PUBLIC HEALTH BOARD MEETING

Montezuma Creek Community Health Center 516 UT-162, Montezuma Creek, UT 84534
September 12, 2024 at 12:00 PM

AGENDA

The public is welcome to join the meeting at this Google Meet video call link: https://meet.google.com/cxn-sqcn-cxb or by dialing : +1 401-702-0746 PIN: 295 228 453#

CALL TO ORDER

APPROVAL OF MINUTES

1. Minutes - San Juan Board of Health Meeting July 20, 2024

PUBLIC COMMENT

BUDGET UPDATE

2. Budget Update by Tyler Ketron, Business Manager

BUSINESS ACTION ITEMS

3. Crisis Workforce Grant - Allowable Expenses

   - Incentives: Incentives, professional development, promotion potential, sign on bonuses, etc. potentially could be used to assist with the recruitment efforts

   - Personnel:

     Wages, benefits, and other costs related to recruiting, hiring, and training of individuals to serve as: Administrative support staff, Clinical or professional staff, Disease investigation staff, School health staff, and Program management staff.

     Dedicated human resources (HR) staff to expedite, recruit, and implement more rapid hiring processes for public health emergency preparedness.

     Sustaining current staff: while funding is primarily to hire new staff, if recipients have staff who were hired for COVID-19-specific work supported by other funding streams that is going to expire, then recipients can continue to employ them.

Hiring clinical staff that provide COVID-19-related services is an allowable cost. One factor to keep in mind is that CDC would not generally be paying for individual clinical treatment; vaccinating students, for instance, is a component of a public health campaign and isn't considered clinical care within our definitions.

Administrative support services necessary to implement and manage activities, including travel and training.

COVID-19:

Spending must be 100% COVID-19 related according to the statute. This is a COVID-19-focused grant. If positions are going to be doing part of their work on other projects, then they should be funded accordingly.

CONFIRM FUTURE MEETING TIME & LOCATION

INFORMATIONAL/RECOGNITION ITEMS

4. Board of Health Training Resources by Commissioner Harvey

- National Association of Counties - The County Role in Public Health
- Utah Association of Local Boards of Health (sent by noreply@myabsorb.com -- email kjones@ualhd.org to gain updated access)
- Mentoring from other Local Boards of Health
- Public Health Infrastructure funds

5. Board Member Reports

DIRECTOR'S REPORT

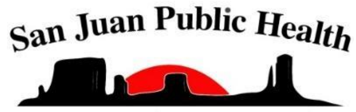
6. Director's Report by Grant Sunada

7. Women, Infants, and Children Program Report by Katie Knight, WIC Director

8. Environmental Health Report and Introduction by Dennis Shumway, Environmental Health Director

ADJOURNMENT

In compliance with the Americans with Disabilities Act, persons needing auxiliary communicative aids and services for this meeting should contact the San Juan County Clerk's Office: 117 South Main, Monticello or telephone 435-587-3223, giving reasonable notice



PUBLIC HEALTH BOARD MEETING

San Juan Public Health Department Conference Room, 735 S. 200 W, Blanding, Utah
July 20, 2024 at 12:00 PM

MINUTES

The meeting will take place and be broadcast from the Large Conference Room San Juan Public Health 735 South 200 West Blanding, UT 84511

CALL TO ORDER 12:08pm

Present

- Chair Ron Skinner
- Vice-Chair Sylvia Benally
- Steve Hiatt
- Lois Young
- Commissioner Jamie Harvey (Virtual)

APPROVAL OF MINUTES

1. San Juan County Board of Health Minutes - June 20, 2024

- **Motion**
- **Second**
- **Favor**
- **Went into Close session 12:13 for** Health Officer Annual Review (Closed Session) (jumped to action item 4)
- **Opened 1:39 pm**

PUBLIC COMMENT: No comments

BUSINESS ACTION ITEMS

1. Consideration and approval of the San Juan County - Minimum Performance Standards SFY22 Amendment 3

Motion: Sylvia

Second: Steve

All in favor

*Board would like to attend the commission meeting when Grant presents this; Ron will send the board the date and time.

2. Consideration and approval of the Public Health Emergency and Healthcare Preparedness Programs FY 24-28 - San Juan County Health Department
   *Note that there will be a carryover from the last fiscal year of $16,000

   Sylvia: Ron is excused at 2:02pm

   Motion: Steve

   Second: Jamie

   All in Favor

4. Health Officer Annual Review (Closed Session) Opened at 12:13 pm and closed at 1:39 pm

5. Set Board Meeting Schedule (Times and Locations) for 12 months)

INFORMATIONAL/RECOGNITION ITEMS

Board of Health Training Resources by Commissioner Harvey (Defer to the next meeting)

DIRECTOR'S REPORT

6. 6. WIC 2023 Report (Defer to next meeting)

BOARD MEMBER REPORTS

CONFIRM FUTURE MEETING TIME & LOCATION

**Possible day for meetings First Thursday at 11:30 or First Mondays at 11:30

Next meeting September 12, 2024 at Noon

Sylvia will check to find a meeting location in Montezuma Creek.

