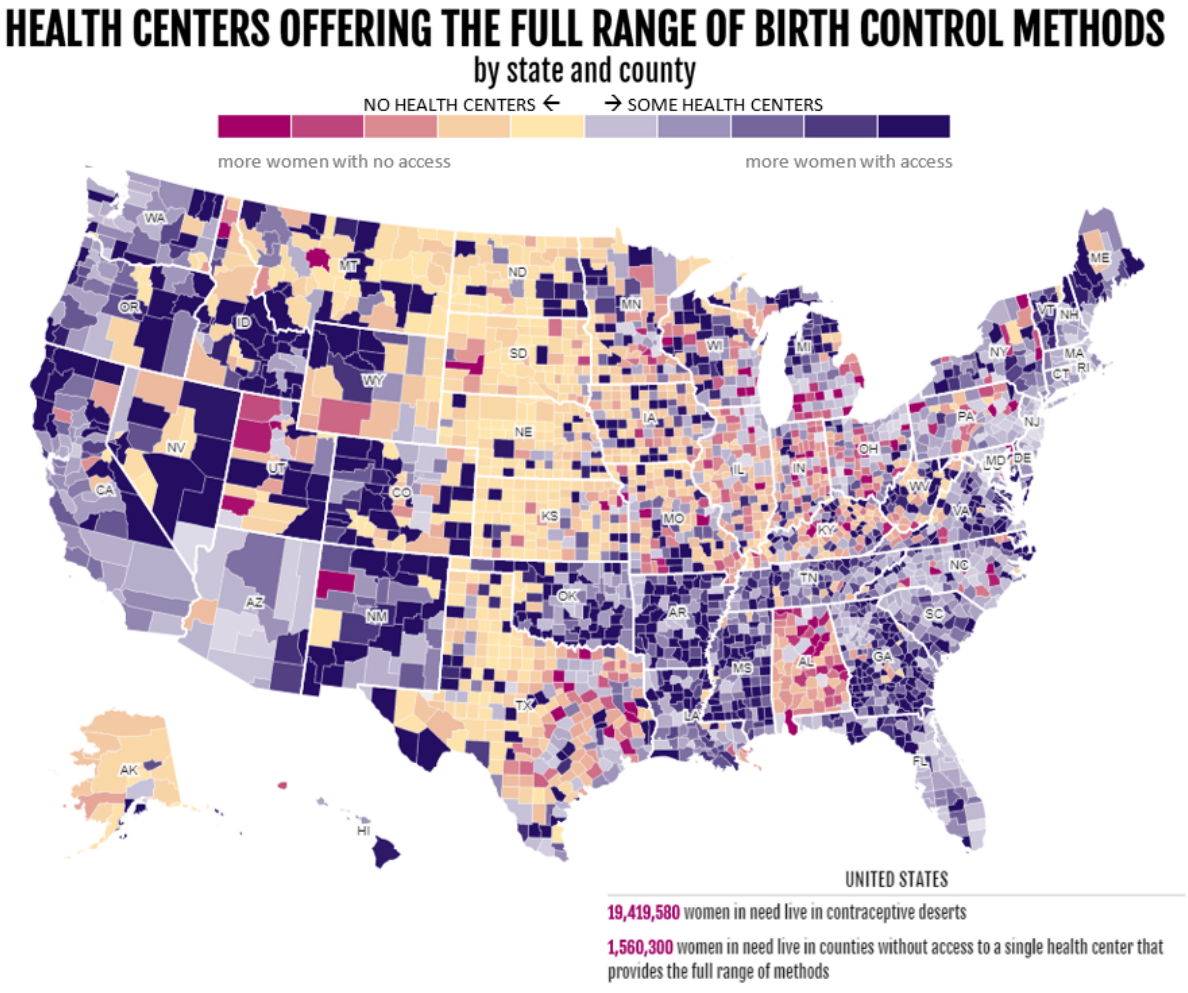
36%
of cases ages 20 - 24

24%
of cases ages 15 - 19



The teen pregnancy rate is decreasing in Colorado but disparities remain among different groups. In Larimer County, the teen birth rate (ages 15-19) is 12 per 1,000 births compared to the teen birth rate for Hispanics, which is 34 per 1,000 births. This data comes from CDPHE.

More than 19.5 million women of reproductive age in the US are in need of access to publicly funded birth contraception options and about 30% of Colorado women (ages 15-44) are in need of publicly funded contraceptive services and supplies.

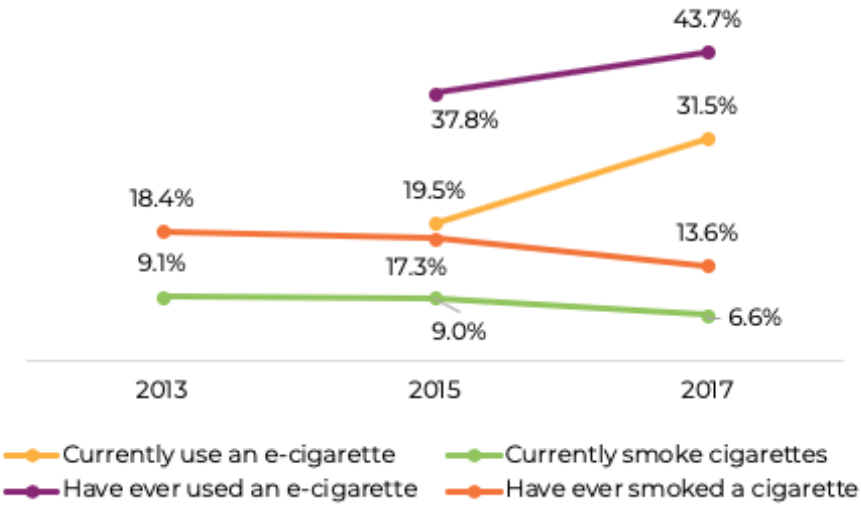


Data from: U.S. Census Bureau, Guttmacher Institute, Centers for Disease Control and Prevention, Federal Communications Commission, and a compilation of data about health centers managed by Power to Decide

**Health centers that provide full range of methods are those that offer IUDs, implants, and most other FDA-approved methods such as birth control pills, the shot, the ring, the patch, cervical caps, diaphragms and emergency contraception on site.*

YOUTH VAPING IS INCREASING.

Larimer County Youth Cigarette Smoking and Vaping Trends (Healthy Kids Survey)



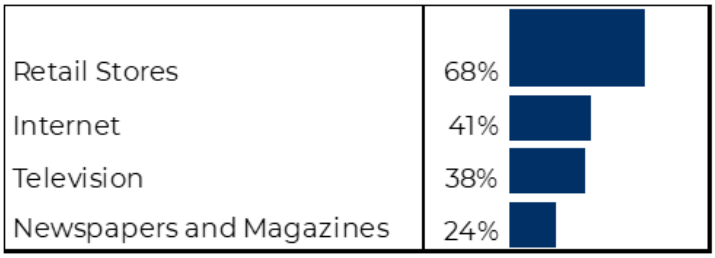
*E-cigarette questions were added to the 2015 Healthy Kids Survey

The 2017 Healthy Kids Survey indicates that one in four teens in Colorado report use of e-cigarette or other vapor device which was the same as 2015. More teens are using e-cigarettes than regular cigarettes (only 14% reported use).

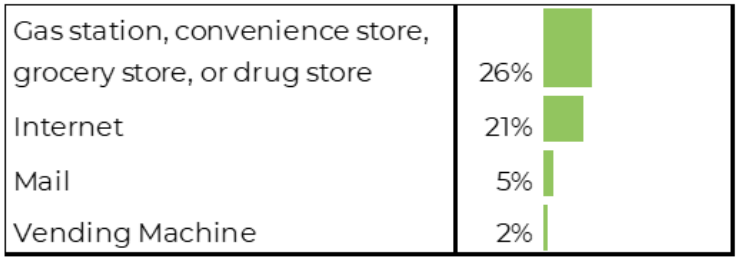
Larimer County has had the greatest increase in vaping use in Colorado with a 12% increase from 2015. The current use for 2017 is 31.5% which is higher than the state average.

There is moderate evidence that suggests using e-cigarettes has been shown to increase the likelihood that youth will smoke cigarettes. In the 2019 study by Berry et al, it was found that US youth are four times more likely to try cigarettes and three times more likely to currently use cigarettes if they had previously used e-cigarettes. Despite these findings, there has been a consistent accelerated reduction in youth and young adult smoking prevalence as vaping has increased

Where young people are most likely to see e-cigarette ads (US)



Where Larimer County youth bought their electronic vapor products



Nationally, there is a growing trend in reported prevalence of marijuana use in e-cigarettes for youth. In 2018, 53.5% of current e-cigarette users, reported ever using marijuana in e-cigs, an increase from 39.5% in 2016. The 2017 Healthy Kids Colorado Survey found that among students who used marijuana in the past 30 days, 20.3% vaporized it. Larimer County was similar with students reporting that 19.5% of students who used marijuana had vaporized it.

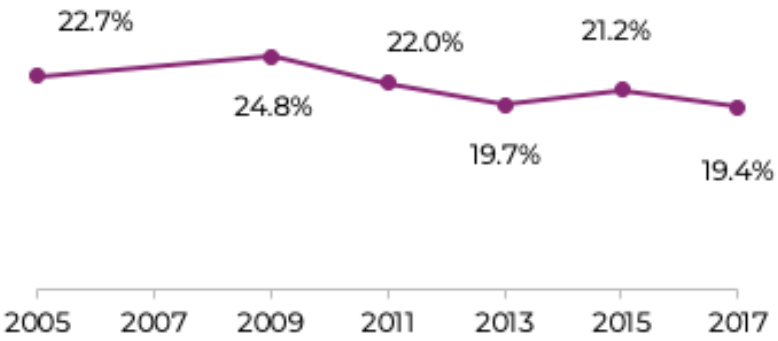
E-Cigarette use has also been related to severe respiratory diseases, with more than 2000 vaping-related lung injury cases reported and 47 deaths confirmed as of November 20, 2019; approximately 77% of cases were in people with a history of vaping tetrahydrocannabinol-containing products.

OTHER SUBSTANCE USE FOR YOUTH REMAINS UNCHANGED.

19%

of youth in Colorado reported using marijuana at leas once in the past 30 days and 19.6% of youth in Larimer County reported marijuana use.

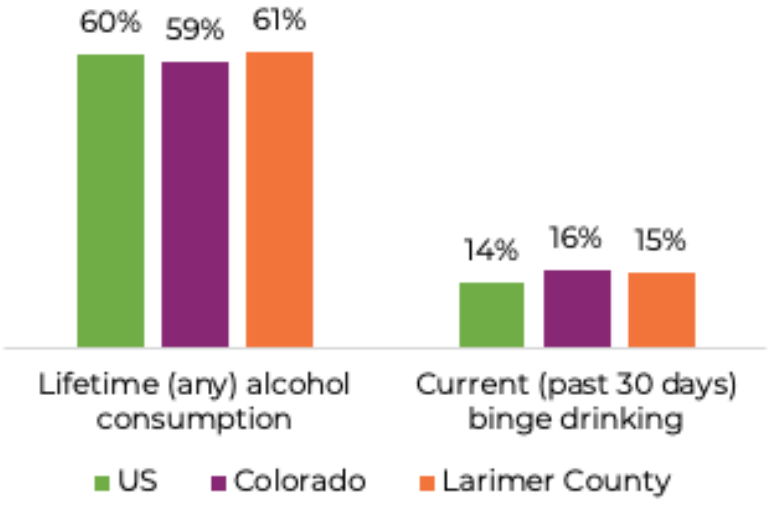
Colorado High School Student
Past 30 Day Marijuana Use



Rates of drinking among youth in Colorado have remained stable since the 2013 Healthy Kids Colorado Survey. Rates of using illicit drugs such as cocaine, heroin, methamphetamine, and ecstasy have declined.

The 2017 Healthy Kids Survey reports that 28.7% of Colorado youth reported drinking at least one alcoholic beverage in the last 30 days. Larimer County is slightly above the state average, with 29.1% of youth reporting having had at least one drink in the past 30 days.

Alcohol Use
(Healthy Kids Survey)



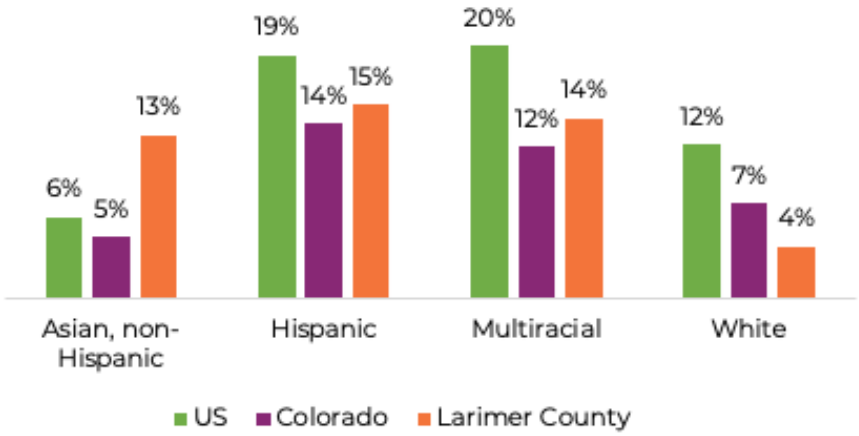
COLORADO YOUTH REPORT STRONGER INDICATORS FOR HEALTHY LIFESTYLES.

In 2017, 35.2% of Larimer County youth attended physical education (PE) classes on one or more days in an average week when they were in school compared to 43.7% of Colorado youth attendance.

50.4% of Larimer County youth report meeting recommended guidelines to be physically active for a total of at least 60 minutes per day on five or more days of the week. For LGB youth in Larimer County, only 32.5% report exercise on five or more days.

Youth Obesity (at or above 95th percentile for BMI)

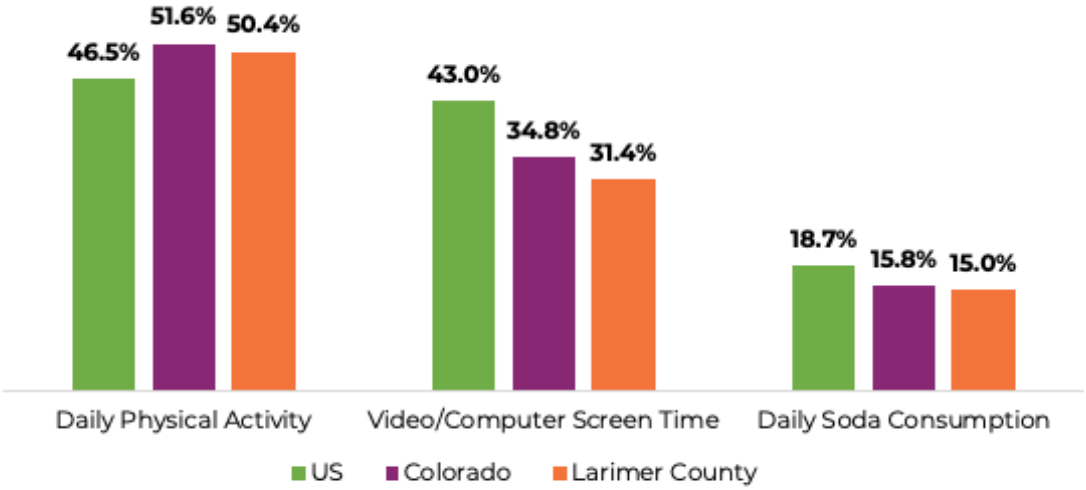
Youth Obesity Based on BMI by Race/Ethnicity (Healthy Kids Survey)



The Healthy Kids Colorado Survey reports **52.2%** of Colorado youth have at least three hours of screen time on an average school day.

9.6% of Colorado youth are obese compared to 14.8% of youth nationally (defined as BMI at or above the 95th percentile). Only 6.4% of Larimer County youth are obese overall, but that number more than doubles for non-white Hispanic youth.

Physical Activity and Nutrition

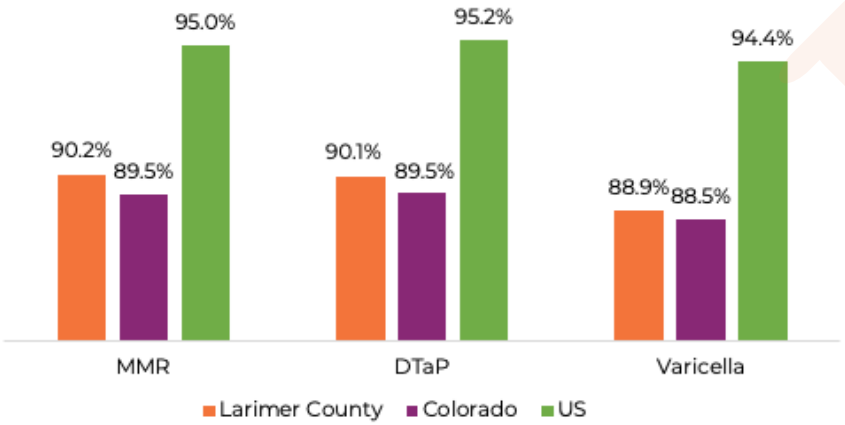


"Physical Activity" defined as at least 1 hour per day for at least 5 days per week
"Video/Computer Screen Time" defined as at least 3 hours per day
"Soda Consumption" defined as at least 1 soda in the past 7 days

VACCINATIONS ARE LOW IN COLORADO.

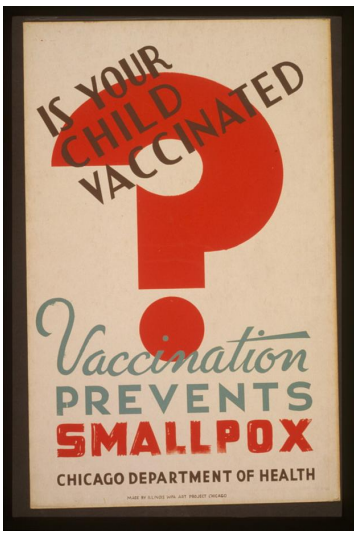
For the 2017-2018 school year, the estimated vaccination coverage for Colorado ranks **49th out of 50** for MMR, DTaP, and Varicella.

2017/2018 Vaccination Rates in Kindergartners



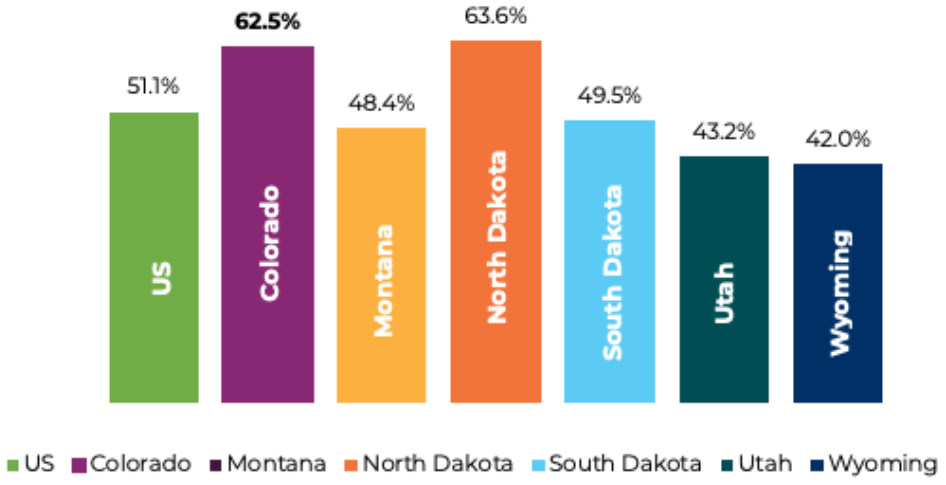
In the most recent 2019 Gallup Poll, 84% of Americans say vaccinating children is important, which is down from 94% in 2001. Among parents of children younger than 18 years old, 77% feel vaccination is important in 2019, down from 92% in 2001 (15% difference).

Colorado and Larimer County did not meet the Healthy People 2020 (HP2020) objectives for school immunization coverage (95% of kindergartners appropriately immunized for DTaP, polio, MMR, hepatitis B and varicella) for all required vaccines. Vaccine data is collected by local and state health departments, and reported by the Centers for Disease Control.



Federal Art Project, S. Is your child vaccinated Vaccination prevents smallpox - Chicago Department of Health. Chicago Illinois, None. [Chicago: illinois wpa art project, between 1936 and 1941] [Photograph] Retrieved from the Library of Congress, https://www.loc.gov/item/98507705/.

Region VIII Estimated HPV Up to Date 2018 Vaccination Coverage, Ages 13-17



In 2018, an estimated 62.5 % of adolescents in Colorado, aged 13 – 17 years have received the HPV UTD ("up to date" includes those with three doses and those with 2 doses) vaccination compared to 51.1% overall in the US.

SOURCES:

Berry, K. M., Fetterman, J. L., Benjamin, E. J., Bhatnagar, A., Barrington-Trimis, J. L., Leventhal, A. M., & Stokes, A. (2019). Association of electronic cigarette use with subsequent initiation of tobacco cigarettes in US youths. JAMA network open, 2(2), e187794-e187794.

Center for Disease Control and Prevention SchoolVaxView

Center for Disease Control and Prevention Fatal Injury Data

Center for Disease Control and Prevention Reproductive Health

Colorado Health Institute

Colorado Department of Health and Environment Healthy Kids Survey

Colorado Department of Health and Environment School and Child Care Immunizations

Colorado Department of Health and Environment Violent Death Reporting System

Colorado Department of Health and Environment STI Epidemiology Reports

County Health Rankings & Roadmaps

Dai, H. (2019). Self-reported marijuana use in electronic cigarettes among US youth, 2017 to 2018. JAMA.