Motion: Lois Young

Second: Steve Hiatt

All in favor

ADJOURNMENT 2:23 pm

Motion: Steve

Second: Lois

All in favor

In compliance with the Americans with Disabilities Act, persons needing auxiliary communicative aids and services for this meeting should contact the San Juan County Clerk's Office: 117 South Main, Monticello or telephone 435-587-3223, giving reasonable notice

UTAH DEPARTMENT OF HEALTH & HUMAN SERVICES
CONTRACT AMENDMENT
PO Box 144003, Salt Lake City, Utah 84114
288 North 1460 West, Salt Lake City, Utah 84116

2229214
Department Log Number

222700714
State Agreement ID

1. CONTRACT NAME: The name of this contract is Public Health Crisis Response Workforce Supplemental SFY 2022 – San Juan County Amendment 3.

2. CONTRACTING PARTIES: This contract amendment is between the Utah Department of Health & Human Services (DEPARTMENT) and San Juan County (CONTRACTOR).

PAYMENT ADDRESS
San Juan County
735 S 200 W, Ste 2
Blanding, UT 84511

MAILING ADDRESS
San Juan County
735 S 200 W, Ste 2
Blanding, UT 84511

Vendor ID: 06866HL
Commodity Code: 99999

3. PURPOSE OF CONTRACT AMENDMENT: The purpose of this amendment is to extend the termination date by 12-months.

4. CHANGES TO CONTRACT:
   1. The contract termination date is being changed. The previous contract termination date was 6/30/24. The new termination date is 06/30/25.

UEI: WCVABP2FEVA2 **Indirect Cost Rate:** 0.0 %

Federal Funds

Federal Program Name		**Award Number**	
Federal Awarding Agency		**Federal Award Identification Number**	
Assistance Listing Title		**Federal Award Date**	
Assistance Listing Number		**Funding Amount**	
		New Agreement Amount	$192,648.00

All other conditions and terms in the original contract and previous amendments remain the same.

5. EFFECTIVE DATE OF AMENDMENT: This amendment is effective 07/01/2024 .

6. DOCUMENTS INCORPORATED INTO THIS CONTRACT BY REFERENCE BUT NOT ATTACHED:
   A. All other governmental laws, regulations, or actions applicable to services provided herein.
   B. All Assurances and all responses to bids as provided by the CONTRACTOR.

7. This contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supersedes all prior written or oral agreements between the parties relating to the subject matter of this contract.

Intentionally Left Blank

Contract with Utah Department of Health & Human Services and San Juan County **, Log #** 2229214

IN WITNESS WHEREOF, the parties enter into this agreement.

CONTRACTOR
Signature

Signed by: ______________________________

____
Jamie Harvey
County Commission Chair

Date Signed: ______________________

CDC Crisis Workforce Supplemtnal Cheat Sheet

Application Due September 1, 2021

Award No. 1 NU90TP922163-01-00 **Budget Period** 7/1/21-6/30/23 **Award** $19,750,412

Purpose

To establish, expand, train, and sustain the state, tribal, local, and territorial public health workforce to support jurisdictional COVID-19 prevention, preparedness, response, and recovery initiatives, including school-based health programs.

Workforce Personnel

Funding can be used to hire personnel for roles that may range from senior leadership positions to early career or entry-level positions and may include, but is not limited to:
1) Permanent full-time and part-time staff (which may include converting part-time positions to full-time positions during the performance period); 2) Temporary or term-limited staff; 3) Fellows; 4) Interns; 5) Contractors or contracted employees.

Hiring and Sustainment of Workforce Activities to include:
1) Update plans, protocols, and systems based on COVID-19; 2) Support of existing staff and those whose funding is expiring; 3) Hiring staff to expedite recruitment and hiring processes.

School-based health staff

At least 25% of the jurisdictional award will support school-based health programs, including nurses or other personnel, including: hiring school-based nurses, converting current nurses from part-time to full-time work, increasing hours, increasing nursing salaries or otherwise supporting retention efforts

Budget Summary	
School Based Health Programs*	$6,677,323
LHDs **	$5,425,124
UALHD Assessment	$100,000
CBOs	$500,000
Tribes	$2,000,000
DCP (HAI, Epi, Infor, Lab, OME)	$2,362,685
BEMSP	$1,776,927
OFO	$246,777
FHP FAST	$197,443
Total Direct	**$19,286,279**
Indirect	$464,133
Total Budget	**$19,750,412**
Remainder to Budget	**$0**