Data Resource Center for Child & Adolescent Health

Gallup Poll

Larimer County Department of Public Health and Environment

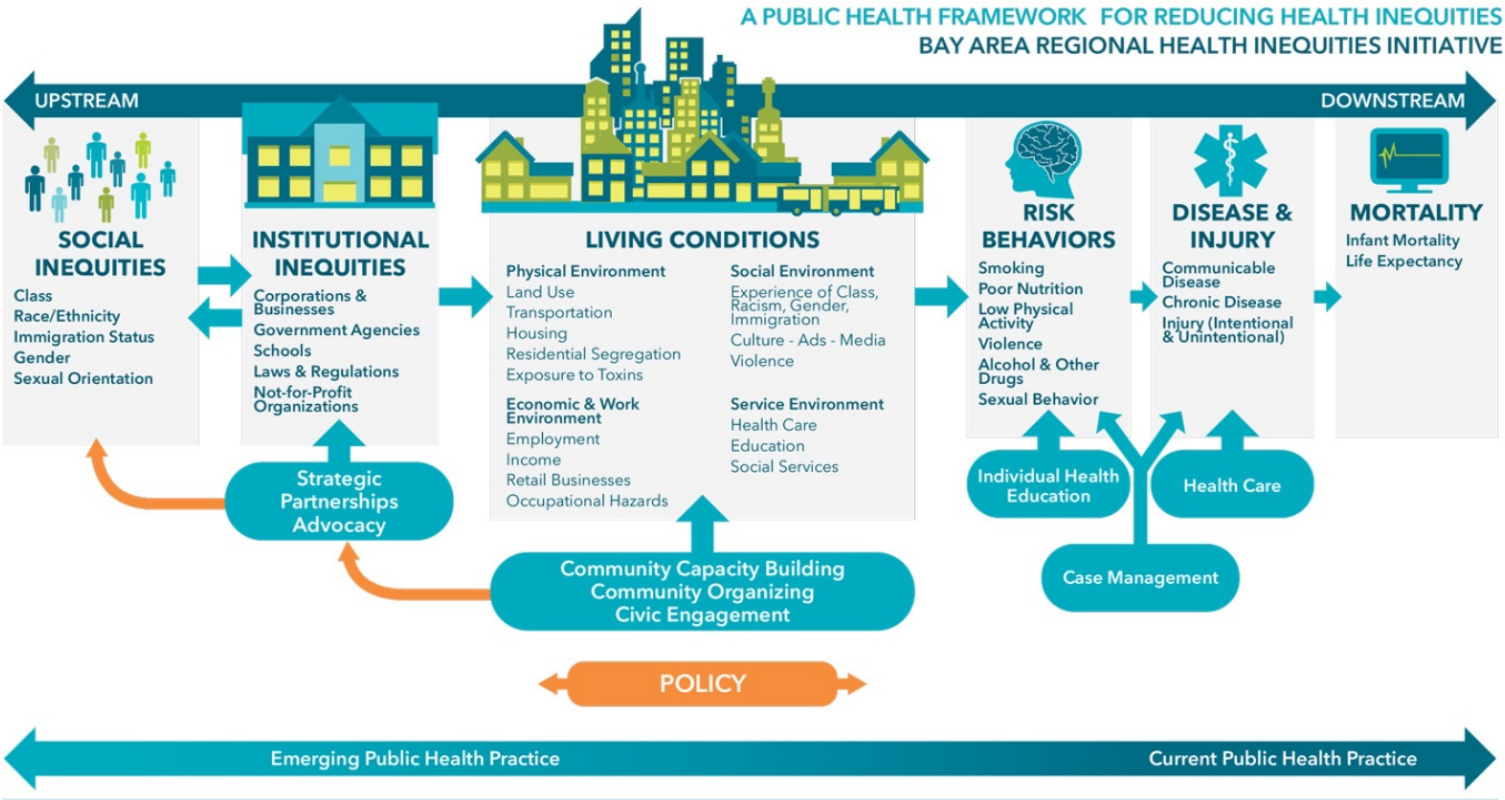
Levy, D. T., Warner, K. E., Cummings, K. M., Hammond, D., Kuo, C., Fong, G. T., ... & Borland, R. (2019). Examining the relationship of vaping to smoking initiation among US youth and young adults: a reality check. Tobacco control, 28(6), 629-635.

Morbidity and Mortality Weekly Report: National Immunization Survey- Teens

Truth Initiative E-Cigarette Fact Sheet

Power to Decide

SOCIAL DETERMINANTS OF HEALTH IN LARIMER COUNTY



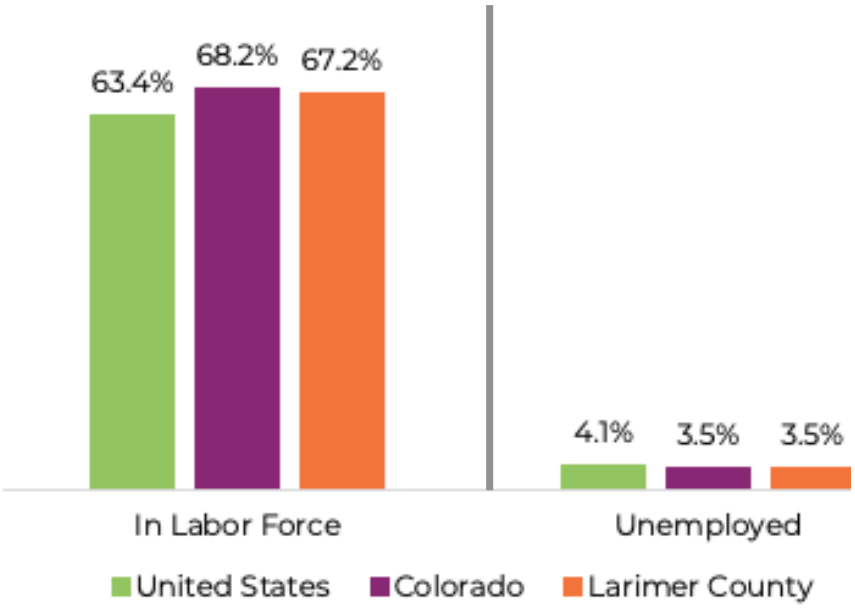
As public health has advanced, researchers and public health practitioners have drawn increasing attention to the social determinants of health (SDoH) – the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Public health organizations including the World Health Organization, the Centers for Disease Control, and other non-profits, foundations, and health care settings have adopted a SDoH framework to understand and affect health at the most upstream source. SDoH encompass a broad range of topics and metrics. The Health District of Northern Larimer County reviewed SDoH frameworks from eleven sources to determine the most common indicators used to assess community-level SDoH. From there, the Health District staff selected those that were most relevant to Larimer County to best understand the determinants that shape health in Larimer County.

ECONOMIC CONDITIONS

EMPLOYMENT STATUS:

Unemployment effects an individual as well as the individual's family, manifesting itself both in physical health and mental health conditions. The stress and psychological toll that comes with being unemployed can lead to feelings of depression and dissatisfaction with life. A 2011 study found that those who had been employed for less than a year were more likely to report lower mental health quality (Pharr, Moonie, & Bungum, 2011). During the Great Recession of 2007-2009, the rate of suicides increased (Margerison-Zilko, Goldman-Mellor, Falconi, & Downing 2016), primarily among working-age men who were most effected by layoffs.

A study of self-reported health found socioeconomic status to be the strongest predictor of health quality (Meyer, Castro-Schilo, & Aguilar-Gaxiola, 2014). Consistent employment allows for many benefits, including improved mental health, paid sick leave, paid maternal leave, and access to employer offered health insurance. Access to care and insurance coverage through an employer increases rates of healthcare access, leading to improved health outcomes.



The chart on the left depicts the proportion of the population eligible for and seeking employment, as defined by the Bureau of Labor, in the US, in CO, and in Larimer County.

Unemployment rates, which depicts the proportion unemployed among those in the labor force, is also depicted in this graphics. Unemployment rate are considered a standardized measure of employment for a community.

INCOME AND POVERTY:

Income, occupational status, and education all contribute to the definition of socioeconomic status (SES); a person's place on the hierarchy of social and economic attainment (Barr, 2014). Socioeconomic status affects almost all aspects of life, including access to healthcare, food and other resources that contribute to healthy living. Higher SES increases access to luxury items such as gym memberships and equipment for recreational opportunities. Lower socioeconomic classes experience higher rates of obesity because of decreased access and affordability of healthy food. Neighborhoods with concentrated poverty and long-standing racial residential segregation are more likely to be exposed to physical and social hazards (e.g., air pollution, crime, healthy food) (Braveman, 2014). It is important to remember that the relationship between SES and health is not just dependent on income, but this factor in combination with others such as education, race, and others.

People who live in neighborhoods with low overall socioeconomic statuses are more likely to report mental illness and have lower life expectancy. The stress generated from being unable to pay bills or afford food often contributes to higher rates of depression (Belle, 2003) in these populations. A 2016 study by Massachusetts Institute of Technology (MIT) found that the richest 1% in the United States had an average life expectancy almost fifteen years greater than the poorest 1% (Chetty, et al. 2016). These inequalities due to differences in socioeconomic status have been increasing since 1980 (Williams, 1999). Socioeconomic status predicts variation in health outcomes among minority and white populations and explains the racial differences in health.

The United States Department of Health and Human Services publishes yearly poverty guidelines based on the number of persons in the household (2020). For a four person household in the contiguous forty-eight, a household income below $26,200 would register as below the poverty line. Various forms of social assistance, such as Supplemental Nutrition Assistance Program (SNAP) and free or reduced lunch programs utilize such guidelines to determine cut-off points for assistance. As of November 2019, roughly 17 percent of Americans, or fifty-six million people, lived with an income less than 125 percent of the federal poverty line (US Census, 2019).

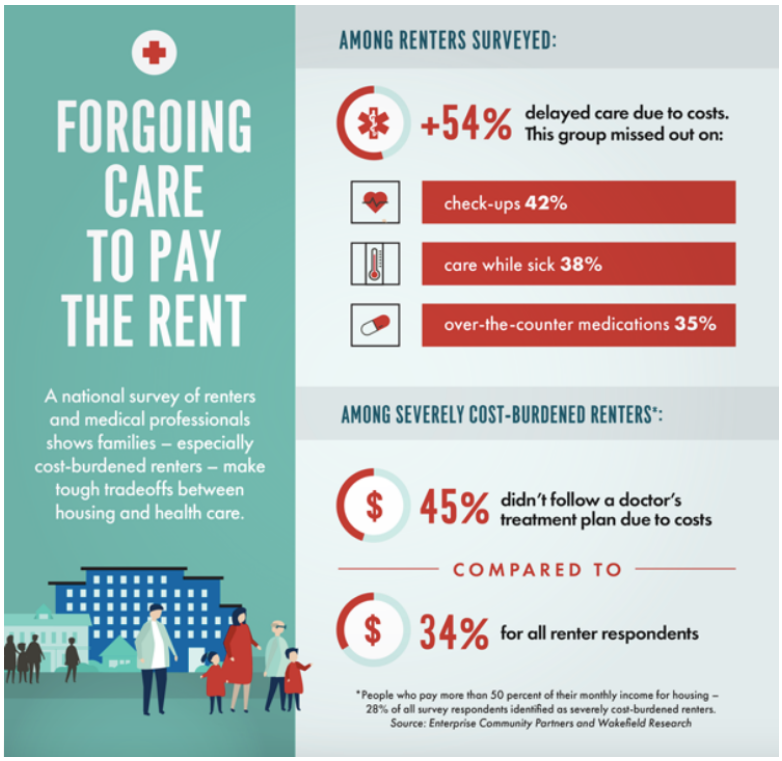
Livable wage describes either the hourly pay rate or yearly income required for an individual or family to live without debt in a specific geographic location. Livable yearly incomes in the United States vary from a high of $136,437 in Hawaii to $58,321 in Mississippi. MIT calculates a living wage based on household size and geographic location. A livable wage in Fort Collins for an individual with no children is $12.84 an hour, or $26,700/year; while a single adult with two children would need to earn $31.49, or $65,500/year while working full-time to provide an adequate life. Currently, minimum wage in Colorado is $12.00 an hour.

HOUSING AND HEALTH:

Families and individuals who must spend over a third of the household income on housing often suffer adverse physical health effects. The quality, affordability, accessibility, safety, and stability of housing directly affect a person's opportunity to live a healthy life. Spending the bulk of one's income on housing and other costs of living leaves little money for healthy eating and access to health care. A study of data from the National Survey of American Families found that housing instability was positively correlated with lacking a usual source of care, as well as postponing medical care and medications (Kushel et al. 2006). When people are forced to choose between paying rent and meeting other needs like medicine, utilities or food, most prioritize housing above health care. In a recent survey conducted by Enterprise Community Partners, they found that 54% of renters with household incomes under $50,000 delayed care due to costs.

Multiple Dimensions of Housing Insecurity

Adapted from Colorado Health Institute: https://www.coloradohealthinstitute.org/research/vision-housing-security-health-and-opportunity



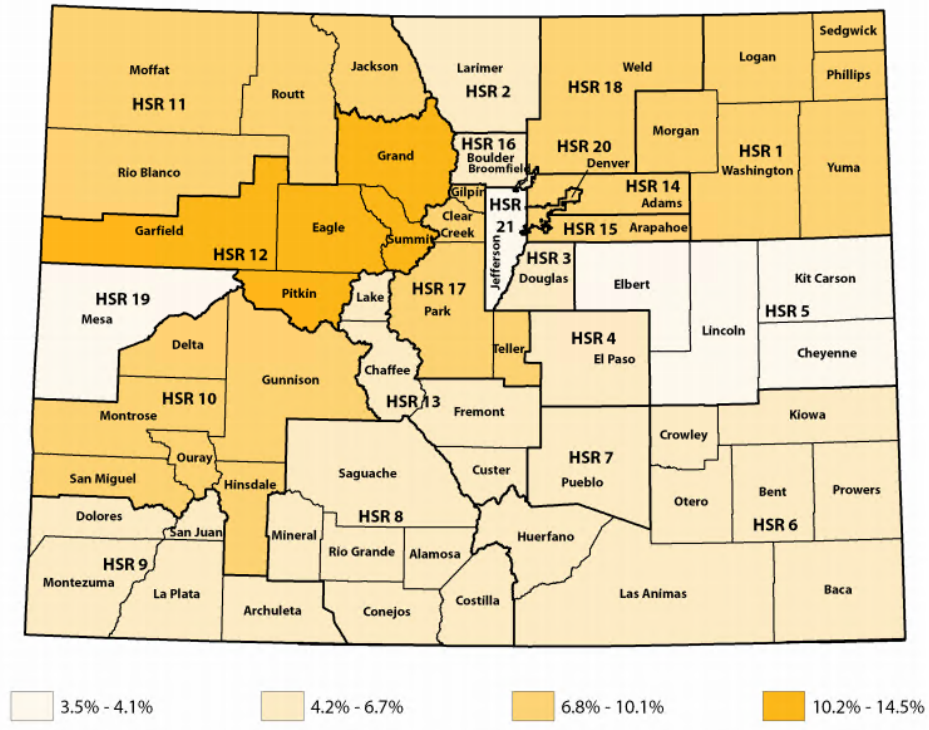
Housing cost burdened describes families or households that pay more than 30% of their income towards rent; those spending more than 50% are considered severely burdened as defined by the US Department of Housing and Urban Development (HUD). Of those in the lowest 20% of income in the United States, 80% are considered housing cost burdened. In Colorado, 26% of white Coloradoans live in households that are cost burdened; among African Americans it is 39%.

Colorado currently has the 14th highest rate of housing cost burden in the US.The average price of a home in Colorado has increased 77% in the last decade, with the median income only increasing by 4.5%.

Approximately 34% of households in Larimer County are housing cost-burdened. In addition to experiencing cost burden, approximately 32% of Larimer County residents are living in suboptimal housing - or housing that is of poor quality that may lack plumbing, a functional kitchen, or be too crowded creating unhealthy living conditions.

In addition, some people in Larimer County have no housing at all. A 2019 point in time study estimated 509 people experiencing homelessness in Larimer County. The Colorado Health Access survey also estimated that approximately 6% of Larimer County residents are housing unstable. Young people 24-39, people of color, and immigrants are most likely to experience housing instability.

HOUSING INSTABILITY (2019 CHAS)



The 2019 CHS found that 6.5% of adults in Larimer County had been worries or stressed about paying their rent or mortgage in the past year. The survey also found that 6.9% had actually been unable to pay all or part of their rent or mortgage in the past three months.

HEALTH AND HEALTH CARE ACCESS

HEALTH INSURANCE STATUS:

8.0%
uninsured 18 to 64
in
Larimer County

6.5%
uninsured 18+
in
Larimer County

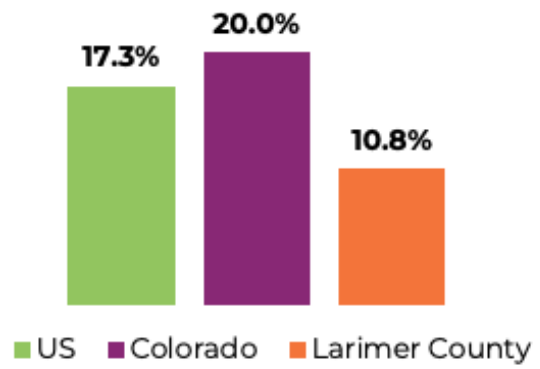
Health insurance status can impact the type of care and timing of care received. For example, because of the common delay in receiving cancer screenings, uninsured adults are more likely to be diagnosed with late-stage, fatal cancers and melanomas. Findings show that for five relatively common chronic conditions (diabetes, cardiovascular disease, end-stage renal disease, HIV, and mental illnesses), uninsured patients have worse clinical outcomes, as a result of less frequent screenings, less adherence to medication, and beginning care at a later stage than their insured counterparts (Kilbourne, 2005). Survival analysis of the third National Health and Nutrition Examination Survey revealed that the uninsured were 80% more likely to die than insured participants. After adjustment for additional variables that could confound the true relationship (such as age, education, body mass index, etc), those who were uninsured were still 40% more likely to die than those with insurance (Wilper et. al, 2009).

Health insurance coverage rates vary along demographic lines. Prior to the Affordable Care Act, uninsured rates in the United States ranged from a low of 13 percent for non-Hispanic whites to a high of roughly 33 percent of Hispanic people living in the United States (Sohn, 2017). Reasons for differences in insurance rates include likelihood to hold a job in which the employer supplies coverage as well as differences in socioeconomic status. Those who are uninsured are less likely to receive preventative care and screening services in a timely manner, leading to adverse health outcomes. Women without private health insurance are 73 percent less likely to access mammography services and fifty-seven percent less likely to receive a Pap test, both markers of regular preventive care for women(Kilbourne, 2005).

ACCESS TO CARE:

The decision to forego health care, including preventative care, is influenced by multiple factors, including health insurance status, poverty status, and employment status. Barriers to healthcare often include uninsured status or high premiums that prevent members from accessing adequate and timely care. CDC States that in the United States in 2018, 4.8 percent of people “failed to obtain needed medical care due to cost” . Those who put off medical care are most likely to also put off dental care (9.5 percent of the US population, 2017).

Adults without a Regular Source of Care



Those who put off health care due to cost are more likely to suffer adverse outcomes from a variety of conditions, including cancer, cardiovascular disease, and diabetes. Those who have a regular source of care, typically a primary care physician, are more likely to receive preventative screenings as well as being 2.8 times more likely to have received a flu shot in the previous year (Blewett, Johnson, Lee, & Scal, 2008).

Two decades of data from the Centers for Disease Control found that non-receipt of medical care due to cost varies by demographics. In 2017, it was reported that African Americans were most likely to put off receiving health care. Increased educational attainment resulted in increased odds of receiving care, with those who had attended college being six percent less likely to forgo medical care. Similarly, those below the federal poverty level were more than three times as likely to not receive medical care than those who earned 400 percent of the poverty level cutoff. Insurance also plays a significant role, with roughly seven percent of insured persons forgoing health care, and 28 percent of uninsured individuals refraining from care due to cost.

SOCIAL/ENVIRONMENTAL

TRANSPORTATION:

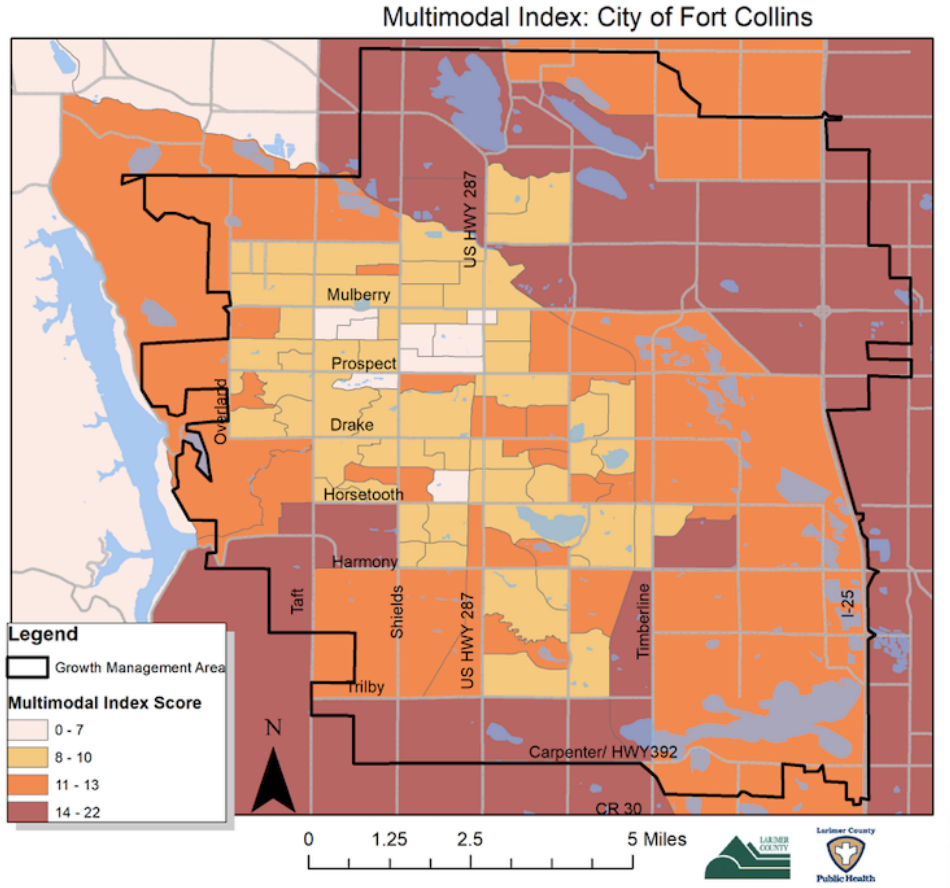
Access to sustainable public transportation system supports and provides residents an inexpensive, reliable and safe option for walking, bicycling and public transit. Transit options can increase access to grocery stores, health care, recreational opportunities and potentially better paying jobs and thus, reducing health inequities. Any type of active transportation can promote health by increasing levels of physical activity, lower blood pressure, decrease risk of heart disease or diabetes, as well as relieve mental stress (Bay Area Regional Health Inequities Initiative, 2015).