**25% Full Award*

***at least 40% of remaining to LHDs and CBOs ($5,925,124)*

Allowable Expenses

Contractual	Subawards or contracts with healthcare institutions may be allowable to meet workforce needs of the public health programs, but health care is not the intent of this funding.
Incentives	Incentives, professional development, promotion potential, sign on bonuses, etc. potentially could be used to assist with the recruitment efforts. Additionally, there are longer-term workforce initiatives being discussed that may provide more sustainable funding.
Mental Health	Consider the mental health impacts of COVID-19 within K-12 schools, not just contact tracing, vaccination, and screening tests. Parental mental health needs should be considered as well. Responder safety and health would also be a consideration and hiring mental health professionals could be an allowable cost in either situation.
Personnel	Wages, benefits, and other costs related to recruiting, hiring, and training of individuals to serve as: **Administrative support staff, Clinical or professional staff, Disease investigation staff, School health staff, and Program management staff.**
	Dedicated **human resources (HR) staff** to expedite, recruit, and implement more rapid hiring processes for public health emergency preparedness
	Sustaining current staff: while funding is primarily to hire new staff, if recipients have staff who were hired for COVID-19-specific work supported by other funding streams that is going to expire, then recipients can continue to employ them.
	Hiring **clinical staff** that provide COVID-19-related services is an allowable cost. One factor to keep in mind is that CDC would not generally be paying for individual clinical treatment; vaccinating students, for instance, is a component of a public health campaign and isn't considered clinical care within our definitions.
	Administrative support services necessary to implement and manage activities, including travel and training
Schools	The focus is on K-12 public schools, rather than community or faith-based private schools, but resources can be used for private schools at the discretion of recipients. CDC encourages recipients to meet their individual jurisdictional and local needs, as applicable.
	School-based clinics are within scope to the extent that that the services are related to COVID-19 activities.
	Support school health services; if sub-awarding funds to the state department of education will accomplish that goal, it would be allowable. However, there are other funds available for other programs, and care should be taken not to be duplicative nor to supplant existing resources.
Supplies / Equipment	Office equipment and furniture for staff that will work remotely for the duration of the project period. This could include minor reconfiguration of existing space, but not construction.
	Purchase of equipment and supplies necessary to support the expanded workforce including personal protective equipment, equipment needed to perform the duties of the position, computers, cell phones, internet costs, cybersecurity software, and other costs associated with support of the expanded workforce.
Training	Training is an integral component of this funding. It can include core competencies, incident management training, specific job-related skills, formal education related to a position, and so forth. If training advances the skills of the public health workforce, it is generally allowable.
Vaccine Clinics	Staff for vaccine clinics would be an appropriate cost. Remember that this funding is for workforce.

Allowable Activities (General)

Contracting Services	Using the General Services Administration (GSA) COVID-19 Related Support Services (CRSS) contract mechanism available at Acquisition Gateway to obtain contract staff or services.
Cross-Training	**Cross-train** staff hired to work on COVID-19 response for other communicable disease response and future pandemic response activities.
Partner	Forming partnerships with academic institutions, creating student internship or fellowship opportunities, and building graduation-to-workforce pipelines.
Planning	Continuity of operations (plans, protocols, and systems-based) related to emergency preparedness is within scope. If that is something that recipients think is important to do for COVID-19 and beyond.
Strategic Planning	LHD strategic planning, if there's an identified a gap in your plans, with how local health department is organized, or need assistance identifying those gaps, that is certainly something CDC would support. This could mean hiring a consultant or purchasing a decision-support tool to help you review your strategic vision for the future.

Strike Force Teams	Developing, training, and equipping response-ready "strike force" teams capable of deploying rapidly to meet emergent needs, including through the Emergency Management Assistance Compact.
Training Education	Focus on COVID-19 and preparedness activities, cross-training of COVID-19 staff for other communicable disease response activities, clinical staff activities

Spending Rules & Requirements	
Allocations	The percentage of distribution can be higher for the school-based health personnel and staff at local health departments (LHDs)
CBOs	Funds cannot be provided to community-based organizations (CBOs) upfront, as federal funds are received on a reimbursement basis. A health department may advance funds to cover costs until federal reimbursement is received.
COVID-19	Spending must be 100% COVID-19 related according to the statute.
	This is a COVID-19-focused grant. If positions are going to be doing part of their work on other projects, then they should be funded accordingly. For example, if staff are partially doing other general work in public health then the positions should probably be split funded. You cannot supplant funds or duplicate funding between grants. Ultimately, the position should match the workload of the personnel that you're putting in your budget.
Diversity	Focusing on diversity, health equity, and inclusion by delineating goals for hiring and training a diverse work force across all levels who are representative of, and have language cultural competence for, the local communities they serve.
Reporting Metrics	Diversity, equity, and inclusion (DEI) measures must be considered within hiring. When identifying metrics to address DEI in hiring, consider collaboration with local champions or trusted voices representative of diverse populations affected by COVID-19. Metrics may include but not be limited to: • Number of personnel hired through community-based organizations and other diversity-focused organizations with brief descriptions of populations they serve, such as communities of color, rural populations, people experiencing homelessness, and people living with disabilities. • Number of employees receiving DEI relevant training, such as cultural competency, working with underserved communities, and health equity. • Establishment of a health equity team to focus on hiring a workforce that represents the diversity in the communities being served.
	Recipients must report on all staff hired, including those hired at the local and subrecipient level, developing and reporting on goals and monitoring metrics regarding diversity of staff hired and equity and inclusion activities based on the 5 employment categories below: • Administrative support staff • Clinical or professional staff • Disease investigation staff • School health staff • Program management staff
Administered by	*Utah Bureau of EMS & Preparedness* *Utah Department of Health* ***Website:*** ***https://www.cdc.gov/cpr/readiness/funding-ph.htm***