One study of transit-associated walking times found that Americans who use transit spend a median of 19 minutes daily walking to and from transit (Besser & Dannenberg, 2005). Access to public transportation is especially important for promoting active lifestyles in low-income and minority groups. Entrenched systems of historical disadvantage for low-income and minority neighborhoods perpetuate inequities if public transportation is unavailable, expensive, or unreliable (Woolf & Braveman, 2011).

As more commuters rely on public transit, the environment will benefit with less greenhouse gases, and air pollution. Expanding on the capacity and infrastructure of public transit results in improved health outcomes, traffic management, environmental protection, and climate change mitigation (Giles-Corti, et al, 2010).

In Larimer County, 24% of respondents to questions about ease of public transit “did not know”, indicating that about three-quarters of adults had some experience with public transit. Of those, 45% agreed that it is easy to ride public transit in my community and 37% agreed that it is possible to get to many places I need to go by public transit.

The Larimer County Department of Health and Environment, along with supporting agencies including the Health District of Northern Larimer County, created a multimodal index (MMI) of the city of Fort Collins to describe differences in transit access across different regions in the city. Regions with higher scores indicated higher need areas – or areas that currently have less transit access.



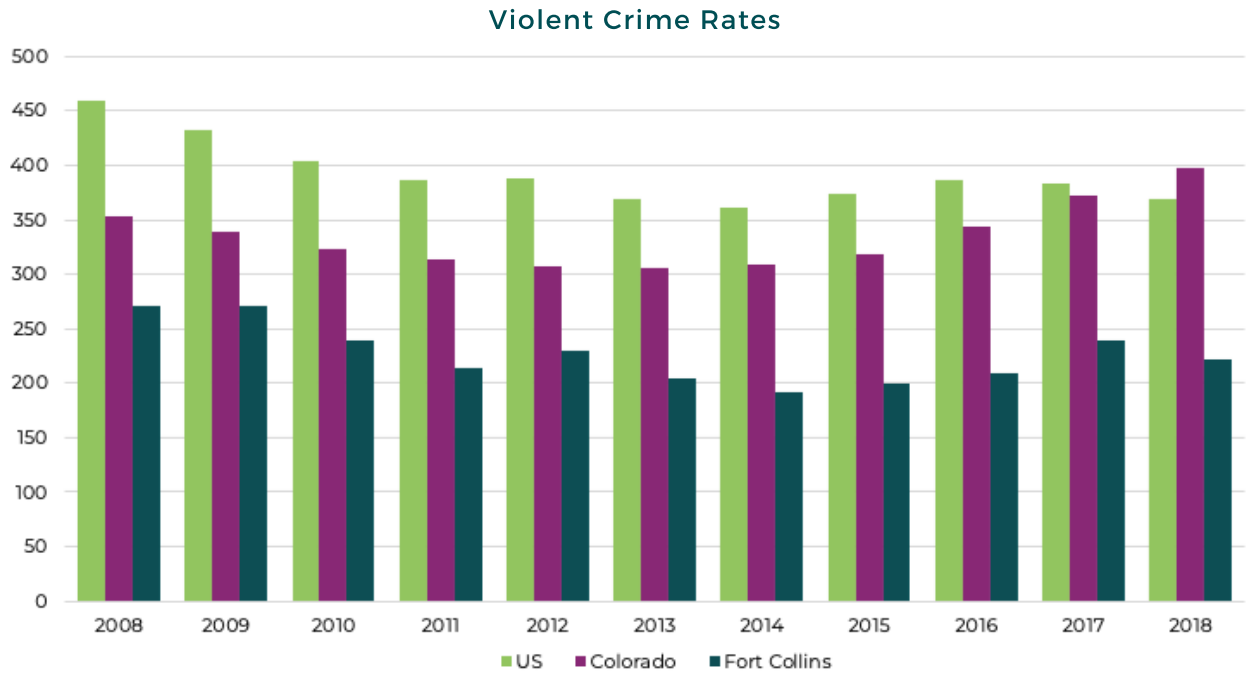
The index displays the availability of the non-motorized (i.e. bike trails, sidewalks) and bus networks within the city. Scores are made up of the following through categories:

- **Health Equity** - Households with children, households with older adults, households with a person who has a disability, households under Area Median Income, households with residents who did not receeive a high school diploma or equivalent
- **Crashes** that resulted in a fatality, serious injury, or included a bicycle and/or pedestrian
- **Proximity to Active Transportation** - presence of transit stops, transit routes, bicycle lanes, sidewalks and trails, higher risk arterials.

The score displays a scale of the MMI's total for the three categories described above. A low score (0-7) indicates more and safer options available in the non-motorized and bus networks and a high score (14-18) indicates fewer options. Tools like the MMI can help prioritize planning and development projects by incorporating different types of data into a single tool.

VIOLENT CRIME:

Although not traditionally considered a determinant of health, violent crime is a reality that affects the lives of many. Violence in a community causes stress and fear among residents as well as reduced trust (Garcia, Taylor, & Lawton, 2007). Reduced trust and feelings of safety discourages outdoor recreation including walking or cycling to work (Meyer, Castro-Schilo, & Aguilar-Gaxiola, 2014). Communities with lower neighborhood safety scored higher in obesity rates and average personal body mass index (BMI) (Brown, et. al, 2014). Increased levels of stress and fear as a result of increased violent crime rates have also been linked to increased blood pressures (James & Kleinbaum, 1976). Neighborhoods which have a higher crime rate are primarily lower socioeconomic status (Cooley-Strickland, et al, 2009).



The youth of a community are often the indirect victims of crimes and suffer negative outcomes from chronic exposure to violence in their communities, including heightened reported levels of distress and increased risks of anxiety disorders (Cooley-Strickland, et al, 2009). The disruptive nature of violence in a community can have a negative impact on the child's academic achievement and cognitive development. Furthermore, caregivers and parents who are faced with chronic, significant stress may be less able to provide adequate support for children under their care (4 Cooley-Strickland, et al, 2009).

ACCESS TO FOOD:

Food insecurity is defined by the USDA as households that "are uncertain of having, or unable to acquire, at some time during the year, enough food to meet the needs of all their members because they had insufficient money or other resources for food". While the Western United States historically has the lowest rates of food insecurity, 10.4 percent of households were food insecure in 2018 nationally. National food insecurity rates peaked at a high of 14.9% in the years following the 2008 Recession before beginning a steady decline that continues today. Families with children below the age of eighteen in the household are more likely to experience food insecurity and make up about half of the recipients of Supplemental Nutrition Assistance Program (SNAP) benefits (Nord, 2009).

Food insecurity must be considered in alignment with whether or not a person lives in a geographic area known as a food desert to understand access to food. Food deserts, often defined at a census tract level, are areas that provide low access to food for residents, generally due to proximity to food providers such as grocery stores. Those who live in food deserts may have to resort to purchasing food from stores with less nutritious food available, such as convenience stores and gas stations. Food deserts are more common in communities and neighborhoods comprised of primarily racial minorities. Access and availability of food stores are independently associated with neighborhood racial composition and poverty. One study found that even after controlling for neighborhood poverty, black and Hispanic neighborhoods had fewer supermarkets than white neighborhoods, and the supermarkets in those communities tended to be smaller (Nord, 2009).

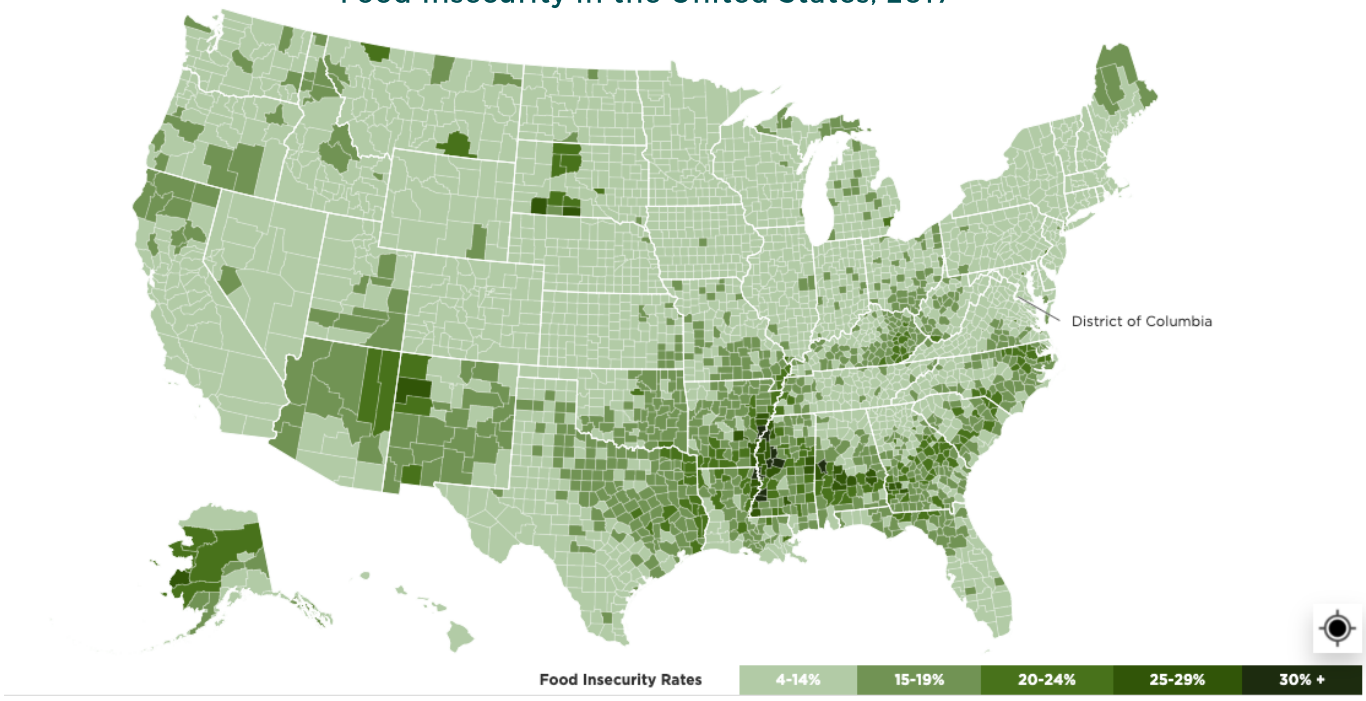
Families that do not have the means to afford higher quality, more expensive food are often forced to consume a less nutritious diet comprised of highly preserved food. A 2003 study of food insecurity in Appalachia found that the prevalence of obesity among food-insecure households was 13 percent higher than food insecure households (48.1% versus 35.1%) (CDC, 2006). Body mass indices were also higher in food insecure households, especially among women . BMI is considered an indicator of obesity which increases risk of mortality, hypertension, many types of cancer, and sleep apnea, among many other health consequences.

Food Insecure Households, 2018

United States	13%
Colorado	11%
Larimer County	12%

Food insecurity can have a marked effect on a child's early development. Children who do not have a guaranteed next meal are more likely to develop iron deficiency, report more stomach and headaches, as well as myriad behavioral concerns, including anxiety, suicidal symptoms, and lower educational achievement in school. A study of data from the National Survey of American Families found that those who are defined as food insecure are 42 percent more likely to be hospitalized (Kushel, et al, 2006). Food insecurity can also greatly affect mental health concerns by increasing rates of chronic stress (Gunderson & Ziliak, 2015). Data from the National Health and Nutrition Examination Survey indicates that those in food insecure households have two times the risk of developing diabetes than those in food secure households.

Food Insecurity in the United States, 2017

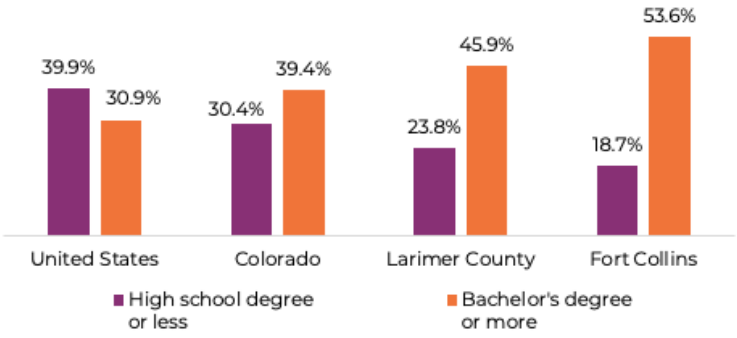


The 2019 CHS found that **8.5%** of adults in Larimer County had been worried or stressed about having enough money for nutritious meals in the past year.

EDUCATIONAL ATTAINMENT:

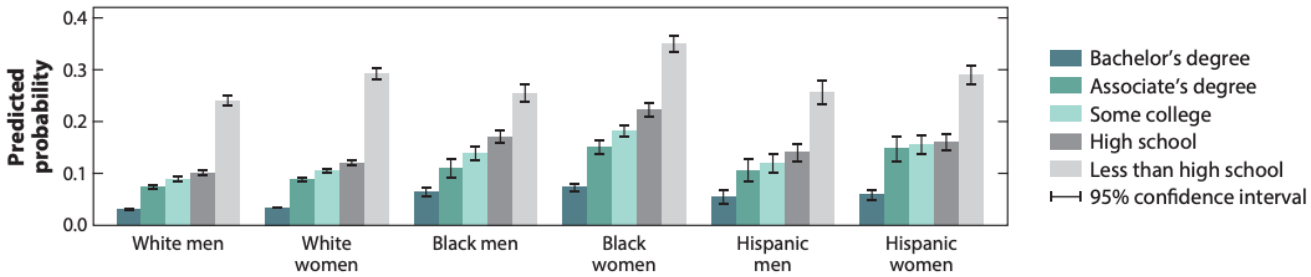
Educational attainment is a term used to define the highest level of education an individual has completed and is often directly linked to lifetime earning potential. With each additional year of compulsory schooling (high school and above), lifetime wealth increases by 15 percent (Oreopoulos, 2007). A Georgetown University study found that the difference in lifetime earnings between a person with a high school diploma and one who did not complete high school amounts to $331,000 (2014). As education attainment increases, access to health care, health insurance and other resources that encourage healthy behavior also increase.

Percent of Population, Educational Attainment



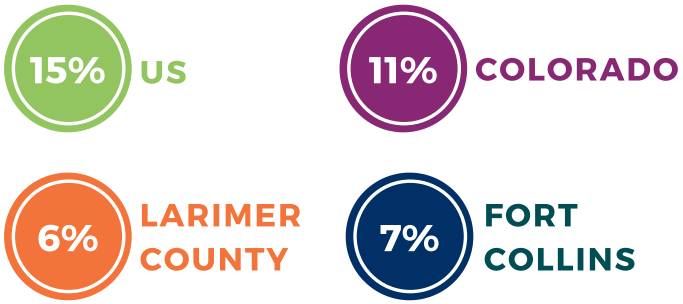
The health outcomes based on education are also reflected in a decreased risk of mortality for each additional year of schooling. A study of those born between 1915 and 1936 found that members of the cohort had a 3.6 percent decrease in mortality risk with each additional year of schooling (Zajacova & Lawrence, 2018). Less educated persons self-report more chronic conditions, poorer health, more limitations and disability, while also scoring lower on objective biological markers. Education levels appear to have stronger health effects for women than men and for non-Hispanic whites than minority adults. These variations reflect systemic social differences in the educational process for schooling, content, type of institution, and overall quality of and access to education.

Predicted Probablity that a Person will have Poor/Fair Health



ENGLISH PROFICIENCY:

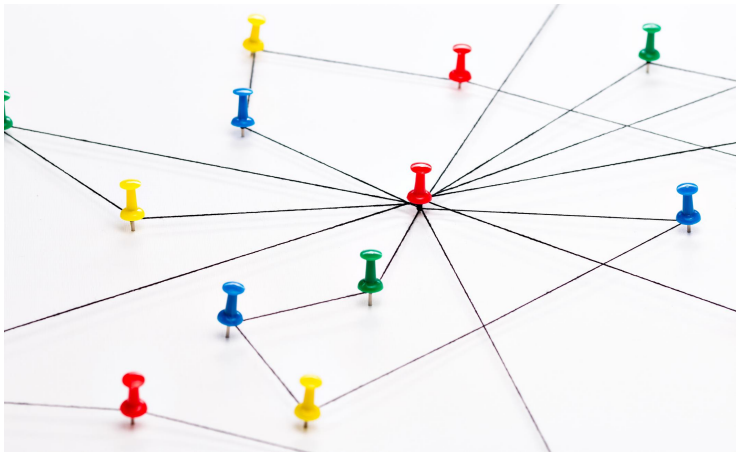
From 2013-2017, Adults over 18 who primarily speak a language other than english:



The ability to effectively communicate with health care providers in a person's native language greatly increases odds of receiving appropriate and timely healthcare. Among older residents living in California, 14 percent of those with limited English proficiency were uninsured, compared to four percent of those who spoke only English. They were also much more likely to self report poor or fair health status than their English proficient counterparts (58 percent versus 21 percent) as well as to report feeling sad all or most of the time (12 percent versus 3 percent) (ponce, Hays, & Cunningham, 2006).

Inability for patients to communicate effectively in English makes collecting accurate medical history difficult, thereby decreasing odds of receiving appropriate treatment and potentially leading to adverse health outcomes. Availability of trained interpreters can reduce clinical errors, to some degree, assisting to elevate the quality of clinical care (Coren, Filipetto, & Weiss, 2009). Low literacy, among both native and non-native English speakers, is also associated with adverse health outcomes (Dewalt et. al, 2004). Multiple studies measuring levels of literacy found significant positive associations between reading ability and knowledge of both available health services as well as outcomes (Dewalt et. al, 2004). Patients with lower literacy levels are also less likely to access various forms of preventative care, including screenings (such as mammograms) and immunizations (Scott, et. al, 2002).

SOCIAL CAPITAL & SUPPORT:



Social capital and support are theories that explain many direct and indirect effects on health. The level of connection a person feels to their community and peers can lead to negative physical and mental health outcomes. A study of the effects of psychosocial factors on mortality rates after a myocardial infarction found that those who lived alone and lacked social support were 60% more likely to be die following hospitalization for a myocardial infraction than those who did not live alone (Schmaltz, et. al, 2007). This was further compounded by gender, with men who lived alone being twice as likely as baseline patients to die (1). Similarly, women who lived with others and did not experience social isolation were twenty-five percent less likely to die following hospitalization than women living alone (Schmaltz, et. al, 2007).

Lack of social support also effects the well-being and mortality in disparate populations, including pregnant women and older adults. Socially isolated pregnant women in a recent study displayed higher stress levels (increase cytokine levels) than their not socially isolated peers (Cousson-Read, et. al, 2007). During the course of a 2007 study, it was discovered that older adults who report never or only rarely feeling useful to peers are over three times as likely to die than their peers, even after controlling for both sociodemographic and behavioral covariates (Gruenewald, et. al, 2007).

Another mechanism for increased or decreased health based on social support is through a theory known as social contagion. Social contagion postulates that health behaviors, both beneficial and harmful, may spread throughout social networks. Spread of health behaviors such as obesity, smoking, and accessing preventative healthcare have been studied in casual social networks (Christakis & Fowler, 2013). The clustering of such behaviors and health occurrences has been found to be due to more than chance alone and depend on the nature of social ties. Data from the Framingham Heart Study found that over a 30 year period of the study, those who had social ties with obese persons were 57 percent more likely to become obese themselves than those who did not have close social relationships with obese persons (Christakis & Fowler, 2007).

Furthermore, communities in which there are feelings of mutual trust and cooperation are able to harness a theory known as “collective efficacy”. Collective efficacy is the mechanism by which communities band together to inspire change in their communities, often through beneficial policies and increased stability in their communities. Individual and neighborhood efficacy are both activated processes that intend to achieve something specific. At the neighborhood level, the willingness of local individuals to participate and intervene for the common good depends on their own level of trust and solidarity with each other. If a community is socially cohesive, they are more likely to be successful in inspiring change (Sampson, Raudenbush, & Earls, 1997).

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2019 COMMUNITY DISCUSSION GROUP REPORT

SUMMARY OF FINDINGS

Every three years, the Health District of Northern Larimer County conducts a community health assessment to determine health status and identify health-care needs of Health District residents. The assessment includes a series of community discussion groups and a community health survey of adult residents in Larimer County.

In 2019, 2,532 Larimer County residents (1,682 Health District residents) completed the survey and in November and December the Health District hosted 11 community discussion groups attended by 158 community members.

Discussion group participants came from a wide variety of perspectives, including the the general community, people of varying incomes and housing statuses, different races and ethnicities, a mix of ages including older adults, business and community leaders, health care providers, mental health providers, dental providers, health and human services organizations, and other non profit organizations.

A professional facilitator led each discussion group. While the discussions were allowed to progress naturally, the facilitator presented two leading questions and asked prompting questions to further discussion or get the group back on track. The two leading questions were:

1. WHAT DO YOU SEE AS HEALTH CHALLENGES FOR YOU, YOUR FAMILY, FRIENDS, AND THE COMMUNITY?

2. WHAT ADVICE DO YOU HAVE FOR THE HEALTH DISTRICT AND THE ORGANIZATIONS THAT WORK WITH THE HEALTH DISTRICT?

Each discussion group emphasized different community issues, but common themes emerged across all groups. The Health District's Evaluation Team took an in-depth look at the discussions and used qualitative analysis software to identify the strongest themes and areas of concern within our community. The team found large umbrellas of themes, and subcategories that related to each. The results of this analysis, detailed in this report, will be used to guide planning, development, implementation, and innovation within the Health District.

ACCESS TO CARE

The problems and barriers regarding access to care have been a consistent theme throughout the history of the Health District community health assessments. Participants in previous assessments have voiced concerns over the cost, availability, and confusing nature of health insurance and health care. Transportation barriers to accessing care reemerged as a frequent theme in the 2019 discussion groups.

COST OF HEALTH INSURANCE AND HEALTH CARE

Concerns over the cost of health care and health insurance have been voiced since 2010 and those worries continue to persist.

Members of the community noted that they, or people they know, have neglected to seek necessary care because of concerns about payment. They described the struggle of choosing between paying for health insurance and covering other necessary bills. One community member explained the dilemma this way: "I work full time but I can't afford health insurance, I mean $8k deductibles, $400 premiums—do I pay rent or do I pay health insurance?"

> **"I work full time but I can't afford health insurance, I mean $8k deductibles, $400 premiums—do I pay rent or do I pay health insurance?"**

Not only were participants concerned with the cost of health insurance, they were worried about the cost of health care itself. For example, one community member stated, "I can afford insurance; I just can't afford to use it." As this discussion progressed, participants were frustrated that they paid a monthly fee to have insurance, but the cost of using the insurance was beyond their budget. Specifically, the high price of prescriptions was a source of irritation among participants.

> **"I can afford insurance; I just can't afford to use it."**

In addition, community members discussed their fear of using emergency services due to the high cost. "Emergency transport … would bankrupt nearly everyone in this room," said one attendee.

Participants currently on Medicaid pointed out that while buying in to the federal health insurance program for those needing financial assistance isn't a problem, the co-pays are too high, highlighting the fact that even though affordable health insurance options exist, actually using the benefits is not always affordable.

Some individuals who do not qualify for Medicaid said they still do not have the income to cover the cost of needed treatment and medications. A community member whose household income was just over the limit for Medicaid told the group about his struggle to pay for prescriptions and treatment for his health issues. Additional concern was voiced about lack of transparency regarding medical bills. Actual out-of-pocket costs for patients are hard to determine up front, and health care providers may not know the costs of various treatment options, leaving the patient stressed about the unknown cost of necessary care.

One individual pointed out the shift towards a gig economy and its impact on insurance enrollment. Specifically, if people are working multiple part-time jobs, they likely are not receiving insurance benefits through any of their employers.

CLIENT AND PROVIDER CONFUSION

Regardless of education level or income, community members noted the difficulty of understanding the health care and health-insurance systems. Anecdotal stories were shared about confusing situations that demonstrated the need to consolidate resources, provide health education, and empower community members to take their health care into their own hands.

> **"So many resources, but the resources don't talk to each other! It's hard to navigate everything."**

Not only did community members describe how confusing it was to navigate the health-care system, health-care providers have a similar issue, especially when trying to understand Medicaid. One provider commented, "More providers might be willing to take [Medicaid] insurance if they had a clue on how to figure it out".

A private therapist stated that it would be beneficial to have training and resources for the therapy community on how to bill for different insurance types.

Discussion group attendees noted that a possible solution could be to address health literacy so patients are empowered to take ownership of their health. Additionally, providers ought to simplify language and explain diagnoses, treatment options, and other medical decisions more clearly to patients.

As one person observed, "It's across the age spectrum that people don't know what is available to them. [Our community] is rich in resources. But sometimes it is overwhelming for those in crisis, those who live on a low income, or those who are facing challenges with the aging process. It is something we can continually work on."

Understanding Medicaid and Medicare (the federal insurance program for people over 65 and for certain people with disabilities) was also a point of confusion for community members who use these programs. They complained that Medicaid changes their policies so often that it is hard to understand what is required to qualify and how to use the services that are available at any given time.

Building on the confusing nature of the health-care system, participants also voiced a need for consolidation, coordination, and better advertising of available resources in our community. "So many resources, but the resources don't talk to each other! It's hard to navigate everything," explained one frustrated community member.

Key leaders in the community and in health care also highlighted the need for coordination of resources. They agreed that there is a lack of defined roles and responsibilities of public health and health services organizations.

> **"In the nonprofit sector, we see duplication and gaps [in services]. Who in Larimer County is taking the lead?"**

Multiple groups discussed how they were unaware of the resources available to them. For example, a group member would bring up an issue they were facing and a different group member would explain an existing, local program that addresses that specific issue. Participants mentioned the lack of communication and coordination inter-organizationally and suggested a different tactic than simply handing out pieces of paper that listed resources. Others supported the idea of a clearing house that directs residents to available resources. One key leader noted, "In the nonprofit sector, we see duplication and gaps [in services]. Who in Larimer County is taking the lead?"

BEHAVIORAL HEALTH SERVICES

A number of discussion groups raised concerns over the availability of behavioral health services, with many emphasizing the need for lower cost mental and behavioral health services. A community member who specifically works with youth trying to access substance use assistance stated that most of her clients are referred down to Denver because there are limited options available in northern Colorado. She also mentioned that Medicaid does not cover residential or sober living options.

Many participants acknowledged the complexities of addressing behavioral health issues. For example, some expressed concern that providers are not recognizing addiction symptoms before patients are discharged from emergency care, further perpetuating any issues. A separate concern was raised about inter-generational support groups as someone pointed out that it does not make sense to put a 70-year-old in a support group with 20 year olds. Care providers could create age-brackets so people potentially have more in common and more relatable based on lived experience. Please see "Burdens of Disease" section (pg 8) for more information related to mental health and substance use.

TRANSPORTATION

Transportation and how it impacts one's ability to get needed health care was brought up in every group, a noted difference from previous Community Health Assessments. Participants described the difficulty in getting to appointments if they do not own a vehicle. Multiple community members, primarily those living on a low income, reported that they would use emergency services to get someplace to receive health care because they could not find or afford reliable transportation. They mentioned that free or lower-cost rides are only an option when scheduled weeks in advance. As one health-care professional stated, "Sometimes, the only transportation is emergency services."

> **"Sometimes, the only transportation is emergency services."**

Specific concerns about the ability of older adults and rural community members to get to their appointments were discussed. A community member noted that people outlive their ability to drive by about 10 years, making transportation a major barrier to health care for older adults.

Additionally, participants brought up problems with current programs that are designed to make transportation to health care easier and more convenient. Medicaid patients said that they would be put on hold for an hour when calling to set up a ride. A health-care professional said that a major problem with these services is the "(low) number of drivers, driver trainings, and customer service."

> **"You better not break your leg on a weekend."**

Health-care professionals suggested multiple solutions, some more feasible than others. Overall, the top solution offered was to develop programs that focus on transportation for those who need it most, specifically rural community members and older adults. There was a consensus that developing programs which transport patients from the hospital to their home would be difficult to implement.

A health care provider noted that their organization's policy was not to provide transportation home from appointments is because a driver must make sure that the patient gets into their home. For example, "Say a man hasn't been home for two months and its winter—is the heat on? It's scary to be the last person to drop someone off." Health-care providers defended the lack of transportation services by noting that their organization's policy limits what they can offer. One person believed that the focus should be on empowering families to take more responsibility, stating, "We can't condition everyone to just think 'voucher.' "

Discrimination within transportation companies was also mentioned as a hurdle. "Taxis are refusing to transport homeless people due to past experience," according to one health-care worker. A participant experiencing homelessness described how limited transportation restricts where he could receive care, noting that the Transfort bus that ran from the Blue Spruce campus to Poudre Valley Hospital did not run on weekends. He summarized this situation by claiming "You better not break your leg on a weekend".

PROVIDER AVAILABILITY

Enduring long wait times to get an appointment was a concern raised primarily among low income community members and those depending on safety net services. Some community members expressed frustration over both a lack of availability of appointment times and not enough options for care. People pointed out that some facilities that could relieve the backup do not offer walk-in hours.

QUALITY OF CARE

While subpar quality of care was mentioned across all discussion groups, this concern was most prominent among those participants living on a low income and/or from groups commonly facing discrimination based on gender, race, ethnicity, or housing status.

Three major subtopics relating to quality of care were identified: perceived discrimination, lack of time spent with patients, and treatment plans.

> **"They're putting a bandage on a battle wound. They're not fixing the problem, they're not even addressing it."**

There were multiple participants who felt doctors did not understand the severity or complexity of their illnesses and chose to give them a simple solution that was not fully addressing the long-term issue. Discussion group participants expressed frustration with a lack of comprehensive treatment plans that could treat the root cause, rather than just the symptom. Further frustration was expressed at the doctor's readiness to prescribe pills, rather than lifestyle changes or alternatives to medication. As one community member put it, "They're putting a bandage on a battle wound. They're not fixing the problem, they're not even addressing it."

The concern over a lack of personal, comprehensive treatment plans stem from the patient perception that medical professionals are not spending enough time with each patient. Community members, specifically those who utilize safety net medical providers, felt that health-care providers did not allocate enough time to evalute their needs and quickly prescribed them inadequate treatment plans to get them out the door.

DISCRIMINATION

Some patients felt as if their inadequate treatment plans and the lack of time spent with them was due to discrimination against the economically disadvantaged, as well as a lack of compassion for their situation. A participant experiencing homelessness told a story about how he felt harassed because of his socioeconomic status at a medical facility. This, in turn, made him not want to seek out care in the future because he was discouraged by the encounter.

Some solutions were discussed as one participant suggested that doctors undergo "compassion training" to better serve everyone in the community regardless of their work or housing situation.
One community member said that perceived discrimination pushes people to not use preventative or non-emergency services. He said, "When everyone is discriminating against you, you have no choice but to go to the ER."

COMMUNITY DYNAMICS/ SOCIAL DETERMINANTS OF HEALTH

HOUSING

Housing was a major topic discussed in multiple discussion groups, with references to rising housing costs and the lack of acceptable affordable housing options. A nonprofit leader emphasized that "We need to put health and housing in the same sentence."

Participants voiced apprehension and frustration with the rising costs of housing in our community because the lack of housing is a health issue. Many participants stated that they are unable to afford rent/mortgages, childcare, health insurance, and other necessary bills. One person noted the connection between mental health and housing prices, "The stress of increasing housing prices is impacting people's general mental health." Those living on lower incomes or fixed incomes were particularly concerned, although increasing housing costs was an issue recognized by all groups.

> **"Permanent supportive housing is a key factor for people not to just cycle through the system. [We] need to stabilize people where they are at."**

Older adult community members noted that they have lived in the community for many years, but now are being priced out of their housing. A local leader shared that "more than half of our population has a concern about housing. Definitely elders are concerned about housing. We have to bring services along with housing to certain high-need populations."

> **"The U+2 Rule is directed at college students, but older adults aren't having raves and putting couches on the roof or anything."**

Additionally, community members have observed that wages have not increased at a comparable rate with the increased cost of housing, causing decreased buying power in the hands of the consumer. This adds to the stress of finding permanent housing, further impacting the health of our community.

Community members also expressed dissatisfaction with current affordable housing options, with special focus on a lack of emergency and permanent housing services for those under 18. The current programs are not addressing root causes of the issue: "Permanent supportive housing is a key factor for people not to just cycle through the system. [We] need to stabilize people where they are at."

Members of the community who participate in addressing housing issues made it clear that these programs are not long-term solutions and expressed frustration with the strict rules enforced in these programs (i.e. no pictures on the walls, limited visitor hours). They voiced the need for a long-term solution, rather than temporary fixes.

The U+2 Rule was discussed multiple times in different discussion groups. The older adult population complained that while they understand this rule's primary intent is to limit rowdy college homes, they are prohibited from living and sharing expenses with other people their age because of this policy. "The U+2 Rule is directed at college students, but older adults aren't having raves and putting couches on the roof or anything."

CHILD CARE COSTS / WORKFORCE

A growing concern among community members focuses on the sky-rocketing cost of childcare. A community member described putting their own health care needs on hold and avoiding treatment because childcare either costs too much or is too difficult to locate.

Participants repeatedly discussed not only the lack of an early childcare workforce, but also problems associated with the high turnover rate in the early childcare profession. "We could use 1,000 more people in the early childcare workforce!" one professional insisted.

Others pointed out that the high turnover rate among early childcare teachers could have a negative impact on our community. **"There is a lack of continuity in childcare. [Parents] can't afford to work or go to school and we're causing problems for young children with attachment issues that relate to mental health."** One mom also expressed that it made more financial sense for her to stay at home with her children then continue to pay childcare costs.

RACE AND REPRESENTATION

Key community leaders admitted that they had limited information about the health issues of marginalized communities, specifically mobile home parks and Spanish-speaking families. Leaders stated that people in these particular populations are not participating in traditional data collection efforts, and thus are not represented in the decision-making process regarding programming and policy. These leaders expressed the need for community outreach tailored to these groups in order to gather quantitative and qualitative data that could better inform programs and policies "The data we have doesn't illuminate the disparities we have in our community, and there isn't a sense of urgency to allow for oppressed people experiencing those disparities to be able to share that information."

"The data we have doesn't illuminate the disparities we have in our community, and there isn't a sense of urgency to allow for oppressed people experiencing those disparities to be able to share that information."

Members of these communities echoed and verified the need for more information on underrepresented communities. A participant in the Spanish-speaking discussion group explained, "Latinos need to be involved in community politics; nobody is inviting those folks in. I never see anyone who looks like me. What are we doing as a community that is telling people like me that you aren't welcome here? Larimer County needs to be intentional." Others echoed this concern, insisting that they would feel less stress and more acceptance if they were represented in local community issues. **"The stress keeps them in the shadows,"** as one participant described. Concerns over documentation status is causing chronic stress among the area's Hispanic community which may lead to members developing substance use disorders.

Community members are worried about the plight of undocumented immigrants, particularly children. They voiced concern about the effects of trauma, like being separated from their parents, and how these experiences can have negative impacts on their future.

Health-care professionals explained that it is difficult to treat undocumented immigrants and there is confusion about where they can go to receive help. Some participants were disgruntled that the Health District does not help undocumented immigrants, as Colorado law prevents the Health District from providing public assistance to undocumented individuals unless it is an emergency or caring for a child.

BURDENS OF DISEASE

ADDICTION

Discussion group participants often mentioned the multi-faceted problem of drug and alcohol addiction in our community, highlighting the physical and emotional effects that addiction can have, as well as the stigma surrounding addiction. Participants agreed that many people are not receiving necessary care to address their addiction because they do not want to face the stigma that comes with seeking treatment.

> **"Addiction stems from mental health, you can't really separate the two."**

One community member stated, "Addiction deserves the same respect as other diseases". This comment led to a separate discussion regarding the need for an increase in quantity and quality of mental health services that focus on addiction.

Citizens voiced concern about alcohol use across all ages and populations. "Alcohol use in the community is also a problem. Continuing to just talk about opioids misses the bigger picture. There's an awareness issue—since alcohol is legal, people think it must be OK. Access to alcohol is overwhelming."

In terms of smoking, an addiction therapist added that addiction to tobacco is particularly prominent in marginalized communities.

Concerns about the increased prevalence of methamphetamine users was discussed. One community member stated that they have seen meth use span across all socioeconomic and racial groups but specifically mentioned the increase of meth use in mobile home parks.

GENERAL MENTAL HEALTH

Stigma surrounding mental health issues was discussed as well as the lack of mental/behavioral health care providers. Health care providers, specifically those already employed in the behavioral health field, spoke about the lack of psychiatrists and psychologists. A suggestion was made to build capacity within the primary care system by training primary care physicians (PCP) to manage medicine for their patients, rather than requiring patients to see a psychiatrist. However, it was noted that some cases are far too complicated to be handled by a PCP and there is an urgent need for more psychiatrists in our community.

> **"I explained to the psychiatrist that there was no pill they could give me to help me with what I'm dealing with—racism and social injustice. We want a doctor that looks like us and understands who we are."**

Community members discussed how difficult it is to have a mental health issue as a person of color in Larimer County. There seems to be a gap of understanding in this area regarding diverse populations. In particular, they said that psychiatrists are generally not sensitive enough to the unique difficulties and stressors that people of color face. One community member stated, "I explained to the psychiatrist that there was no pill they could give me to help me with what I'm dealing with—racism and social injustice. We want a doctor that looks like us and understands who we are."

As one therapist put it, "We need culturally competent treatment, not based on income." The participants stressed that there needs to be more non-religious addiction services for those who do not hold the same beliefs.

AGING

Participants discussed a variety of concerns regarding our community's aging population. A lack of mental/behavioral health providers who specialize in geriatrics was identified as a big gap in our system that should be addressed with urgency. As one mental health provider put it, "There is a need for a specialist who can understand the difference between diagnosing dementia, substance abuse, and other mental health issues. When not diagnosed correctly, clients get misplaced."

Other major themes included the need for insurance coverage in retirement, confusion around Medicare benefits, and how to connect with all of the community resources for older adults.

Discussion group members mentioned training and using care coordinators to better help older adults navigate the health care system. There is a lot of existing confusion around what Medicare covers or provides with no clear solution for who can address those questions and concerns. Some participants said that the current care coordinators are not educated or informed on certain aspects of Medicare.

> **"Without health insurance coverage, it's hard to act on the knowledge that you may have."**

In addition, a lack of coordination of resources was also pointed to as an ongoing problem for older adults. There are a variety of programs and institutions that aim to help this specific population, but awareness seems to be lacking, "There aren't coordinated resources for our aging population the way there may be for cancer or other medical issues," one person said.

While there is a need for both coordination and overall awareness of health information and resources, "Without health insurance coverage, it's hard to act on the knowledge that you may have."

As a result, people feel the need to continue working even when they want to retire to keep their insurance and avoid the confusion of public benefits and options after age 65. They also worry that they cannot afford Medicare copays or paying out of pocket for dental, vision, or hearing services that may not be covered by Medicare without purchasing supplemental plans."

CAREGIVERS AND LONG-TERM CARE

When an older adult needs daily help or supervision, hard choices have to be made since many people cannot afford assisted living facilities while others want to remain in their homes and in a community where they are comfortable.

Many participants stressed a need to focus on the health of caregivers for older adults as well as older adults themselves. Community Nurse Assistants (CNAs) are in short supply, or families have no savings to pay them, so family members or loved ones are left with the burden of becoming a caregiver. This poses a great challenge, as these people are generally not trained to be caregivers and causes stress on both the person and their caregiver. **"I see that affecting mental health. Caregivers suffer from mental health issues,"** one person noted.

Caregiver burnout was a common concern among individuals and it was recognized that CNAs often leave their roles for higher paying jobs, creating frequent turnover. It was suggested that pay should be increased and better incentives should be created to mitigate this turnover

SUGGESTIONS:

The 2019 discussion groups identified a wide variety of challenges, such as gaps in access to care, confusion over what services exist, challenges in navigating the health care system, challenges in social determinants of health, such as housing and transportation, and much more. Participants proposed a number of suggestions for the Health District to partner with other agencies, or become a more vocal advocate for solutions.

Some of these suggestions include: Creating a resource clearing house for northern Colorado; Facilitating frequent intra-agency collaboration among patient navigators and inter-agency meetings with area navigators to provide up-to-date information on available resources (including Medicaid/Medicare and local providers accepting those insurance programs); Teaching public health literacy courses and hosting presentations on the roles and responsibilities of public health agencies in Larimer County; Creating workshops for regional health-care providers about culturally competent care and understanding the concerns of diverse populations; and creating a transportation task force to find reliable, affordable ways to transport patients to and from appointments and to pick up prescriptions, eliminating the use of emergency response vehicles for non-urgent services.

Although these groups represented different populations, socioeconomic statuses, and perspectives, the issues and concerns were consistent throughout. Overall, the 2019 community discussion groups play a crucial role in informing and educating the Health District about the lived experience of those in Larimer County.

2022–2024 Community Health Needs Assessment

Joint Report for UCHealth Poudre Valley Hospital
and UCHealth Medical Center of the Rockies

uchealth

Table of Contents

Introduction

The following report contains the 2022–2024 Community Health Needs Assessment (CHNA) for UCHealth Poudre Valley Hospital (PVH) and UCHealth Medical Center of the Rockies (MCR). The CHNA was conducted to identify significant community health needs and to help inform the development of an implementation strategy to address the identified needs.

In compliance with federal and state regulations, non-profit hospitals conduct CHNAs once every three years in collaboration with other health care providers, public health departments and community organizations. CHNAs also help guide our investments in community health programs and partnerships that extend UCHealth's not-for-profit mission beyond the walls of our hospitals, improving the lives of those we serve.

This is a joint report for both hospitals. The IRS permits hospital facilities to produce a joint CHNA report as long as the facilities use the same definitions of community and conduct a joint CHNA process. We have adhered to those requirements for this report.

Our mission.

We improve lives.
In big ways through learning, healing and discovery.
In small, personal ways through human connection.
But in all ways, we improve lives.