UTAH DEPARTMENT OF HEALTH & HUMAN SERVICES CONTRACT AMENDMENT

PO Box 144003, Salt Lake City, Utah 84114
288 North 1460 West, Salt Lake City, Utah 84116

2229214
Department Log Number

222700714
State Contract Number

1. CONTRACT NAME: The name of this contract is Public Health Crisis Response Workforce Supplemental SFY 2022 – San Juan County Amendment 2.

2. CONTRACTING PARTIES: This contract amendment is between the Utah Department of Health & Human Services (DEPARTMENT) and San Juan County (CONTRACTOR).

   PAYMENT ADDRESS
   San Juan County
   735 S 200 W, Ste 2
   Blanding UT, 84511

   MAILING ADDRESS
   San Juan County
   735 S 200 W, Ste 2
   Blanding UT, 84511

   Vendor ID: 06866HL
   Commodity Code: 99999

3. PURPOSE OF CONTRACT AMENDMENT: The Purpose of this amendment is to update the Special Provisions and extend the terminate date of the contract by one year.

4. CHANGES TO CONTRACT:

   1. The contract termination date is being changed. The original contract termination date was 6/30/23. The contract period is being increased by one year. The new termination date is 06/30/24.
   2. Attachment A, effective 05/17/23, is replacing Attachment A, which was effective 11/17/2022.

All other conditions and terms in the original contract and previous amendments remain the same.

5. EFFECTIVE DATE OF AMENDMENT: This amendment is effective 05/17/2023.

6. DOCUMENTS INCORPORATED INTO THIS CONTRACT BY REFERENCE BUT NOT ATTACHED:
   A. All other governmental laws, regulations, or actions applicable to services provided herein.
   B. All Assurances and all responses to bids as provided by the CONTRACTOR.
   C. Utah Department of Health & Human Services General Provisions and Business Associate Agreement currently in effect until 6/30/2023.

7. This contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supersedes all prior written or oral agreements between the parties relating to the subject matter of this contract.

Intentionally Left Blank

Contract with Utah Department of Health & Human Services and San Juan County**, Log #** 2229214

IN WITNESS WHEREOF, the parties enter into this agreement.

CONTRACTOR		**STATE**	
By: ____________________	__________	By: ____________________	__________
Bruce Adams County Commission Chair	Date	Tracy S. Gruber Executive Director, Department of Health & Human Services	Date

ATTACHMENT A - SPECIAL PROVISIONS
CDC Crisis Response Cooperative Agreement:
COVID-19 Public Health Workforce Supplemental Funding
Amendment 2

I. Definitions

A. "CDC" means the Centers for Disease Control and Prevention.
B. "CWF" means Crisis Workforce Supplemental Funding Cooperative Agreement.
C. "DEI" means diversity, equity, and inclusion.
D. "Department" means the Utah Department of Health and Human Services, Bureau of Emergency Medical Services and Preparedness.
E. "FTE" Full Time equivalent.
F. "General Provisions" means the agreement between the parties titled "General Provisions and Business Associate Agreement" effective July 1, 2019 through June 30, 2024.
G. "STLT" means State, Tribal, Local, and Territorial governments.
H. "Subrecipient" means Local Health Department.

II. Purpose

A. The purpose of this agreement is to recruit, hire, and train personnel to address projected jurisdictional COVID-19 response needs, including hiring personnel to build capacity to address STLT public health priorities deriving from COVID-19, which supports Department efforts to enhance Utah's public health workforce through the CDC Crisis COVID-19 Public Health Workforce Response.

III. Department Contact Information

A. Department encourages inquiries concerning this grant and special provisions, which should be directed to the following Department contacts:

For programmatic technical assistance, contact:
Tonya Merton, Grants Coordinator
Office of Emergency Medical Services and Preparedness
prepgrants@utah.gov
(385) 441-9194

For financial or budget assistance, contact:
Jerry Edwards, Financial Manager
Office of Fiscal Operations, Utah Department of Health
(801) 538-6647

IV.Funding

A. The federal funding supporting this grant is approved under the CDC Crisis Response Agreement: COVID-19 Public Health Workforce supplemental funding guidance, located at https://www.cdc.gov/cpr/readiness/funding-ph.htm.