Our vision.

From health care to health.

Our values.

Patients first
Integrity
Excellence

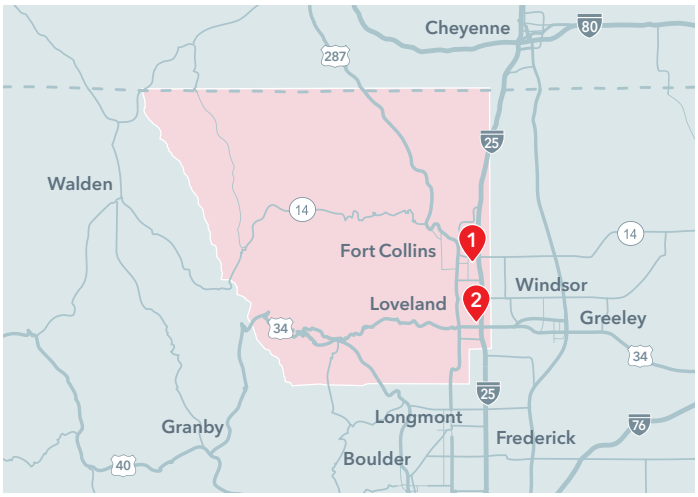
UCHealth Poudre Valley Hospital and UCHealth Medical Center of the Rockies overview.

PVH and MCR are located in Larimer County, Colorado, along with a broader network of UCHealth primary care and specialty care clinics. PVH is a 303-bed hospital that specializes in orthopedic surgery, neurosciences, cancer, bariatric weight-loss surgery and women's and family services. MCR is a 185-bed regional medical center with a full spectrum of services, specializing in heart and trauma care. MCR also provides women's services, critical care and general and robotic-assisted surgery and is home to Air Link, UCHealth's emergency medical and critical care air transportation program. PVH and MCR are committed to improving the lives of the community's most vulnerable residents and cared for more than 180,000 inpatient admissions and outpatient visits for Medicaid patients during fiscal year 2021.

PVH and MCR are part of UCHealth, a Colorado-based health system that offers the most advanced care throughout the Rocky Mountain Region, extending from Colorado to Wyoming and western Nebraska. As Colorado's only integrated community and academic health system, UCHealth is dedicated to improving lives and providing the highest quality medical care with an exceptional patient experience. With more than 150 locations throughout the region, UCHealth pushes the boundaries of medicine, providing advanced treatments and clinical trials to ensure excellent care and outcomes for 2.3 million patients each and every year. UCHealth is also the largest provider of Medicaid services in Colorado, with nearly 836,000 inpatient admissions and outpatient visits for Medicaid patients during fiscal year 2021, an increase of 310% since fiscal year 2013.

Communities served.

For the purposes of this CHNA, the community for PVH and MCR is defined as Larimer County in Colorado. Larimer County represents the geographic area most proximal to the hospitals and the areas in which a large portion of PVH and MCR patients reside.



1 UCHealth Poudre Valley Hospital

2 UCHealth Medical Center of the Rockies

Demographic characteristics of the communities served.

Demographic characteristics of the population residing within the county, in comparison with the state overall, are shown in the tables below. Values highlighted in red indicate measures that vary from the state value and have the potential to influence the type or level of resources needed in the community.

Population:

	Colorado	Larimer County
Population	5,758,736	356,899

Age:

	Colorado	Larimer County
Percentage below 18 years of age	21.9%	19.4%
Percentage 65 years of age and older	14.6%	**16.2%**

Race and ethnicity:

	Colorado	Larimer County
Percentage Non-Hispanic Black	4.1%	1.0%
Percentage American Indian and Alaskan Native	1.6%	1.1%
Percentage Asian	3.5%	2.4%
Percentage Native Hawaiian/Other Pacific Islander	0.2%	0.1%
Percentage Hispanic	21.8%	11.9%
Percentage Non-Hispanic White	67.7%	**82.1%**

Economic stability and poverty:

	Colorado	Larimer County
Median household income	$77,100	**$75,300**
Percentage of population who lack adequate access to food	10.0%	10.0%

Source for all values above: 2021 County Health Rankings

Community Health Needs Assessment

Between November 2021 and April 2022, PVH and MCR conducted the CHNA which provided an opportunity for the hospitals to engage public health experts, medical providers and community stakeholders in a formal process to ensure that community benefit programs and resources are focused on significant health needs identified within the communities served.

Methods used to conduct the Community Health Needs Assessment.

A multi-phased approach was used to identify the top health priorities for future impact. The process included:

- A comprehensive analysis of local population health indicators.
- Solicitation of community input on local health issues through a web-based survey.
- A web-based survey distributed to health care providers at PVH and MCR to gather input on community health needs.

After collecting data and soliciting input from the community and health care providers, the Internal Advisory Group (IAG) for PVH and MCR, a subset of the hospitals' leadership teams, reviewed all information obtained from the activities described above and identified recommended health needs areas of focus for the 2022–2024 CHNA. As described later in this report, recommendations for priority areas of focus were presented to the PVH and MCR Board of Directors for review and approval.

The following illustrates the CHNA process components and participants.

Identify community health needs.

Secondary data analysis:
- Population characteristics.
- Social and economic factors.
- Health data.

Community and health care provider input:
- Brainstorming of the community health issues.
- Ranking of community's most significant issues.

Prioritize significant community health needs.

Consolidation and synthesis of information:
- In-depth secondary data analysis.
- Community and provider input.
- IAG recommendations.

Prioritization of issues:
- Scope and severity.
- Hospital's ability to impact the issue.
- Availability of evidence-based strategies to address the need.
- Alignment with goals of UCHealth, local community, Colorado and the U.S. overall.

Written comment on previously conducted CHNA.

The 2019–2021 PVH and MCR CHNA and corresponding implementation strategy reports have been available to the public on the UCHealth website since 2019. Opportunities for the community to provide input on the hospitals' efforts to impact community health needs have been provided in a variety of forums, including individual discussions with community leaders and attendance at local community meetings. In addition, during 2020 and 2021, PVH and MCR conducted a community benefit public meeting to solicit input from local public health and community organizations, other health care providers and the general public. Our non-profit partnering agencies stated their appreciation of PVH's and MCR's collaborative approach to serving community needs and no comments requiring a response were received specific to the CHNA, CHNA process or implementation plan.

Findings

Secondary data review and analysis.

The initial phase of the secondary data review included an assessment of local population health indicators obtained through the County Health Rankings (2021 report year), the Colorado Health Indicators database and the 2019 Healthy Kids Colorado Survey. Indicator values were assessed at the county and state levels and, where available, at the national level.

Summary tables of the key health indicators in the PVH and MCR community were developed to illustrate the overall health of the community (see Appendix 1 for the data tables and related sources).

Key health needs were determined based on the indicator values and trends, current priorities of the local county health department, the potential to impact the issues using evidence-based practices and alignment with the priorities of PVH and MCR.

Categories evaluated include:

- Demographics, education and socioeconomic status.
- Health care access and services.
- Health behaviors (including unintentional injury).
- Maternal and child health.
- Mental health (including attempted-suicide hospitalizations and mortality).
- Nutrition, physical activity and body-mass index.
- Substance use disorders.
- Specific health conditions (including hospitalization, morbidity and mortality rates).

From this review, the most significant issues identified were:

- Access to care.
- Behavioral health (including mental health, suicide and substance use disorders).
- Cancer.
- Chronic disease.
- Injury.
- Maternal health.
- Social and economic factors.

Information gaps impacting ability to assess needs.

Within the review of the secondary data, gaps were identified related to the health status of minority populations as well as individuals who are medically underserved due to lack of adequate insurance or who encounter barriers to receiving timely and comprehensive health care services.

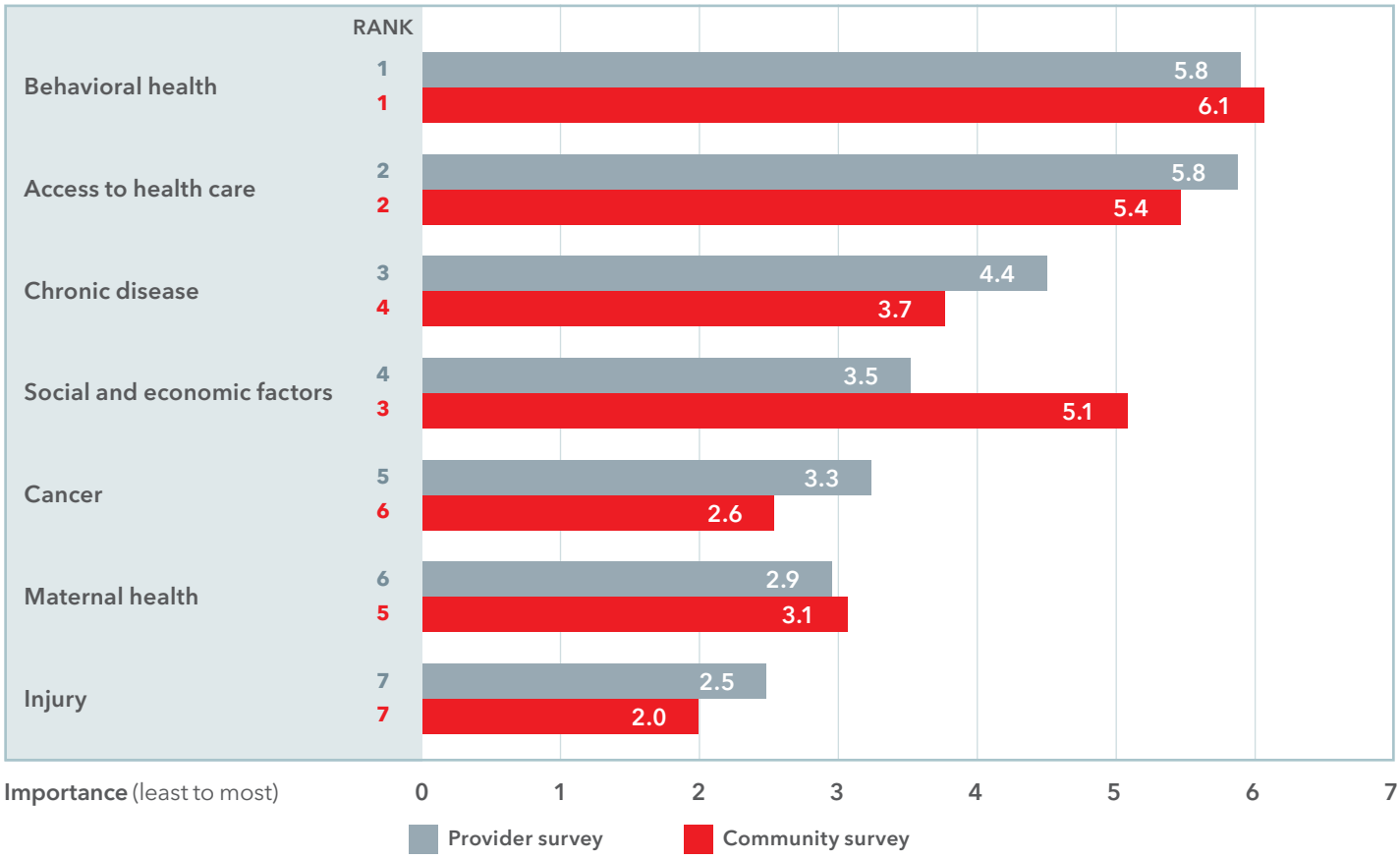
To gather additional insights, PVH and MCR regularly participate in meetings facilitated by the Larimer County Department of Public Health and Environment, the Health District of Northern Larimer County and other local partner agencies that focus on identifying and implementing best practices for reducing these barriers.

Community engagement synopsis.

To gather input on the most significant health issues, PVH and MCR provided a web-based survey to health care providers and key community stakeholders throughout Larimer County. Respondents were asked to rank each of the significant issues identified above and describe other health issues for consideration. Results from these surveys follow.

Provider and community survey results.

The survey asked respondents to rank a set of community health needs in order of importance to the community. Nearly 100 providers and 40 representatives from local community organizations responded to the survey. The results from both surveys are provided in the table below. The score represents the weighted average for all responses on a scale from 1–7, and higher values indicate a higher priority.



Specific to social and economic factors, health issues described by respondents included health equity and racial disparities, food insecurity, housing and transportation.

Survey respondents also identified community agencies addressing these issues and with whom PVH and MCR could potentially partner or help support. This input will be used during the development of the CHNA implementation strategy later this year.

Community-wide health care resources available to address needs.

Recognizing the current scope of services available to meet the health care needs of community members is an important component of a community health needs assessment. The PVH and MCR community is served by several acute-care hospitals, community-based health centers and a network of medical and mental health providers. In addition, PVH and MCR offer a wide array of virtual health options. Though services may be available, the CHNA findings reveal that the ability to receive care in a timely and coordinated manner remains a challenge for many vulnerable residents.

Proven strategies available to impact health issues.

An important factor for consideration during the health-issue prioritization process was recognizing the availability of proven strategies or evidence-based interventions that, if implemented, could make an impact on the significant health issues identified. Resources reviewed included:

- Community Preventive Services Task Force Findings
- County Health Rankings Guide–What Works for Health
- Healthy People 2020 Evidence-Based Resources

Summary of actions taken by hospitals since last Community Health Needs Assessment.

To understand the effectiveness and scope of actions taken by PVH and MCR since the completion of the 2019–2021 CHNA, a review of community-benefit activities was completed. The prior CHNA identified access to care, mental health and suicide prevention and substance use disorders as priorities. A few examples of programs and initiatives currently in process to address the 2019 findings are listed below.

Access to Care:

- Expanded telehealth and virtual care options.
- COVID-19 response and vaccinations.
- Community paramedic home visits, outreach clinics and proactive visits.
- Family Medicine Center Food Pantry.
- Postpartum nurse home visits for Medicaid clients.
- Medical care coordination for high-risk youth and Medicaid clients with complex health issues.
- Chronic disease self-management programs.

Mental Health and Suicide Prevention:

- Integrated primary care and behavioral health.
- Virtual behavioral health.
- Suicide prevention awareness education.
- Support for Larimer County Gun Safety Awareness campaign.
- Elementary and middle school-based education and support programs.

Substance Use Disorders:

- Alternatives to Opioids (ALTO).
- Opioid awareness campaign.
- Pain management support groups.
- Medication-assisted addiction treatment services.
- Prevent Alcohol & Risk-Related Trauma in Youth program.

Prioritization and Board of Directors Approval

Internal Advisory Group recommendations.

The PVH and MCR Internal Advisory Group (IAG) reviewed all findings obtained from the activities described previously. The IAG conducted a meeting specifically to identify health needs priorities for the CHNA and considered the following criteria during the decision-making process:

- Scope and severity of the health need.
- Potential for PVH and MCR to impact the health need.
- Alignment with UCHealth, PVH and MCR strategies, as well as local, state and national objectives.
- Economic feasibility to address the health need.

The PVH and MCR IAG identified the following health needs as priorities for the 2022–2024 CHNA:

- Behavioral health
- Access to care
- Chronic conditions

A synopsis of key CHNA findings specific to these issues is provided in the following sections of this report.

In addition, it is important to note that, while social determinants of health was not selected as a priority for this CHNA, the hospitals address a range of social determinants through initiatives and programs focused on behavioral health, access to care, chronic conditions and other health needs.

Behavioral health.

According to the U.S. Department of Health and Human Services, mental health disorders are among the most common causes of disability in the United States. The resulting disease burden of mental illness is among the highest of all diseases.

In Larimer County, 18.6% of high school students reported that they seriously considered attempting suicide during the past 12 months, which is higher than the state average of 17.5%. Also, as shown in the table below, the rates of both suicide-related and mental health-diagnosed hospitalizations in Larimer County are significantly higher than the state averages.

According to the National Institutes of Health, a substance use disorder (SUD) is a condition that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol or medications.

In Larimer County, 23.0% of adults reported binge drinking (5+ drinks on one occasion) during the past month, which is higher than the state average of 21.0%. In addition, public health and medical professionals in Larimer County recognize that opioid use and addiction is becoming an increasing problem in the county for both youth and adults.

	Colorado	Larimer County
Percentage of high school students who seriously considered attempting suicide during the past 12 months	17.5%	**18.6%**
Suicide hospitalizations (age-adjusted rate of hospitalizations per 100,000 residents)	66.9	**72.6**
Suicide mortality (age-adjusted rate per 100,000 residents)	21.4	**22.3**
Mental health-diagnosed hospitalizations (age-adjusted rate of hospitalizations per 100,000 residents)	2,947.3	**3,138.3**
Percentage of adults who report binge drinking (5+ drinks on one occasion in the past month)	21.0%	**23.0%**

See Appendix 1 for additional supporting information and relevant data sources.

Values highlighted in red indicate measures that are less favorable when compared to the state values.

Access to care.

Since the advent of the Affordable Care Act, there has been a sharp decline in the proportion of residents without any health insurance in Larimer County; however, there are still many barriers to accessing primary and behavioral health care services through both Medicaid and other payer sources.

Research shows that access to primary care is associated with positive health outcomes. Individuals with an established primary care physician are more likely to receive recommended preventive services such as flu shots, blood pressure screenings and cancer screenings. Disparities in access to primary health care include language-related barriers, physical disabilities, inability to take time off work to attend appointments and transportation-related barriers. Despite a favorable ratio of the population to primary and behavioral health care providers in Larimer County, these disparities may decrease access to services and increase the risk of poor health outcomes for individuals with limited resources.

In addition, feedback from the provider and community surveys indicates that access to mental and behavioral health services, primary care and palliative care support remains a challenge in the community, particularly for those at higher risk of health inequities.

Chronic conditions.

According to the Centers for Disease Control and Prevention, chronic diseases and conditions are one of the leading causes of death and disability in the United States. Chronic conditions—including some cancers, cerebrovascular disease, heart disease, obesity, diabetes and lung disease—share risk factors such as tobacco use, excessive alcohol use, unhealthy diet, physical inactivity and lack of access to preventive care.

As shown in the table below, public health data shows that there is a higher rate of many chronic diseases and conditions in Larimer County compared to the state of Colorado. Examples include the incidence of breast, cervical and prostate cancer and hospitalizations for acute myocardial infarctions and stroke (which often result from chronic uncontrolled hypertension), among others.

	Colorado	Larimer County
Breast cancer (age-adjusted incidence rate per 100,000 females)	67.3	**79.4**
Invasive cervical cancer (age-adjusted incidence rate per 100,000 females)	3.0	**4.6**
Prostate cancer (age-adjusted incidence rate per 100,000 males)	45.1	**64.4**
Stroke hospitalizations (age-adjusted rate per 100,000 residents)	329.4	**335.8**
Acute myocardial infarction hospitalizations (age-adjusted rate per 100,000 residents)	179.1	**190.3**
Mortality rate for cerebrovascular disease (age-adjusted per 100,000 residents)	34.9	**38.9**
Percentage of children aged 5–14 years who were overweight or obese	24.3%	**32.0%**

See Appendix 1 for additional supporting information and relevant data sources.

Values highlighted in red indicate measures that are less favorable when compared to the state values.

Board of Directors review and approval.

During their April 2022 meeting, the PVH and MCR Board of Directors—which includes representatives from the surrounding communities—reviewed, discussed and approved the information contained within this report.

Acknowledgments, recommendations and next steps.

We would like to thank our partnering agencies as well as medical providers and community members who provided insight and expertise that greatly assisted in the completion of this report.

In the following months, implementation strategies designed to address the identified health needs within Larimer County will be prepared and presented to the PVH and MCR Board of Directors for approval.

The PVH and MCR CHNA report will be made available to the public for viewing or download on the UCHealth website, as well as in hard copy located in the PVH and MCR administrative offices.

Appendices

Appendix 1–Data tables and sources

DEMOGRAPHICS	Year/Source	Colorado	Larimer County
Population	2021 CHR	5,758,736	356,899
% below 18 years of age	2021 CHR	21.9%	19.4%
% 65 and older	2021 CHR	14.6%	**16.2%**
% Non-Hispanic Black	2021 CHR	4.1%	1.0%
% American Indian and Alaskan Native	2021 CHR	1.6%	1.1%
% Asian	2021 CHR	3.5%	2.4%
% Native Hawaiian/Other Pacific Islander	2021 CHR	0.2%	0.1%
% Hispanic	2021 CHR	21.8%	11.9%
% Non-Hispanic White	2021 CHR	67.7%	**82.1%**
% Not Proficient In English	2021 CHR	3.0%	1.0%
% females	2021 CHR	49.6%	50.2%
% rural	2021 CHR	13.8%	11.7%
HEALTH OUTCOMES			
Quality of Life			
% of adults reporting poor or fair health (age-adjusted)	2021 CHR	14.0%	11.0%
Maternal and Child Health			
% of live births with low birthweight (LBW) (<2500 grams)	2021 CHR	9.0%	9.0%
% LBW (Asian)	2021 CHR	n/a	**14.0%**
% LBW (Black)	2021 CHR	n/a	**13.0%**
% LBW (Hispanic)	2021 CHR	n/a	9.0%
% LBW (White)	2021 CHR	n/a	8.0%
Number of all infant deaths (within 1 year) per 1,000 live births	2021 CHR	5	3
Mental Health			
% of adults who currently had depressive symptoms	2016-2018 COHI	11.4%	7.8%
% of adults reporting that their mental health was not good for 14+ days during the past 30 days	2016-2018 COHI	10.9%	10.2%
% of high school students who felt sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	2019 HKCS	34.7%	34.6%
% of high school students who seriously considered attempting suicide during the past 12 months	2019 HKCS	17.5%	**18.6%**

Footnotes and sources:

- n/a = no data or data suppressed due to small sample size
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- COHI: Colorado Health Indicators (provides access to state and local-level data compiled by Colorado Department of Public Health and Environment) (Colorado Health Information Dataset)
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- Values highlighted in red indicate measures that are less favorable when compared to the Colorado average.

HEALTH FACTORS	Year/Source	Colorado	Larimer County
Tobacco Use			
% of adults who are current smokers	2016-2018 COHI	15.0%	13.2%
% of high school students who have ever used an electronic vapor product	2019 HKCS	45.9%	43.0%
% of high school students who smoked cigarettes on one or more of the past 30 days	2019 HKCS	5.7%	5.2%
Weight Status and Physical Activity			
% of children ages 5–14 who were overweight or obese (i.e., at or above the 85th percentile for body mass index by age and gender)	2015–2017 CHS	24.3%	**32.0%**
% of high school students who were overweight or obese (i.e., at or above the 85th percentile for body mass index by age and gender)	2019 HKCS	21.6%	16.7%
% of adults (18+) who were overweight or obese (Body Mass Index [BMI] > = 25)	2016–2018 COHI	58.5%	54.5%
% of children (ages 5–14) physically active for at least 60 minutes/day for the past 7 days	2015–2017 CHS	47.8%	52.4%
% of high school students physically active for a total of at least 60 minutes per day on five or more days in the past week	2019 HKCS	48.0%	52.0%
% of adults age 20 and over reporting no leisure-time physical activity	2016–2018 COHI	16.1%	11.6%
Alcohol and Drug Use			
% of high school students who binge drank (4+ drinks for females, 5+ drinks for males, within two hours) on one or more of the past 30 days	2019 HKCS	14.2%	13.4%
% of adults who report binge drinking (5+ drinks on one occasion in past month)	2021 CHR	21.0%	**23.0%**
% of driving deaths with alcohol involvement	2021 CHR	34.0%	33.0%
Number of drug-poisoning deaths per 100,000 population	2021 CHR	18	14
Sexual Activity			
Number of newly diagnosed chlamydia cases per 100,000 population	2021 CHR	519.4	436.7
Number of births per 1,000 female population ages 15–19	2021 CHR	18	10
Teen birth rate (Asian)	2021 CHR	n/a	n/a
Teen birth rate (Black)	2021 CHR	n/a	8
Teen birth rate (Hispanic)	2021 CHR	n/a	**27**
Teen birth rate (White)	2021 CHR	n/a	7
Clinical Care			
Access to care			
– % of population under age 65 without health insurance	2020 CEN	9.3%	7.7%
– Ratio of population to primary care physicians	2021 CHR	1,210:1	1,170:1
– Ratio of population to dentists	2021 CHR	1,220:1	1,260:1
– Ratio of population to mental health providers	2021 CHR	270:1	270:1
Quality of care			
– Number of hospital stays for ambulatory-care-sensitive conditions per 1,000 Medicare enrollees	2021 CHR	2,617	2,257

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SOCIAL AND ECONOMIC FACTORS	Year/Source	Colorado	Larimer County
Education			
High school graduation rate	2021 CHR	81.0%	83.0%
% of teens and young adults ages 16–24 who are neither working nor in school (disconnected youth)	2021 CHR	6.0%	3.0%
% of adults ages 25–44 with some post-secondary education	2021 CHR	72.0%	79.0%
Employment			
Unemployment rate	2021 CHR	2.8%	2.4%
Income			
Median household income	2021 CHR	$77,100	**$75,300**
% of children under age 18 in poverty	2021 CHR	11.0%	9.0%
% of children eligible for free/reduced school lunch	2021 CHR	41.0%	33.0%
% of population who lack adequate access to food (food insecurity)	2021 CHR	10.0%	10.0%
Community Safety			
Violent crime rate per 100,000 population	2021 CHR	326	201
Number of motor vehicle crash deaths per 100,000 population	2021 CHR	11	10
Number of deaths due to injury per 100,000 population	2021 CHR	80	71
Number of deaths due to homicide per 100,000 population	2021 CHR	4	2
Number of deaths due to firearms per 100,000 population	2021 CHR	14	13
SPECIFIC HEALTH CONDITIONS—SELF-REPORTED			
% of children with asthma (ages 1–14)	2015–2017 CHS	7.3%	**8.1%**
% of high school students who had ever been told by a doctor or nurse that they had asthma	2019 HKCS	20.2%	17.8%
% of adults who currently had asthma	2016–2018 COHI	8.9%	5.0%
% of adults aged 65+ who reported they had a fall resulting in injury in the past 12 months	2016–2018 COHI	10.1%	**12.4%**
% of adults aged 20 and above with diagnosed diabetes	2021 CHR	7.0%	5.0%
Number of persons living with a diagnosis of HIV infection	2021 CHR	265	95
AGE-ADJUSTED INCIDENCE RATES OF CANCER PER 100,000			
All cancer sites combined	2018 COHI	384.9	**425.9**
Lung and bronchus	2018 COHI	37.2	31.5
Breast cancer (females)	2018 COHI	67.3	**79.4**
Prostate cancer (males)	2018 COHI	45.1	**64.4**
Colorectal cancer	2018 COHI	30.5	29.8
Invasive cervical cancer (females)	2018 COHI	3.0	**4.6**
Melanoma of skin	2018 COHI	20.5	18.1

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AGE-ADJUSTED RATE OF HOSPITALIZATION PER 100,000	Year/Source	Colorado	Larimer County
Stroke	2018-2020 COHI	329.4	**335.8**
Heart disease	2018-2020 COHI	2,024.5	1,904.6
Acute myocardial infarction	2018-2020 COHI	179.1	**190.3**
Congestive heart failure	2018-2020 COHI	809.7	765.8
Mental-health diagnosed hospitalizations	2018-2020 COHI	2,947.3	**3,138.3**
Suicide-attempt hospitalizations	2018-2020 COHI	66.9	**72.6**
Influenza (ages 65+)	2018-2020 COHI	194.4	186.3
AGE-ADJUSTED MORTALITY RATES PER 100,000			
All causes	2020 COHI	738.7	634.3
Malignant neoplasms (all cancers)	2020 COHI	125.1	116.7
Breast cancer	2020 COHI	124.7	110.3
Heart disease	2020 COHI	67.8	26.9
Accidents	2020 COHI	59.7	40.4
Chronic lower respiratory diseases	2020 COHI	38.5	25.6
Cerebrovascular diseases	2020 COHI	35.6	**46.2**
Alzheimer's disease	2020 COHI	34.9	**38.9**
Suicide	2020 COHI	21.4	**22.3**
Falls	2020 COHI	16.2	10.2
Diabetes	2020 COHI	17.8	12.9
Prescription opioid overdose	2020 COHI	13.5	7.4

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Appendices

Appendix 2—Community organizations

- Alliance for Suicide Prevention
- Alternatives to Violence
- Brookdale Senior Living
- CASA of Larimer County
- Catholic Charities
- ChildSafe Colorado
- City of Fort Collins Senior Advisory Board
- Colorado School of Public Health
- Colorado State University
- Columbine Health Systems
- Crossroads Safehouse
- Dementia Together
- Disabled Resource Services
- Early Childhood Council of Larimer County
- Eighth Judicial District Attorney's Office
- Elderhaus Adult Day Programs
- Finally Home
- Food Bank for Larimer County
- Foothills Gateway, Inc.
- Fort Collins Area Interfaith Council
- Grief Support of the Rockies
- Health District of Northern Larimer County
- Homeward Alliance
- House of Neighborly Service
- Larimer County Behavioral Health Services
- Larimer County Board of Commissioners
- Larimer County Board of Health
- Larimer County Health Department
- Larimer County Office on Aging
- Larimer County Sheriff's Office
- LifeStance Health
- Los Ancianos Unidos
- Loveland Community Health Center/Sunrise Clinic
- Loveland Housing Authority
- Lutheran Family Services Rocky Mountains Refugee & Asylee Program
- Neighbor to Neighbor
- Northern Colorado Health Sector Partnership
  - Aims Community College
  - Associates in Family Medicine
  - Banner Health
  - Brookdale Senior Living
  - Centennial Area Health Education Center
  - City of Greeley
  - City of Fort Collins
  - Colorado State University
  - Colorado Workforce Development Council
  - Columbine Health Systems
  - Emergency Physicians of the Rockies
  - Fort Collins Area Chamber of Commerce
  - Front Range Community College
  - Golden Peaks Rehabilitation Center
  - Health District of Northern Larimer County
  - Hearing Rehab Center
  - Home Instead
  - Hospice of Northern Colorado
  - Job Corps
  - Kaiser Permanente
  - Larimer County
  - Larimer County Workforce Center
  - Mountain Wellness
  - Northern Colorado Rehabilitation Hospital
  - North Range Behavioral Health
  - Pathways
  - Rocky Mountain Family Physicians
  - SummitStone Health Partners
  - Unemployment Services of Weld County
  - University of Northern Colorado
  - UCHealth
  - Workforce Boulder County
- Poudre School District
- Project Self-Sufficiency
- Salud Family Health Center
- SAVA Center
- Serve 6.8
- SummitStone Health Partners
- The Center for Family Outreach
- The Crawford Child Advocacy Center
- The Family Center/La Familia
- Thompson School District
- United Way of Larimer County

uchealth.org/about/community-health-needs-assessment

uchealth

22-CH-4451

Appendices

Appendix 3–Prioritization matrix

	Prioritization Criteria				
Identified Health Issues	Scope and severity of the health need.*	Potential for hospital to impact the health need.**	Alignment with current UCHealth system strategies and local/state/ national objectives.	Economic feasibility of addressing the health need.***	Total score.
Access to care					
Behavioral health					
Cancer					
Chronic disease					
Food insecurity					
Homelessness / inadequate housing					
Maternal health					

Instructions:
Rank each health issue against the criteria using the rating scale below:
4 = High 3 = Moderate 2 = Low 1 = None

Definitions:
*How many people affected; impact of issue on mortality rates.
**Availability of effective interventions, staffing expertise and community readiness.
***Costs of internal resources (e.g., workforce, operational budget).

Health District
OF NORTHERN LARIMER COUNTY

July 22, 2022

AGENDA

- About Istonish
- Your Criteria
- Strategic Assessment
- Case Studies
- Financials
- Implementation and Next Steps

Your Success. Our Expertise. Technology Empowered.

ISTONISH

ISTONISH

at a Glance

- HQ in Greenwood Village, Colorado
- 30+ years in business serving businesses in Colorado founded by Annette and Victoria Quintana
- 95 Employees with over 927-years of combined IT experience crossing numerous technologies and disciplines
- Ranks in top 25% of all MSPs nationally based on size & capabilities
- Proven service delivery approach focused on people, process and best-in-class toolset

COLORADO CO USA MADE

Celebrating 30 YEARS In Business

TOP 25 MSP

NMSDC National Minority Supplier Development Council

certified WBENC WOMEN'S BUSINESS ENTERPRISE

ITIL®

Your Success. Our Expertise. Technology Empowered.

ISTONISH

Key Criteria

- Design a roadmap for technology modernization
  - Strategic plan for data storage (on-prem vs cloud)
  - Strategic and tactical plan for MS Suite deployment including Teams
  - Change management (i.e. training)
  - Snapshot of application ecosystem including potential security vulnerabilities
  - Best practices for patching, AV, and other desktop/infrastructure support
- Identify a strategic partner that can help with roadmap and projects

Strategic Assessment

Assess Technology

Perform a lifecycle assessment of existing technology which reports on the age of hardware and software. Run penetration tests and vulnerability scans. Assess environment security configuration.

Assess People and Process

Conduct interviews with key stakeholders to determine opportunities and priorities. Conduct all employee survey to baseline satisfaction level with technology and processes.

Executive Report

Compile an Executive Report with our findings which contains: **Findings, Recommendations, and a Strategic Roadmap.**

Executive Report

- **Findings Report**
  - Inventory of Technology Assets
  - Vulnerability Status
  - List of Applications
  - “What we saw and what we heard” report
- **Actionable remediations sorted by priority**
  - Critical Items
    - Security issues or down systems
    - Compliance concerns
    - Systems which cause inefficiencies or are obsolete
  - Quick Wins
    - Changes which will have high impact throughout the organization
    - Changes that are relatively easy or low-cost to implement
  - Best Practices
    - Address any items that could benefit from following best practices
    - Identify key areas that are outside of best practices
- **Strategic Roadmap**
  - Plans for technology upgrades and to make sure technology is continually serving the needs of the users
  - Proactive planning approach

Case Studies

QUESTIONS

and

NEXT STEPS

Luke Martin
Account Executive
303-475-1282
lmartin@istonish.com

Michael Carroll
Chief Revenue Officer
720-289-0804
mcarroll@istonish.com

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Scope of Work

A human resource audit is a means by which an organization can review current human resources activities to determine what, if anything, needs done to improve the function. It involves systematically reviewing all aspects of human resources, ensuring that government regulations and company policies are being adhered to and key practices are in place. It also includes highlighting current strengths, reviewing processes where HR could operate more efficiently and effectively, and identifying problem areas. The audit is a tool that approaches HR practices from a broad perspective and is a learning or discovery tool, not a test. There will always be room for improvement in every organization.

Some key reasons to conduct periodic human resource audits include:

- To ensure the effective utilization of an organization's human resources.
- To review the organization's compliance with current legal regulations.
- To compare current human resource practices against best practices across industries.
- To perform a "due diligence" review for management, shareholders or potential investors/owners.

In addition, because of the multitude of laws affecting each stage of the employment process, it is extremely important for employers to regularly review their policies and practices to ensure regulatory compliance, potentially resulting in costs of fines and/or lawsuits.

Penalties signify the importance of conducting periodic human resource audits and to maintain fair and consistent policies and procedures across the organization.

Examples of penalties that could affect your business depending upon your industry and/or size include:

- FLSA - Fines for violation for non-payment of overtime for non-exempt employees.
- COBRA - Failure to comply may subject an employer to ERISA penalties of up to $100 per day.
- Federal Immigration Reform Act - Non-compliance can result in a fine of up to $1,000 per employee.
- ADA - Violations may result in reinstatement of terminated employees, back pay, benefits, attorney fees, and punitive damages.
- FMLA - Violations could cost the organization lost wages, benefits, and attorney fees.

OPTION 1 – COMPREHENSIVE HR AUDIT:

Serving as your professional partner, Employers Council proposes a comprehensive review of current employment practices using our HR Audit Instrument. Employers Council will provide

two HRPS Consultants to identify policies and procedures that need to be developed, enhanced or eliminated in order to operate more effectively.

HRPS consultants will help you evaluate and improve your HR practices by interviewing key staff, reviewing relevant documentation, helping you complete a comprehensive questionnaire, and making specific recommendations to streamline processes and develop user-friendly systems.

Employers Council will provide a review including, but not limited to the following components: (not all will be applicable for all organizations)

Organization Demographics

- Employee size, locations, employee groups
- Government contracts, industry, private/public/nonprofit sector
- HR department structure, positions

Employee Files

- Employee file structure – section/form separation, HIPAA standards
- Employee form review – including I-9s, Colorado Affirmations, W-4s
- Documentation review – offer letter, employee promotions/disciplinary actions, performance reviews completed, termination documentation, exit interview information
- Records retention – terminated employee files, submitted applications

Pre-employment Screening & Selection

- Employment application
- Candidate background check procedures
- Interview and screening process meet EEO standards, definition of an applicant, candidate testing tools and practices
- Candidate reference check procedures
- E-verify requirement

Regulatory Reporting

- New employee reporting to State of Colorado (other States?)
- EEO-1 filed

- EEOP/Affirmative Action program (if required)
- Form 5500 (if required)
- OSHA regulations followed and log maintained (if required)
- Workers Compensation documentation – work-related injury reporting, return-to-work procedures reviewed

Wage & Hour

- Fair Labor Standards Act (FLSA) compliance – job classifications correct (exempt/non-exempt), job descriptions accurate and ADA compliant, minimum wage paid (if applicable)
- Colorado Wage and Hour – overtime pay practices, timesheet procedures, final paycheck compliance, PTO accrual/payout
- Equal Pay Act compliance
- Federal, state, and local payroll withholding implemented
- Child labor considerations – employment of minors

Benefits Administration

- COBRA and FMLA administration process and procedures – COBRA letter sample, new hire disclosures, FMLA communication
- Benefit plan documents for healthcare and retirement plans, plan summary distributed

HR Administration

- Employment posters – sufficient number, in proper locations?
- ADAAA – reasonable accommodation practices, accessibility for disabled employees
- Employee Handbook – most recent update?
    - At-will disclosure, employee acknowledgement/sign-off
    - EEO statement – training provided?
    - Employee classifications defined – regular, full-time, part-time
    - Drug and Alcohol Policy

- Sexual Harassment statement/procedures – clear reporting process and non-retaliatory policies, supervisor and employee training provided

- Specific review of HR practices and functional areas (as requested by member)

Phase I: HRPS representative will initially conduct a telephone conference to outline the audit process and explain what areas will be reviewed. During this initial call the scope of the audit will be discussed and the audit's goals defined.

Phase II: The primary purpose of this Phase is to gather specific information on current human resource practices, review employee files and other documents, and evaluate procedures related to regulatory issues.

Phase III: A final report providing 80-100 pages of findings will be delivered to document positive processes already in place and to identify and prioritize key areas to be addressed and to recommend best practices to consider in the future.

Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS
REGULAR MEETING
August 23, 2022

Health District Office Building
120 Bristlecone Drive, Fort Collins
Hybrid Meeting

MINUTES

BOARD MEMBERS PRESENT: Molly Gutilla, MS, DrPH, Board President
Julie Kunce Field, JD, Board Vice President
Joseph Prows, MD, MPH, Board Treasurer
Celeste Holder Kling, JD, Liaison to UCH-North/PVH
Ann Yanagi, MD, Board Secretary

Staff Present:
Robert B. Williams, Executive Director
Chris Sheafor, Support Services Director
Dana Turner, Human Resources Manager
James Stewart, MD, Medical Director
Karen Spink, Deputy Director
Laura Mai, Finance Director
Richard Cox, Communications Director
Mike Ruttenberg, Connections Director
Rosie Duran, LHC Program Coordinator
Anita Benavidez, Executive Assistant

Staff Present:
Andrea Holt, Integrated Care Program Manager
Dr. Usha Udupa, CAYAC Psychiatrist
Lex Loutzenhiser, Outreach & Education Spec.
Marybeth Rigali-Oiler, CAYAC Psychologist
Mindy Rickard, ACP Team Lead
Jessica Shannon, Resource Development Coord.
Alyson Williams, Policy Advisor
Xochitl Fragoso, Finance Assistant Director
Kristen Gilbert, Graphic Designer

Public Present:

CALL TO ORDER; INTRODUCTIONS & APPROVAL OF AGENDA

Director Molly Gutilla called the meeting to order at 5:03 p.m.
The agenda was amended to remove the July 26 Board Meeting Minutes from the Consent Agenda

MOTION: To approve the agenda as Amended
Motion by Julie Kunce Field / Second by Celeste Holder Kling / Carried Unanimously

EXECUTIVE SESSION

MOTION: To enter Executive Session for the purpose of conferencing with the Health District's attorney to receive legal advice on specific legal questions, pursuant to C.R.S. §24-6-402(4)(b)
Motion by Celeste Holder Kling / Second by Joseph Prows / Carried Unanimously

PUBLIC COMMENT

None

CONSENT AGENDA

- ~~Approval of the July 26, 2022 Board of Directors Meeting Minutes~~

- May 2022 and June 2022 Financials

MOTION: To approve the consent agenda as amended
Motion by Celeste Holder Kling / Second by Joseph Prows / Carried Unanimously

PRESENTATIONS

Introduction – Robert B. Williams
Tonight's presentations will focus on two behavioral health programs: Integrated Care and CAYAC.

Integrated Care – Andrea Holt
Ms. Holt introduced the eight-member staff including a program manager, program assistant, psychiatrist, and five behavioral health providers. As Program Manager, Ms. Holt's work is largely administrative. She is the last remaining member from the inception of Integrated Care. In 2005, the program was created with a focus on filling behavioral health gaps in two safety net clinics. The effort involved intensive case management with a notable portion of work taking place in the community or in patient's homes. It is a collaborative approach with the physician and other providers coordinating care for total health. The Integrated Care team is heavy on the behavioral health side. The majority of care is provided side-by-side with the physician but some receive individual care. Since then, services have evolved to be much more specialized, collaborative and clinic based. Offerings include the Behavioral Attending Model (assigning shifts to be available "in-the-moment"), Specialty Clinics – MAT and Pain Clinic, and youth and adult assessments (screening and clinical interview).

The two safety net clinics, Salud and Family Medicine Center (FMC), apply very different models: Salud is a Federally Qualified Health Center with significant Medicaid and uninsured/underinsured clients. Roughly 50% of their patients prefer to receive care in Spanish. Salud embraces a consultation model with Dr. Ivanovic individually. FMC is a family practice residency program within the University of Colorado, with an equally high Medicaid population (60-70%). They take private insurance and also have some sliding scale options through CICP. FMC embraces a consultation model involving residents (for education). SummitStone Health is a partner. There is an interdisciplinary pain clinic that residents rotate through with an integrative clinic that includes acupuncture, massage and yoga. MAT is staffed in-house. Current challenges and barriers include staff salaries, a shift to insurance billing creating gaps, behavioral health demand and workforce shortage (FMC has a wait list of about 800 patients for primary care). Last fall the waiting time for therapy was two to three months. Due to the insurance billing situation, more people have to be sent out into the community because they cannot be treated within an existing clinic. The Health District receives reimbursement from FMC at about 90%. Salud contract pays the Health District for FTEs working. Without Integrative Care, Salud would just hire someone. However, at FMC, a lot of programs would evaporate if the Health District staff wasn't there.