B. Cost Reimbursement - This is a cost reimbursement contract. The Department agrees to reimburse the Contractor up to the maximum amount of the contract for allowable expenditures made by the Contractor directly related to the performance of this contract.

V. Payments

A. Subrecipient shall submit a final Monthly Expenditure Report, as required by the General Provisions, and for the final funding transfer (no later than July 5, 2023).

B. Department agrees to reimburse Subrecipient up to the maximum amount of the contract for expenditures made by the Subrecipient directly related to the program, as defined in the General Provisions.

VI. Budget and Reporting

A. Subrecipient may begin spending funds on reimbursable personnel costs as described in Subrecipient's submitted budget upon full execution of this contract. (See Section IX.A.1-4 for examples of such costs.) Non-personnel cost categories (See Section IX.A.5-6 for examples of such costs) require budget review and approval by the Department (via email) prior to Subrecipient expenditure.

B. Subrecipient shall submit to Department semi-annual progress and fiscal reports by:
   1. January 7, 2022 (for activity period July 1, 2021 - December 31, 2021);
   2. July 7, 2022 (for activity period January 1, 2022 - June 30, 2022);
   3. January 7, 2023 (activity period July 1, 2022 - December 31, 2022);
   4. July 7, 2023 (activity period January 1, 2023 - June 30, 2023).
   5. January 7, 2024 (activity period July 1, 2023 - December 31, 2023); and
   6. July 7, 2024 (activity period January 1, 2024 - June 30, 2024).

C. Progress Reporting Requirements:
   1. Subrecipient shall provide progress reports to Department regarding hiring goals and DEI metrics by using the Hiring Diversity Goals template located within the Crisis Workforce Development template, tab 9.

D. Fiscal Reporting Requirements:
   1. Subrecipient shall provide fiscal reports to Department on the status update of fiscal commitments made by using the Spend Plan template located within the Crisis Workforce Development template, tab 11.

E. Closeout Reporting Requirements, due September 14, 2024:
   1. Subrecipient shall submit a closeout report, using a template provided by Department, and will include:
      a) Final performance progress and evaluation;
      b) Fiscal report;
      c) Equipment and supplies tangible personal property report; and
      d) Final report on DEI metrics.

F. Subrecipient shall submit additional information to Department upon request to support state and federal reporting requirements.

G. Subrecipient shall update the Department with any changes to programmatic, and financial points of contact as they occur.

VII. Department Responsibilities

A. Department agrees to distribute additional closeout report templates via email no later than thirty (30) days prior to the due date.

B. Department agrees to provide technical assistance upon request by Subrecipient.

VIII. Allowable Costs

A. This list is not exhaustive; CDC encourages individual jurisdictional and local needs to be met, as applicable.

1. Overtime costs are a very likely and reasonable expense during the response to COVID-19, subrecipient may include projected overtime in their budgets.
    a) Subrecipient should be careful to estimate costs based on current real-time needs and will still be required to follow federal rules and regulations in accounting for the employees' time and effort.
2. Funding can be used to hire personnel for roles that may range from senior leadership positions to early career or entry-level positions and may include, but is not limited to:
    a) Permanent full-time and part-time staff (which may include converting part-time positions to full-time positions during the performance period)
    b) Temporary or term-limited staff
    c) Fellows
    d) Interns
    e) Contractors or contracted employee
3. The costs, including wages and benefits, related to recruiting, hiring, and training of individuals to serve as:
    a) Professional or clinical staff, including public health physicians and nurses (other than school-based staff); mental or behavioral health specialists to support workforce and community resilience; social service specialists; vaccinators; or laboratory scientists or technicians;
    b) Disease investigation staff, including epidemiologists; case investigators; contact tracers; or disease intervention specialists;
    c) School nurses and school-based health services personnel, including hiring school-based nurses, converting current nurses from part-time to full-time work, increasing hours, increasing nursing salaries or otherwise supporting retention efforts;
    d) Program staff, including program managers; communications and policy staff; logisticians; planning and exercise specialists; program evaluators; pandemic preparedness and response coordinators to support the current pandemic response and identify lessons learned to help prepare for possible future disease outbreaks; health equity officers or teams; data managers, including informaticians, data scientists, or data entry personnel; translation services; trainers or health educators; or other community health workers;

   e) Administrative staff, including human resources personnel; fiscal or grant managers; clerical staff; staff to track and report on hiring under this cooperative agreement; or others needed to ensure rapid hiring and procurement of goods and services and other administrative services associated with successfully managing multiple federal funding streams for the COVID-19 response; and
   f) Any other positions as required to prevent, prepare for, and respond to COVID–19.
4. These individuals may be employed by:
   a) STLT public health governments or their fiscal agents;
   b) Schools, school boards, school districts, or appropriate entities for providing school-based health care;
   c) Nonprofit private or public organizations or community-based organizations with demonstrated expertise in implementing public health programs and established relationships with STLT public health departments, particularly in medically underserved areas; or
   d) Employment agencies, contracted vendors, or other temporary staffing agencies.
5. Purchase of equipment and supplies necessary to support the expanded workforce including personal protective equipment, equipment needed to perform the duties of the position, computers, cell phones, internet costs, cybersecurity software, and other costs associated with support of the expanded workforce (to the extent these are not included in recipient indirect costs).
6. Administrative support services necessary to implement activities funded under this section, including travel and training (to the extent these are not included in recipient indirect costs).

B. See https://www.cdc.gov/orr/readiness/funding-ph.htm for detailed guidance on this funding opportunity.

IX. Allowable Activities

A. This list is not exhaustive; CDC encourages individual jurisdictional and local needs to be met, as applicable, and to use a variety of mechanisms to expand the public health workforce, including, but not limited to:
1. Using CDC's Social Vulnerability Index (located at https://www.atsdr.cdc.gov/placeandhealth/svi/index.html) data and tools to inform jurisdiction COVID-19 planning, response, and hiring strategies.
2. Contracting services: Using the General Services Administration (GSA) COVID-19 Related Support Services (CRSS) contract mechanism available at Acquisition Gateway to obtain contract staff or services.
3. Cross-training: Cross-train staff hired to work on COVID-19 response for other communicable disease response and future pandemic response activities.

4. Forming partnerships: Form partnerships with academic institutions, creating student internship or fellowship opportunities, and building graduation-to-workforce pipelines.
5. Planning: Continuity of operations (plans, protocols, and systems-based) related to emergency preparedness is within scope. If that is something that recipients think is important to do for COVID-19 and beyond.
6. Strategic Planning: LHD strategic planning, if there is an identified gap in your plans, with how the local health department is organized, or need assistance identifying those gaps, that is certainly something CDC would support. This could mean hiring a consultant or purchasing a decision-support tool to help you review your strategic vision for the future.
7. Strike Force Teams: developing, training, and equipping response-ready "strike force" teams capable of deploying rapidly to meet emergent needs, including through the Emergency Management Assistance Compact.
8. Training: Focus on COVID-19 and preparedness activities, cross-training of COVID-19 staff for other communicable disease response activities, clinical staff activities.

X. Unallowable Costs
   A. Research;
   B. Clinical care; or
   C. Publicity and propaganda (lobbying):
      1. Other than for normal and recognized executive-legislative relationships, no funds may be used for:
         a) Publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
         b) The salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
      2. See Additional Requirement 12 for detailed guidance on this prohibition an additional guidance on lobbying: https://www.cdc.gov/grants/documents/Anti-Lobbying_Restrictions_for_CDC_Grantees_July_2012.pdf.

XI. Contractor shall comply with the following required disclosures for Federal Awardee Performance and Integrity Information System (FAPIIS):

Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the CDC, with a copy to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Subrecipients must disclose, in a timely manner in

writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the CDC and to the HHS OIG at the following addresses:

CDC, Office of Grants Services
Shirley K Byrd, Grants Management Officer
Centers for Disease Control and Prevention
Branch IV, Team II
2935 Flowers Road
Atlanta, GA
Email: skbyrd@cdc.gov (Include "Mandatory Grant Disclosures" in subject line)

AND

U.S. Department of Health and Human Services
Office of the Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW
Cohen Building, Room 5527
Washington, DC 20201
Fax: (202)-205-0604 (Include "Mandatory Grant Disclosures" in subject line) or
Email: MandatoryGranteeDisclosures@oig.hhs.gov

Item 4.
NATIONAL ASSOCIATION of COUNTIES
NACo
THE COUNTY ROLE IN PUBLIC HEALTH
FEBRUARY 2024

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INTRODUCTION

Counties play a critical role in promoting and protecting the health of people and the communities in which they live, learn, work and play. As administrators and operators of the local health safety net, county agencies employ a wide range of public health services that protect resident health and well-being through the prevention of illness, injury and other adverse health outcomes.

A robust public health system centers equity and actively promotes policies, systems and overall community conditions that drive optimal health.[1]

Public health is an intersectional field that works to address the underlying causes of health outcomes. This work requires both intergovernmental collaboration between federal, state and local governments, as well as multisectoral partnerships across local government agencies.

This brief provides an overview of how counties provide integral public health services for all Americans, describes their public health authority, their role in preparedness and response efforts, and local public health efforts to address social determinants of health (SDOH) in our communities. The brief will also outline key federal policy recommendations for our federal partners to safeguard funding and authority for local public health services and programs.