Child, Adolescent, and Young Adult Connections (CAYAC) – Dr. Udupa, Lex Loutzenhiser and Marybeth Rigali-Oiler
Mr. Williams is the acting program manager for CAYAC. Staff members Dr. Usha Udupa, Marybeth Rigali-Oiler PhD, and Lex Loutzenhiser (Outreach and Education Specialist) will collectively review the program. CAYAC is housed in the 425 W. Mulberry building and have four different sectors of the program. Dr. Udupa introduced herself and the team including Lindsay Woodworth who is the school liaison and Ana Pasini who helped with the vaccination clinic and COVID shelter. She is also a world-class babysitter for their offices. Ms. Rigali-Oiler was one of the original hires for CAYAC and helped to establish policies and procedures, as well as doing a lot of outreach.

CAYAC was formed in 2015 to provide centralized behavioral health care for youth in our District, including support, resources, and direct services in a timely and affordable manner. In the beginning, an

Early Identification, Early Intervention (EIEI) Workgroup was established, meeting from 2010 to 2012. Dr. Udupa was a part of this work group. The largest community gaps in youth mental health were defined from delays in child psychiatric access to families confused by the maze of behavioral health care, to psychological testing. In 2016, the Health District established CAYAC, receiving a 3-year pilot grant from EIEI. A multidisciplinary team of five offered an integrated model of mental health, therapist, and medical provider.

CAYAC direct services include psychiatry, brief (bridge-the-gap) therapy, and psychological evaluations. A unique medication model is utilized with two to eight visits including a thorough diagnostic examination and a walk to the psychologist or psychiatrist if medication is needed. Clients are then referred back to primary care for medication management. It is CAYAC's goal to keep the wait list at no more than four weeks. The team can also assist with interim care. Ms. Rigali-Oiler is the lead CAYAC psychologist. Psychologists at CAYAC can provide consultation to families and providers. Referrals come from 26 primary care offices, the Poudre School District, therapists and other community providers, and self-referral. Clientele served is youth ages 2 to 18 and some 19+ individuals that haven't "launched". Forty-one to forty-four percent of clients are on Medicaid and/or CHP+, though CHP+ doesn't cover psychological evaluation and Medicaid covers very few. Care coordinators are bilingual, serving 71 clients with 368 services provided in Spanish. The team is seeing an increase in family needs as a national state of emergency is declared for child mental health issues. They anticipate a large increase in referrals as children return to school.

Evaluation of the three-year pilot showed that CAYAC had reduced barriers, reduced wait times, improved communication between client providers, and increased hopefulness for families. Care coordinators are the first point of contact, referring clients to three paths (psychiatry, behavioral health provider, psychology testing). The goal is to achieve wrap-around care for the family. Ms. Loutzenhiser noted that outreach and education programs are provided in the community in trusted spaces as well as participating in tabling outreach, working with community partner events and local festivals and celebrations. Staff routinely attend coalition and community groups, providing education to community members. An ADHD education series is currently offered virtually and is free to the public with additional community presentations in Behavioral Health 101 and the Role of Medications in Child and Adolescent Behavioral Health. Several more presentations are scheduled, working with SummitStone and the Poudre School District. The greatest challenge is capacity as we see greater needs arising out of the pandemic. Director Prows commented that he has sent countless patients to CAYAC over the years. The Board offered their gratitude.

DISCUSSION AND ACTIONS

Board Priorities Following Work Sessions

Board President Molly Gutilla expressed her gratitude for the Board's commitment to work sessions, open conversation and moving forward with both head work and heart work. Three priorities floated to the top and, in no particular order, they are behavioral health, including mental health and substance use across the lifespan; improving oral health and capitalizing on existing structure for dental care; and access to care through coverage. When we approach these and all work of the Health District we must center the pursuit of health equity, use data to measure outcomes and track progress, and pursue strategies that are known to impact population health, such as policy intervention.

The Board generally agreed that there is no doubt that behavioral health and substance abuse rose to the top – it has worsened during the pandemic. For many years, behavioral/mental health has been underrated and underfunded. The Health District continues to uncover so much need in our community, with stigmatization remaining, as we scramble to fill the need. These priorities really reflect the greatest need, and the greatest shortage, in our community. Throughout the pandemic we have done things outside of the scope of our mission and vision and the demand is only increasing. The Health District has gained

experience and credibility, as well as strong relationships in the community in these areas. Director Gutilla noted the increased demand for mental health services for youth, post-pandemic.

Board Discussion and Decisions
There was some discussion about the wording of the third priority: access to care through coverage. The goal seems larger than "coverage" – reducing barriers, access to resources, information and education. It was agreed that the overarching approach is to center on health equity using data and strategies to define that work.

MOTION: To adopt three priority areas, not in ranked order: behavioral/mental health/substance abuse across the lifespan; oral health; and access to care through coverage.
Motion by Julie Kunce Field / Second by Joseph Prows / Carried Unanimously

July 26 Board of Directors Meeting Minutes
Director Kling noted that the "mini retreats" reflected on page five were not truly retreats. She expressed her concern with that language since not all of the Board were together in a group. It was suggested that "mini retreats" be changed to "non-quorum small group meetings".

MOTION: To approve the July 26 minutes with identified changes.
Motion by Joseph Prows / Second by Julie Kunce Field / Carried Unanimously

UPDATES & REPORTS

Liaison to PVHS/UCHealth North Report – Celeste Holder Kling
Ms. Kling noted that a joint meeting of our two Boards is set for November 16 at 4:00 p.m. The UCHealth North boards reviewed year-end financials and current contracts. The financial situation is strong overall. Big hits have been salaries for traveling doctor and nurses, capital expenses, retirement expenses, and construction costs. Phase 2 of the PVH construction (including moving Mountain Crest services into the PVH campus) has been placed on a short-term hold. Bed space is tight at PVH, not due to COVID patient census (although some staff have been out for COVID), but largely due to population growth on the front range exceeding bed capacity at times. Phase 2 construction will continue after 34 more beds open in the Greeley hospital next spring. UCHealth, and PVH and MCR in particular, have received many accolades from the Colorado Medical Society (5 star ratings for both hospitals), US News & World Report (5th and 4th top rated hospitals in CO, respectively), and Merative Top 100 Hospitals award: PVH was in this group for the 16th year in a row. Ongoing challenges at UCH include staffing, and they are currently undergoing performance evaluations and recalibrating pay scales post-pandemic.

Executive Director Updates – Robert B. Williams
Mr. Williams announced that the Board Portal is live. Please let the staff know if you experience any problems accessing the portal. A financial snapshot for each of the two programs reviewed today was included in your Board packet. Integrated Care serves the community in two facilities. CAYAC has had very little revenue while their expenditures are similar to Integrated Care. Leadership is seeking ways in which revenue can be increased while we provide needed services to the community. These reports are a snapshot reflecting the 7-month actual and the variance to a 12-month budget. Please let Mr. Williams know if you have questions.

PUBLIC COMMENT (2nd opportunity)
None

ANNOUNCEMENTS

- September 19, 8:00 am – 6:00 pm, Board of Directors Retreat
- September 27, 4:00 pm, Board of Directors Regular Meeting
- October 27, 4:00 pm, Board of Directors Regular Meeting
- November 14, 4:00 pm – Board of Directors Regular Meeting and Budget Hearing

Board President Gutilla reminded Board members that their self-assessments are due by August 28th.

ADJOURN

MOTION: To adjourn the Regular Meeting

Motion by Ann Yanagi / Second by Joseph Prows / Carried Unanimously

The Regular Board Meeting was adjourned at 7:12 pm.

Respectfully submitted:

_____

Anita Benavidez, Assistant to the Board of Directors

_____

Molly Gutilla, MS, DrPH, Board President

_____

Julie Kunce Field, JD, Board Vice President

_____

Celeste Holder Kling, JD, Liaison to UCH-North and PVHS Board

_____

Joseph Prows, MD MPH, Board Treasurer

_____

Ann Yanagi, MD, Board Secretary

Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS
RETREAT/SPECIAL MEETING
September 19, 2022

Health District Office Building
120 Bristlecone Drive, Fort Collins
Remote Meeting

MINUTES

BOARD MEMBERS PRESENT: Molly Gutilla, MS, DrPH., Board President
Julie Kunce Field, JD, Board Vice President
Joseph Prows, MD MPH, Board Treasurer
Celeste Kling, JD, Liaison to UCH-North/PVH
Ann Yanagi, MD, Board Secretary

CALL TO ORDER & APPROVAL OF AGENDA

Director Molly Gutilla called the meeting to order at 5:35 p.m.

MOTION: To approve the agenda as Presented
Moved/Seconded/Carried Unanimously

EXECUTIVE SESSION

A motion was made to adjourn the Retreat and go into Executive Session.

MOTION: To adjourn the Regular Meeting and retire to Executive Session for the purpose of personnel matters regarding an evaluation of the Executive Director's performance, pursuant to §24-6-402(4)(f) of the C.R.S.
Moved/Seconded/Carried Unanimously

The Board retired to Executive Session at 5:36 p.m.

The Executive Session closed at 6:03 p.m.

Respectfully submitted:

Anita Benavidez, Assistant to the Board of Directors

Molly Gutilla, MS, DrPH., Board President

Julie Kunce Field, JD, Board Vice President

Celeste Holder Kling, J.D., Liaison to UCH-North and PVHS Board

Joseph Prows, MD MPH, Board Treasurer

Ann Yanagi, MD, Board Secretary

HEALTH DISTRICT
of Northern Larimer County
July 2022
Summary Financial Narrative

Revenues

The Health District is .35% ahead of year-to-date tax revenue projections. Interest income is 4.8% ahead year-to-date projections. Lease revenue is 34.8% behind of year-to-date projections. Yield rates on investment earnings increased to 1.49% (based on the weighted average of all investments). Fee for service revenue from clients is 11% behind year-to-date projections and revenue from third party reimbursements is 6.2% ahead of year-to-date projections. Total operating revenues for the Health District (excluding grants and special projects) are .16% behind of year-to-date projections.

Expenditures

Operating expenditures (excluding grants and special projects) are 18.8% behind year-to-date projections. Program variances are as follows: Administration 9.8%; Board 11%; Connections: Mental Health/Substance Issues Services 23.24%; Dental Services 20%; MH/SUD/Primary Care 16.3%; Health Promotion 10.8%; Community Impact 28.8%; Program Assessment and Evaluation 9.5%; Health Care Access 22.7%; Resource Development 12.3% and Mulberry Offices 34.6%.

Capital Outlay

Capital expenditures are 101.4% behind year-to-date.

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY
BALANCE SHEET
As of 7/31/2022

ASSETS

Current Assets:	
Cash & Investments	$10,127,580
Accounts Receivable	88,631
Property Taxes Receivable	261,127
Specific Ownership Tax Receivable	54,381
Prepaid Expenses	28,375
Total Current Assets	10,560,093
Other Assets:	
Lease Receivable	59,098,363
Total Other Assets	59,098,363
Property and Equipment	
Land	4,592,595
Building and Leasehold Improvements	7,275,626
Equipment	1,235,877
Accumulated Depreciation	(3,273,435)
Total Property and Equipment	9,830,663
Total Assets	79,489,119

LIABILITIES AND EQUITY

Current Liabilities:	
Accounts Payable	865,683
Deposits	10,316
Deferred Revenue	299,152
Total Current Liabilities	1,175,151
Long-term Liabilities:	
Compensated Absences	32,899
Total Long-term Liabilities	32,899
Deferred Inflows of Resources	
Property Taxes	152,851
Leases	59,587,442
Total Deferred Inflows of Resources	59,740,293
Total Liabilities & Deferred Inflows of Resources	60,948,343
EQUITY	
Retained Earnings	14,288,299
Net Income	4,252,477
TOTAL EQUITY	18,540,776
TOTAL LIABILITIES AND EQUITY	79,489,119

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY
STATEMENT OF REVENUES AND EXPENSES
As of 7/31/2022

	Current Month	Year to Date
Revenue		
Property Taxes	108,276	8,565,527
Specific Ownership Taxes	54,380	372,268
Lease Revenue	113,300	1,228,385
Interest Income	11,775	29,351
Fee For Service Income	13,346	86,761
Third Party Income	62,561	499,646
Grant Income	69,047	423,344
Special Projects	0	12,825
Miscellaneous Income	945	16,766
Total Revenue	433,630	11,234,873
Expenses:		
Operating Expenses		
Administration	62,524	568,066
Board Expenses	3,108	56,061
Connections: Mental Health/Substance Issues Svcs	153,165	1,112,078
Dental Services	244,885	1,812,523
Integrated Care (MHSA/PC)	86,682	622,319
Health Promotion	60,621	442,277
Community Impact	50,038	314,531
Program Assessment & Evaluation	18,215	142,208
Health Care Access	79,314	587,816
Resource Development	14,673	99,891
Mulberry Offices	12,516	74,400
Contingency -Operational	953	5,768
Special Projects	42,861	575,836
Grant Projects	63,787	425,011
Total Operating Expenses	893,343	6,838,785
Depreciation and Amortization		
Depreciation Expense	20,594	143,611
Total Depreciation and Amortization	20,594	143,611
Total Expenses	913,937	6,982,396
Net Income	(480,307)	4,252,477

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY
Statement of Revenues and Expenditures - Budget and Actual
As of 7/31/2022

	Current Month			Year to Date			Annual	Remaining
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Funds
Revenue:								
Property Taxes	$130,175	$108,276	$21,899	$8,535,913	$8,565,527	($29,614)	$8,700,766	$135,239
Specific Ownership Taxes	59,050	54,380	4,670	370,391	372,268	(1,877)	625,000	252,732
Lease Revenue	112,292	9,066	103,226	774,090	504,717	269,373	1,335,549	830,832
Interest Income	7,000	11,775	(4,775)	28,000	29,351	(1,351)	65,000	35,649
Sales Revenue	25	0	25	175	0	175	300	300
Fee for Services Income	13,918	13,346	572	97,426	86,761	10,665	167,021	80,260
Third Party Reimbursements	79,023	78,045	978	553,161	587,689	(34,528)	948,273	360,584
Grant Revenue	34,740	69,047	(34,306)	322,967	423,344	(100,377)	1,246,441	823,097
Partnership Revenue	0	0	0	0	12,825	(12,825)	0	(12,825)
Miscellaneous Income	1,892	945	947	13,244	16,766	(3,522)	22,704	5,938
Total Revenue	$438,115	$344,880	$93,235	$10,695,367	$10,599,248	$96,119	$13,111,054	$2,511,806
Expenditures:								
Operating Expenditures								
Administration	$67,015	$62,524	$4,490	$629,647	$568,066	$61,581	$952,280	$384,214
Board Expenses	3,142	3,108	34	63,006	56,061	6,945	79,118	23,057
Connections: Mental Health/Substance Issues Svcs	194,015	153,165	40,851	1,370,545	1,112,078	258,467	2,339,007	1,226,929
Dental Services	328,713	244,885	83,828	2,266,285	1,812,523	453,762	3,894,293	2,081,770
Integrated Care (MH/SUD/PC)	107,661	86,682	20,979	743,776	622,319	121,457	1,275,292	652,973
Health Promotion	71,329	60,621	10,708	495,827	442,277	53,550	854,448	412,171
Community Impact	64,121	50,038	14,083	441,580	314,531	127,049	757,422	442,891
Program Assessment & Evaluation	22,769	18,215	4,554	157,178	142,208	14,970	269,530	127,322
Health Care Access	109,254	79,314	29,940	759,977	587,816	172,161	1,312,744	724,928
Resource Development	16,526	14,673	1,853	113,862	99,891	13,971	195,262	95,371
Mulberry Office	12,887	12,516	371	113,805	74,400	39,405	178,020	103,620
Contingency (Operations)	5,000	953	4,047	35,000	5,768	29,232	60,000	54,232
Special Projects	163,440	42,861	120,579	1,168,980	575,836	593,144	3,078,726	2,502,890
Grant Projects	101,275	63,787	37,488	788,710	425,011	363,699	1,246,441	821,431
Total Operating Expenditures	$1,267,148	$893,343	$373,805	$9,148,178	$6,838,785	$2,309,393	$16,492,583	$9,653,798
Net Income	($829,032)	($548,463)	($280,570)	$1,547,189	$3,760,463	($2,213,274)	($3,381,529)	($7,141,993)

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF NON OPERATIONAL EXPENDITURES - BUDGET TO ACTUAL

For 7/1/2022 to 7/31/2022

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Annual Funds Remaining
Non-Operating Expenditures								
Land	-	-		-	-			
Building	10,000	-	10,000	190,000		190,000	1,064,500	1,064,500
Construction in Progress		21,575	(21,575)	-	69,476	-	-	-
Capital Equipment	-	-	-	25,000	-	25,000	50,000	50,000
General Office Equipment	-	-	-	10,000	-	10,000	10,000	10,000
Medical & Dental Equipment	3,500	(3,285)	6,785	23,712	(8,219)	31,931	34,487	42,706
Computer Equipment	-	-	-		-	-	-	-
Computer Software	-	-	-	-	-	-	-	-
Equipment for Building	5,000	-	5,000	56,000	4,000	52,000	132,000	128,000
Total Non-Operating Expenditures	$ 18,500	$ 18,290	$ 210	$ 304,712	$ 65,257	$ 308,931	$ 1,290,987	$ 1,295,206

For 7/1/2022 to 7/31/2022

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY
Statement of Program Revenues and Expenditures - Budget and Actual
As of 7/31/2022

	Current Month			Year to Date			Annual	Remaining
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Funds
Administration								
Revenue:								
Miscellaneous Income	$875	$0	$875	$6,125	$10,013	($3,888)	$10,500	$487
Total Revenue	875	0	875	6,125	10,013	(3,888)	10,500	487
Expenditures:								
Salaries and Benefits	49,508	47,988	1,520	346,550	303,413	43,137	594,079	290,666
Supplies and Purchased Services	17,507	14,536	2,970	283,097	264,652	18,444	358,201	93,549
Total Expenditures	67,015	62,524	4,490	629,647	568,066	61,581	952,280	384,214
Board of Directors								
Expenditures:								
Salaries and Benefits	0	0	0	8,612	20,692	(12,080)	8,612	(12,080)
Supplies and Purchased Services	3,142	3,108	34	22,394	10,825	11,569	38,506	27,681
Election Expenses	0	0	0	32,000	24,545	7,456	32,000	7,456
Total Expenditures	3,142	3,108	34	63,006	56,061	6,945	79,118	23,057
Connections: Mental Health/substance Issue								
Revenue:								
Fees, Reimbursements & Other Income	3,083	2,236	847	21,581	21,464	117	37,000	15,536
Total Revenue	3,083	2,236	847	21,581	21,464	117	37,000	15,536
Expenditures:								
Salaries and Benefits	164,182	138,281	25,901	1,149,274	977,812	171,462	1,970,180	992,368
Supplies and Purchased Services	29,833	14,883	14,950	221,271	134,266	87,005	368,827	234,561
Total Expenditures	194,015	153,165	40,851	1,370,545	1,112,078	258,467	2,339,007	1,226,929
Dental Services								
Revenue:								
Fees, Reimbursements & Other Income	61,678	52,102	9,576	431,746	488,990	(57,244)	740,136	251,146
Total Revenue	61,678	52,102	9,576	431,746	488,990	(57,244)	740,136	251,146
Expenditures:								
Salaries and Benefits	261,536	202,976	58,560	1,830,752	1,444,755	385,997	3,138,417	1,693,662
Supplies and Purchased Services	67,177	41,909	25,268	435,533	367,768	67,765	755,876	388,108
Total Expenditures	328,713	244,885	83,828	2,266,285	1,812,523	453,762	3,894,293	2,081,770

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY
Statement of Program Revenues and Expenditures - Budget and Actual
As of 7/31/2022

	Current Month			Year to Date			Annual	Remaining
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Funds
Integrated Care (MHSA/PC)								
Revenue:								
Fees, Reimbursements & Other Income	19,285	22,363	(3,078)	134,995	81,806	53,189	231,419	149,613
Total Revenue	19,285	22,363	(3,078)	134,995	81,806	53,189	231,419	149,613
Expenditures:								
Salaries and Benefits	94,990	80,339	14,651	664,930	562,960	101,970	1,139,873	576,913
Supplies and Purchased Services	12,671	6,344	6,327	78,846	59,359	19,487	135,419	76,060
Total Expenditures	107,661	86,682	20,979	743,776	622,319	121,457	1,275,292	652,973
Community Impact								
Revenue:								
Fees, Reimbursements & Other Income	0	0	0	0	0	0	0	0
Total Revenue	0	0	0	0	0	0	0	0
Expenditures:								
Salaries and Benefits	55,254	45,618	9,636	386,778	274,896	111,882	663,073	388,177
Supplies and Purchased Services	8,867	4,419	4,448	54,802	39,635	15,167	94,349	54,714
Total Expenditures	64,121	50,038	14,083	441,580	314,531	127,049	757,422	442,891
Program Assessment & Evaluation								
Revenue:								
Fees, Reimbursements & Other Income	0	0	0	0	0	0	0	0
Total Revenue	0	0	0	0	0	0	0	0
Expenditures:								
Salaries and Benefits	19,645	16,898	2,747	137,515	123,920	13,595	235,728	111,808
Supplies and Purchased Services	3,124	1,316	1,808	19,663	18,288	1,375	33,802	15,514
Total Expenditures	22,769	18,215	4,554	157,178	142,208	14,970	269,530	127,322
Health Promotion								
Revenue:								
Fees, Reimbursements & Other Income	231	150	81	1,617	899	718	2,770	1,871
Total Revenue	231	150	81	1,617	899	718	2,770	1,871
Expenditures:								
Salaries and Benefits	57,566	54,584	2,982	402,962	373,004	29,958	690,780	317,776
Supplies and Purchased Services	13,763	6,038	7,725	92,865	69,273	23,592	163,668	94,395
Total Expenditures	71,329	60,621	10,708	495,827	442,277	53,550	854,448	412,171

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY
Statement of Program Revenues and Expenditures - Budget and Actual
As of 7/31/2022

	Current Month			Year to Date			Annual	Remaining
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Funds
Health Care Access								
Revenue:								
Fees, Reimbursements & Other Income	0	0	0	0	0	0	0	0
Total Revenue	0	0	0	0	0	0	0	0
Expenditures:								
Salaries and Benefits	90,114	71,454	18,660	630,798	509,969	120,829	1,081,343	571,374
Supplies and Purchased Services	19,140	7,860	11,280	129,179	77,847	51,332	231,401	153,554
Total Expenditures	109,254	79,314	29,940	759,977	587,816	172,161	1,312,744	724,928
Health Info Source								
Revenue:								
Expenditures:								
Resource Development								
Revenue:								
Fees, Reimbursements & Other Income	0	0	0	0	0	0	0	0
Total Revenue	0	0	0	0	0	0	0	0
Expenditures:								
Salaries and Benefits	14,249	13,576	673	99,743	92,070	7,673	170,985	78,915
Supplies and Purchased Services	2,277	1,097	1,180	14,119	7,821	6,298	24,277	16,456
Total Expenditures	16,526	14,673	1,853	113,862	99,891	13,971	195,262	95,371
Mulberry Offices								
Revenue:								
Fees, Reimbursements & Other Income	9,706	15,485	(5,779)	67,942	88,043	(20,101)	116,473	28,430
Total Revenue	9,706	15,485	(5,779)	67,942	88,043	(20,101)	116,473	28,430
Expenditures:								
Salaries and Benefits	2,892	2,811	81	20,248	19,722	526	34,694	14,972
Supplies and Purchased Services	9,995	9,705	290	93,557	54,678	38,879	143,326	88,648
Total Revenue	12,887	12,516	371	113,805	74,400	39,405	178,020	103,620

Health District of Northern Larimer County

Investment Schedule
July 2022

Investment	Institution	Current Value	%	Current Yield	Maturity
Local Government Investment Pool	COLOTRUST	$ 1,387	0.014%	1.24%	N/A
Local Government Investment Pool	COLOTRUST	$ 8,535,213	87.093%	1.65%	N/A
Flex Savings Account	First National Bank	$ 238,669	2.435%	0.30%	N/A
Certificate of Deposit	Advantage Bank	$ 142,682	1.456%	0.40%	12/27/2023
Certificate of Deposit	Advantage Bank	$ 115,231	1.176%	0.25%	9/2/2022
Certificate of Deposit	Points West	$ 116,093	1.185%	0.28%	6/12/2023
Certificate of Deposit	Points West	$ 158,229	1.615%	1.00%	4/2/2024
Certificate of Deposit	Adams State Bank	$ 242,563	2.475%	0.35%	10/7/2023
Certificate of Deposit	Cache Bank & Trust	$ 250,000	2.551%	0.10%	1/9/2023
Total/Weighted Average		$ 9,800,067	100.000%	1.49%	

Notes:

The local government investment pool invests in U.S. Treasury securities, U.S. Government agency securities, certificate of deposits, commercial paper, money market funds and repurchase agreements backed by these same securities.