10 Essential Public Health Services[1]

1. Assess and monitor population health status, factors that influence health and community needs and assets

2. Investigate, diagnose and address health problems and hazards affecting the population

3. Communicate effectively to inform and educate people about health, factors that influence it and how to improve it

4. Strengthen, support and mobilize communities and partnerships to improve health

5. Create, champion and implement policies, plans and laws that impact health

6. Utilize legal and regulatory actions designed to improve and protect the public's health

7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy

8. Build and support a diverse and skilled public health workforce

9. Improve and innovate public health functions through ongoing evaluation, research and continuous quality improvement

10. Build and maintain a strong organizational infrastructure for public health

CHAPTER 1

COUNTY PUBLIC HEALTH INFRASTRUCTURE

Local Health Departments

Since the U.S. has a largely decentralized public health system, much of the responsibility for disease control and prevention falls on state and local health departments (LHD). Counties support the majority of America's approximately 2,800 local health departments and protect our residents' health, safety and quality of life.

SOCIAL DETERMINANTS OF HEALTH

*Healthy People 2030 defines the social determinants of health (SDOH) as the conditions in which we are born, live, work and play that both directly and indirectly impact overall health and well-being. This framework also highlights **five domains** to organize the social determinants of health, including economic stability, education access and quality, health care access and quality, neighborhood and built environment and social and community context.*

Approximately 70 percent of all local health departments are county-based, and another eight percent that serve multiple counties. Sixty-one percent of LHDs serve rural counties, or those with a population of less than 50,000 residents.[2]

With a shortage of rural health care providers and the closure of many rural health care facilities, LHDs are becoming an increasingly critical resource in these communities, providing essential health care services.

Additional Partners in the Local Public Health System

Local health departments are not doing this work alone, but in partnership with many other agency partners that make up the county public health system. **More than 95 percent of LHDs work with external partners like emergency responders, school systems, hospitals and others.**[2]

KEY COUNTY PARTNERS IN LOCAL PUBLIC HEALTH AND THEIR RESPECTIVE ROLES:

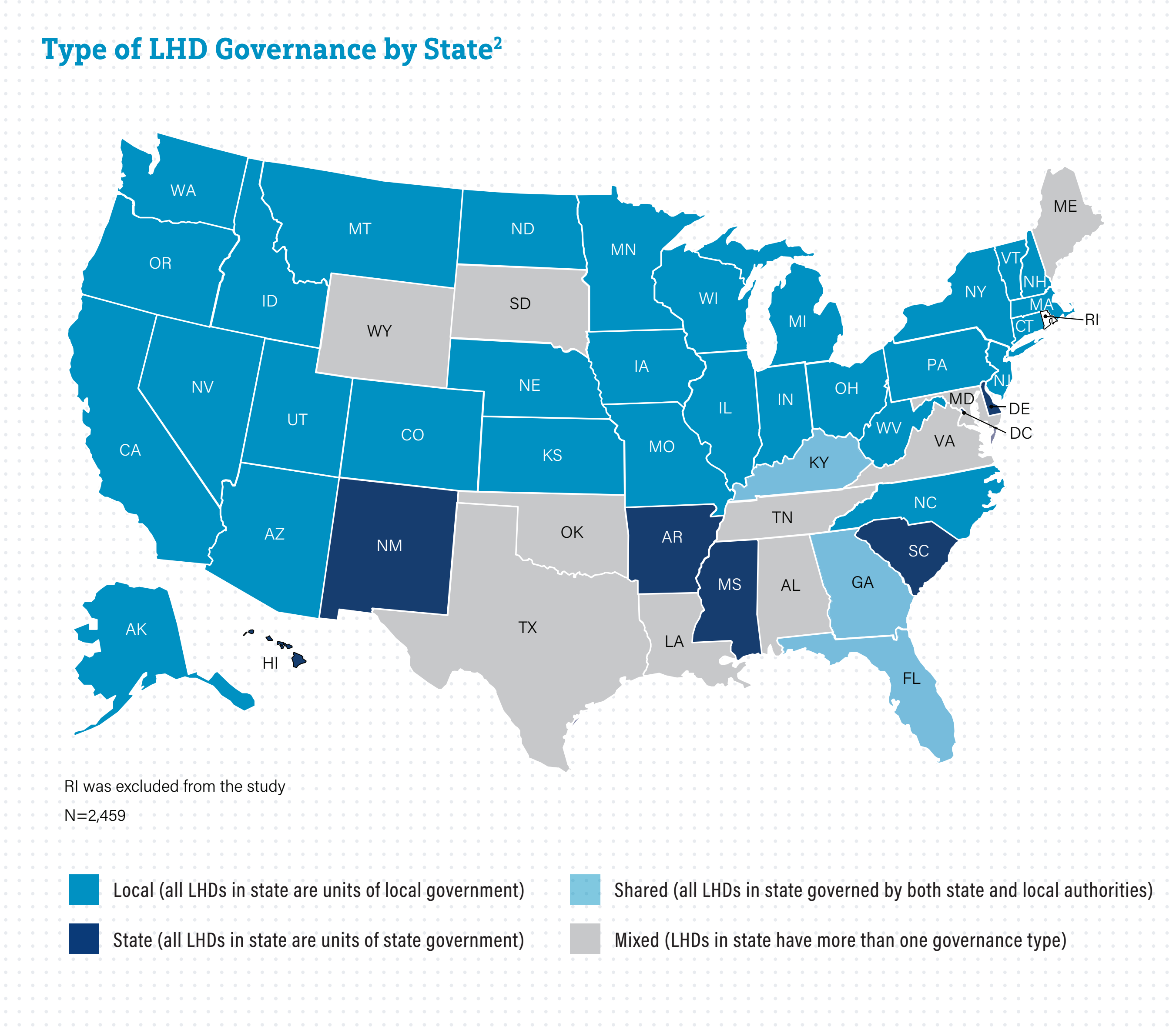
PARTNERS	PARTNERSHIP ROLE AND IMPORTANCE
Emergency Management Services (EMS)	EMS and first responders provide emergency medical care, promote public safety and security, and prevent real time death and injury during emergency situations.[4] EMS collaboration with LHDs is essential to get accurate data on emergencies, resident health and social determinants, and more. EMS is also an important partner for non-emergent care like vaccines, testing, planning responses to potential threats and acquiring the necessary resources to respond, such as PPE.[4]
K-12 Schools and Universities	K-12 schools assist LHDs by facilitation outreach to youth and families regarding available public health resources and interventions. Universities partner with LHDs and public health officials as thought leaders, providing resources to conduct research on public health issues impacting systems and populations and help to develop targeted solutions.
Local Government Partners	LHDs partner with many other sectors of local government to reach different populations and extend the reach of public health services to the jurisdiction. A common partner is the county human services department (if it is a separate entity), justice and public safety, parks and recreation, environment and natural resources, planning and development, transportation, and more. LHDs work collaboratively with all sectors of the local government and often serve as conveners of these systems to discuss the intersections of health and the respective field, as well as targeted solutions for the community.[5]
Hospitals	LHDs and hospitals have an important partnership, as they can collaborate and share their data on the local jurisdiction and patient populations to track risk factors, social determinants, chronic and infectious disease prevalence, and more. These relationships are also critical in times of crisis or large disease outbreaks when resources need to be coordinated to meet the need.
Community Health Centers	Partnerships with Federally Qualified Health Centers (FQHCs), Certified Community Behavioral Health Clinics (CCBHCs) and other community-based health centers are crucial for expanding access to shared resources, knowledge and data, and opportunities to collaborate on research like community health and needs assessments. These partnerships allow for greater capacity to assist residents in need and increase access to basic health and human services.[6]
Mental Health and Substance Use Providers	Mental health and substance use providers providers work with those with lived experience and can advocate on their behalf when making policy and programmatic decisions. They help to enhance connection to resources and services, while also bringing diverse perspectives to inform solutions, emergency preparedness planning, new initiatives, funding choices, etc.[7]
Community Health Workers (CHWs)	CHWs are trusted community members that work to connect people to culturally appropriate care, give informal counseling and guidance on health behaviors and facilitate communication between patients and health care providers. In some counties, CHWs can be known as promotores de salud, community health advisors, outreach workers, patient navigators and peer counselors.[8] CHWs are sometimes contracted through the LHD, while others are independent contractors.[9]