Health District
OF NORTHERN LARIMER COUNTY

2010-01: FINANCIAL ACCOUNTS SIGNATURE POLICY

[Amended September 28, 2021)]

Presented for Approval: ~~April 14, 2022~~September 27, 2022

Purpose of Policy

In order to maintain internal control on the financial accounts for the Health District of Northern Larimer County while still allowing for a reasonable flow of business, the following designations and restrictions on signatures shall apply:

1) Designated officials for expenditures (excluding funds transfers):

- **Expenditures of Up to $25,000**: require **one** of the following signatures
- **Expenditures of Over $25,000**: require **two** of the following signatures (officials with an asterisk "*" must be one of the signatures)
    - *Executive Director
    - Finance Director (limit: $15,000)
    - Board President
    - Board Secretary
    - *Board Treasurer

Generally the signatures of the Finance Director and/or Executive Director will be used.

2) Fund Transfers by Phone, ONLY to Health District Accounts

The following individuals are authorized to contact banks and investment firms to transfer funds, but only between Health District accounts. There is no limit on the amount of funds that can be transferred between Health District accounts. Expenditures from those accounts are limited by the policies above. Funds transfer report forms will be kept and filed with bank statements

- Finance Director
- Executive Director
- Board Treasurer
- Board Secretary

3) Automated Clearing House (ACH) transactions

The following individuals are authorized to initiate Automated Clearing House (ACH) transactions through the First National Bank Cash Management System for:

- Vendor payments for goods and services (excluding employee benefit premiums and insurance premiums). Individual vendor invoices for payment must include authorized signature(s) in accordance with Policy 21-01: Contract Signature Policy. (Invoices over $25,000 require two signatures). No dollar amount limit).

- Payments of employee benefit premiums and insurance premiums (No dollar amount limit).

Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director

4) Wire Transfers

Most fund transfers will take place only between District accounts. In rare occasions, a wire transfer may be necessary from the District checking account. Should such a wire transfer be necessary, the following procedure will apply:

a) Individuals authorized to initiate wire transfers include:
   - Finance Director
   - Executive Director
   - Board Secretary
   - Board Treasurer

b) Wire transfer authorization must be performed in person at the bank by **two** of the individuals listed above, which must include one staff member and one board member.

c) Wire transfer report forms will be kept and filed with bank statements.

ADOPTED, this ~~14~~27th day of ~~April~~September, A.D., 2022.

Attest:

_____ _____

~~Michael D. Liggett~~Molly J. Gutilla, President ~~Molly J. Gutilla~~Julie Kunce Field, Vice President

_____ _____

~~Johanna Ulloa Giron~~Ann Yanagi, Secretary Joseph W. Prows, Treasurer

_____

Celeste Holder Kling,
UCHealth North/PVHS Board Liaison

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR CERTIFICATE OF DEPOSIT ACCOUNTS

Resolution 2022-~~13~~23

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that the following signators are approved for signing authorization to purchase, renew or close Certificates of Deposit at any eligible public depository bank approved by the Colorado Division of Banking in accordance with the Health District of Northern Larimer County Investment Guidelines. All allowable signatures or authorizations must conform to Policy 2010-01: Financial Accounts Signature Policy adopted by the Health District on the 28th day of September, 2021.

Approved to purchase or close Certificates of Deposit (two signatures required); requires prior approval by Executive Director or designee. The disbursement of funds from closed Certificates of Deposit must be made through an Automated Clearing House (ACH) transaction only to an authorized Health District bank account or by check made payable to the Health District.

Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director
Joseph W. Prows, Treasurer

Approved to renew Certificates of Deposit (one signature required).

Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director
Joseph W. Prows, Treasurer

ADOPTED, this ~~14~~27th day of ~~April~~September, A.D., 2022.

Attest:

_____ _____

~~Michael D. Liggett~~Molly J. Gutilla, President ~~Molly J. Gutilla~~Julie Kunce Field, Vice President

_____ _____

~~Johanna Ulloa Giron~~Ann Yanagi, Secretary Joseph W. Prows, MD, Treasurer

_____
Celeste Holder Kling

UC Health-North/PVHS Board Liaison

Replaces the Following Resolutions:
2018-11 Adopted September 25, 2018
2022-13 Adopted April 14, 2022
2022-32 Adopted September 27, 2022

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR ACCESS TO SAFE DEPOSIT BOXES 2219 AND 5542

Resolution 2022-~~15~~24

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that any two of the following signators are approved to have access to the Health District's Safety Deposit Boxes 2219 and 5542 at the First National Bank, 205 West Oak Street, Fort Collins, Colorado.

Approved for Signatures

Ann Yanagi, Secretary
Joseph W. Prows, Treasurer
Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Manager
Anita K. Benavidez, Assistant to the Executive Director and the Board of Directors

ADOPTED, this ~~28~~27th day of ~~June~~September, A.D., 2022.

Attest:

_____ _____
Molly J. Gutilla, President Julie Kunce Field, Vice President

_____ _____
Ann Yanagi, Secretary Joseph W. Prows, Treasurer

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Celeste Holder Kling
UC Health-North/PVHS Board Liaison

Replaces the Following Resolution:
2010-10 Adopted July 21, 2010
2014-10 Adopted May 21, 2014
2016-14 Adopted July 21, 2016
2018-12 Adopted September 25, 2018
2019-03 Adopted March 28, 2019
2022-03 Adopted April 14, 2022
2022-24 Adopted September 27, 2022

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR ACCESS TO SAFE DEPOSIT BOX 4919

Resolution 2022-~~16~~25

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that any one of the following signators are approved to have access to the Health District's Safety Deposit Box 4919 at the First National Bank, 205 West Oak Street, Fort Collins, Colorado.

Approved for Signatures

Ann Yanagi, Secretary
Joseph W. Prows, Treasurer
Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director
Anita K. Benavidez, Assistant to Executive Director and Board of Directors

ADOPTED, this ~~28~~27th day of ~~June~~September, A.D., 2022.

Attest:

_____
Molly J. Gutilla, President

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Julie Kunce Field, Vice President

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Ann Yanagi, Secretary

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Joseph W. Prows, Treasurer

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Celeste Holder Kling
UC Health-North/PVHS Board Liaison

Replaces the Following Resolution:
2012-5 Adopted September 6, 2012
2014-11 Adopted May 21, 2014
2016-15 Adopted July 21, 2016
2018-13 Adopted Sept. 25, 2018
2019-04 Adopted March 28, 2019
2022-04 Adopted April 14, 2022
2022-25 Adopted September 27, 2022

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR ACCESS TO SAFE DEPOSIT BOX 5546

Resolution 2022-~~17~~26

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that any one of the following signators are approved to have access to the Health District's Safety Deposit Box 5546 at the First National Bank, 205 West Oak Street, Fort Collins, Colorado.

Approved for Signatures

Ann Yanagi, Secretary
Joseph W. Prows, Treasurer
Robert B. Williams , Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director
Anita K. Benavidez, Assistant to Executive Director and Board of Directors

ADOPTED, this ~~28~~27th day of ~~June~~September, A.D., 2022.

Attest:

Molly J. Gutilla, President	Julie Kunce Field, Vice President
Ann Yanagi, Secretary	Joseph W. Prows, Treasurer

Celeste Holder Kling
UC Health-North/PVHS Board Liaison

Replaces the Following Resolution:
2018-14 Adopted Sept. 25, 2018
2019-04 Adopted March 28, 2019
2022-05 Adopted April 14, 2022
2022-26 Adopted September 27, 2022

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR ACCESS TO SAFE DEPOSIT BOX 5742

Resolution 2022-~~18~~27

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that any one of the following signators are approved to have access to the Health District's Safety Deposit Box 5742 at the First National Bank, 205 West Oak Street, Fort Collins, Colorado.

Approved for Signatures

Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director
Anita K. Benavidez, Assistant to Executive Director and Board of Directors
Ann Yanagi, Secretary
Joseph W. Prows, Treasurer

ADOPTED, this ~~28~~27th day of ~~June~~September, A.D., 2022.

Attest:

_____	_____
Molly J. Gutilla, President	Julie Kunce Field, Vice President
_____	_____
Ann Yanagi, Secretary	Joseph W. Prows, Treasurer

_____
Celeste Holder Kling
UC Health-North/PVHS Board Liaison

Replaces the Following Resolutions:
2016-18 Adopted on November 15, 2016
2018-15 Adopted on September 25, 2018
2019-06 Adopted on March 28, 2019
2022-06 Adopted on April 14, 2022
2022-27 Adopted on September 27, 2022

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR FIRST NATIONAL BANK ACCOUNT NUMBER XXX4934

Resolution 2022-~~19~~28

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that the following signators are approved for signing checks, making fund transfers from this Health District account at First National Bank, 205 West Oak Street, Fort Collins, CO, or signing investment documents in accordance with Health District of Northern Larimer County Investment Guidelines. All allowable signatures or authorizations must conform to Policy 2010-01: Financial Accounts Signature Policy adopted by the Health District on the 28th day of September, 2021.

Approved for Check Signatures (two signatures required for checks over $25,000, one signature required for checks $25,000 or less)

Molly J. Gutilla, Board President
Ann Yanagi, Secretary
Joseph W. Prows, Treasurer
Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director
(limit: $15,000)

Approved to Authorize Fund Transfers ONLY to Health District Accounts

Ann Yanagi, Secretary
Joseph W. Prows, Treasurer
Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director

Approved to Make Automated Clearing House (ACH) transactions through the First National Bank Cash Management System for:

- Vendor payments for goods and services (excluding employee benefit premiums and insurance premiums). Individual vendor invoices for payment must include authorized signature(s) in accordance with Policy 21-01: Contract Signature Policy. (Invoices over $25,000 require two signatures). No dollar amount limit).
- Payments of employee benefit premiums and insurance premiums (No dollar amount limit).

Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director

Approved to Make Wire Transfers (two in-person authorizations required; one must be a Board member, the other a staff member)

Ann Yanagi, Secretary (Board Member)
Joseph W. Prows, Treasurer (Board Member)
Robert B. Williams, Executive Director (Staff member)
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director (Staff member)

Approved to Sign Investment Documents (two signatures required); requires prior approval by Executive Director or designee.

Ann Yanagi, Secretary
Joseph W. Prows, Treasurer
Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director

ADOPTED, this ~~28~~27th day of ~~June~~September, A.D., 2022.

Attest:

Molly J. Gutilla, President	Julie Kunce Field, Vice President
Ann Yanagi, Secretary	Joseph W. Prows, MD, Treasurer

Celeste Holder Kling
UC Health-North/PVHS Board Liaison

Replaces the Following Resolutions:

2018-07	Adopted July 21, 2016
2014-05	Adopted May 21, 2014
2010-05	Adopted June 29, 2010
2008-13	Adopted June 24, 2008
2008-4	Adopted
2006-5	Adopted June 27, 2006
2004-8	Adopted February 24, 2004
2002-5	Adopted June 25, 2002
2001-3	Adopted August 28, 2001
2000-16	Adopted October 24, 2000
2000-9	Adopted August 22, 2000
2018-07	Adopted September 25, 2018
2022-09	Adopted April 14, 2022
2022-28	Adopted September 27, 2022

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR FIRST NATIONAL BANK ACCOUNT NUMBER XXXX0218

Resolution 2022-~~20~~29

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that the following signators are approved for signing checks, and making fund transfers to/from this Health District account at First National Bank, 205 West Oak Street, Fort Collins, Colorado. All allowable signatures or authorizations must conform to Policy 2010-01: Financial Accounts Signature Policy adopted by the Health District on the 28th day of September, 2021.

Approved for Check Signatures (two signatures required for checks over $25,000, one signature required for checks $25,000 or less)

Molly J. Gutilla, Board President
Ann Yanagi, Secretary
Joseph W. Prows, Treasurer
Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director (limit: $15,000)

Approved to Authorize Fund Transfers ONLY to Health District Accounts

Ann Yanagi, Secretary
Joseph W. Prows, Treasurer
Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director

Approved to Make Automated Clearing House (ACH) transactions through the First National Bank Cash Management System for vendor payments. (Dollar amount limits as specified above).

Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director

ADOPTED, this ~~28~~27th day of ~~June~~September, A.D., 2022.

Attest:

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Molly J. Gutilla, President

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Julie Kunce Field, Vice President

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Ann Yanagi, Secretary

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Joseph W. Prows, Treasurer

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Celeste Holder Kling
UC Health-North/PVHS Board Liaison

Replaces the Following Resolutions:
2009-04 Adopted May 6, 2009
2010-08 Adopted June 29, 2010
2014-08 Adopted May 21, 2014
2016-10 Adopted July 21, 2016
2018-08 Adopted September 25, 2018
2022-10 Adopted April 14, 2022
2022-29 Adopted September 27, 2022

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR FIRST NATIONAL BANK ACCOUNT NUMBER XXX6405

Resolution 2022-~~21~~30

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that the following signators are approved for signing checks or making fund transfers from this Health District account at First National Bank, 205 West Oak Street, Fort Collins, CO. This account is to be used solely as a payroll imprest account. All allowable signatures or authorizations must conform to Policy 2010-01: Signature Policy adopted by the Health District on the 28th day of September, 2021.

Approved for Check Signatures (two signatures required for checks over $25,000, one signature required for checks $25,000 or less)

Molly J. Gutilla, Board President
Ann Yanagi, Secretary
Joseph W. Prows, Treasurer
Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director (limit: $15,000)

Approved to Authorize Fund Transfers ONLY to Health District Accounts

Ann Yanagi, Secretary
Joseph W. Prows, Treasurer
Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director

ADOPTED, this ~~28~~27th day of ~~June~~September, A.D., 2022.

Attest:

_____ _____
Molly J. Gutilla, President Julie Kunce Field, Vice President

_____ _____
Ann Yanagi, Secretary Joseph W. Prows, Treasurer

_____
Celeste Holder Kling

Replaces the Following Resolution(s):
2000-10 Adopted August 22, 2000
2002-06 Adopted June 25, 2002
2004-07 Adopted February 24, 2004
2006-06 Adopted February 27, 2006
2008-12 Adopted June 24, 2008
2010-06 Adopted June 29, 2010
2014-06 Adopted May 21, 2014
2016-11 Adopted July 21, 2016
2018-09 Adopted September 25, 2018
2022-11 Adopted April 14, 2022
2022-30 Adopted September 27, 2022

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR FIRST NATIONAL BANK SAVINGS ACCOUNT NUMBER XXXX7351

Resolution 2022-~~22~~31

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that the following signators are approved for fund transfers to/from this Health District account at First National Bank, 205 West Oak Street, Fort Collins, Colorado. All allowable signatures or authorizations must conform to Policy 2010-01: Financial Accounts Signature Policy adopted by the Health District on the 28th day of September, 2021.

Approved to Authorize Fund Transfers ONLY from/to Health District Accounts

Ann Yanagi, Secretary
Joseph W. Prows, Treasurer
Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director

ADOPTED, this ~~28~~27th day of ~~June~~September, A.D., 2022.

Attest:

_____
Molly J. Gutilla, President

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Julie Kunce Field, Vice President

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Ann Yanagi, Secretary

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Joseph W. Prows, Treasurer

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Celeste Holder Kling
UC Health-North/PVHS Board Liaison

Replaces the Following Resolutions:
2009-05 Adopted August 18, 2009
2010-07 Adopted June 29, 2010
2014-07 Adopted May 21, 2014
2016-12 Adopted July 21, 2016
2018-10 Adopted September 25, 2018
2022-12 Adopted April 14, 2022
2022-31 Adopted September 27, 2022

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR COLOTRUST *PRIME* + FINANCIAL ACCOUNT NUMBER CO-XX-XX27-4001

Resolution 2022-~~07~~32

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that any one of the following signators are approved for signing authorization or making fund transfers from the Health District's Colorado Local Government Liquid Asset Trust (COLOTRUST) financial account Number CO-XX-XX27-4001, but only to account numbers CO-XX-XX27-8001 at COLOTRUST or XXXX934 at First National Bank, 205 West Oak Street, Fort Collins, CO., and only according to the Revised Board Policy 2010-01: Financial Accounts Signature Policy adopted by the Health District's Board on the 28th day of September, 2021.

Approved for Signatures

Joseph W. Prows, Treasurer
Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director

ADOPTED, this 1~~4~~4th ~~-~~27th day of ~~April~~September, A.D., 2022.

Attest:

_____ _____

~~Michael D. Liggett~~Molly J. Gutilla, President ~~Molly J. Gutilla~~Julie Kunce Field, Vice President

_____ _____

~~Johanna Ulloa Giron~~Ann Yanagi, Secretary Joseph W. Prows, MD, Treasurer

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Celeste Holder Kling
UC Health-North/PVHS Board Liaison

Replaces the Following Resolution:
2008-19 Adopted October 21, 2008
2014-13 Adopted July 22, 2014
2016-07 Adopted July 21, 2016
2018-05 Adopted September 25, 2018

Health District
OF NORTHERN LARIMER COUNTY

2022-07 Adopted April 14, 2022
2022-32 Adopted September 27, 2022

Health District
OF NORTHERN LARIMER COUNTY

RESOLUTION TO APPROVE SIGNATORS FOR COLOTRUST *PLUS* + FINANCIAL ACCOUNT NUMBER CO-XX-XX27-8001

Resolution 2022-~~08~~33

BE IT RESOLVED BY THE Board of Directors of the Health District of Northern Larimer County that any one of the following signators are approved for signing authorization or making fund transfers from the Health District's Colorado Local Government Liquid Asset Trust (COLOTRUST) financial account Number CO-XX-XX27-8001, but only to account number: CO-XX-XX27-4001at Colorado Trust or XXXX934 at First National Bank, 205 West Oak Street, Fort Collins, CO., and only according to the Revised Board Policy 2010-01: Financial Accounts Signature Policy adopted by the Health District's Board on the 28th day of September, 2021.

Approved for Signatures

Joseph W. Prows, Treasurer
Robert B. Williams, Executive Director
~~Laura B. Mai, Finance Director~~Karen Spink, Deputy Director/Acting Finance Director

ADOPTED, this ~~14~~27th day of ~~April~~September, A.D., 2022.

Attest:

_____ _____

~~Michael D. Liggett~~Molly J. Gutilla, President ~~Molly J. Gutilla~~Julie Kunce Field, Vice President

_____ _____

~~Johanna Ulloa Giron~~Ann Yanagi, Secretary Joseph W. Prows, MD, Treasurer

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Celeste Holder Kling
UC Health-North/PVHS Board Liaison

Replaces the Following Resolution:
2008-17 Adopted October 21, 2008
2014-15 Adopted July 22, 2014
2016-08 Adopted July 21, 2016
2018-05 Adopted September 25, 2018
Resolution 2022-33~~08~~

2022-08 Adopted April 14, 2022
2022-33 Adopted September 27, 2022