Counties support the majority of America's approximately 2,800 local health departments and protect our residents' health, safety and quality of life.

Item 4.

CHAPTER 2

ROLE OF PUBLIC HEALTH AUTHORITY



Local health departments (LHDs) get their authority and much of their funding from the state government. State law dictates the responsibilities, funding, and scope of work of the LHD and what resources are available to address our community's public health concerns.

Across different states, a few common authority structures that exist are:[10]

- **Centralized/State:** The LHDs are a part of the state government
- **Decentralized/Local:** Local governments are the leaders of the LHDs

- **Mixed/Hybrid:** Mixture of local or state governed LHDs
- **Shared:** LHDs are governed by both state and local government

Beyond this distinction, there is even more variety in the authority and governance of LHDs. Up to one in five LHDs are combined into a Health and Human Services Agency (HHSA), instead of being a standalone health department, and 70 percent are governed by a local board of health (LBOH)[2]. It is more likely that if a state is decentralized, the LHD is governed by a LBOH, whereas those in a centralized state see their LBOH engage in more of an advisory role and are overseen by the state health agency.[11]

LBOHs receive authority from the state government and are often comprised of elected or appointed members who are meant to lead and oversee the delivery of public health services in their community. They can propose policy and rule recommendations and serve as an adjudicating body in the county or counties under the board's jurisdiction.[12] **The general role of LBOHs includes (but is not limited to):** [10, 13]

1. **Review and propose public health regulations**
2. **Recommend public health policies and priorities for the community and LHDs**
3. **Collaborate with LHDs on strategy and implementation**
4. **Ensure accountability to state statutes and other standards**
5. **Advocate for specific public health services based on community needs**

Public Health Authority Limitations

Since the COVID-19 public health emergency, the authority of state and local public health has changed dramatically. In many cases, this authority has become increasingly limited by local legislation. According to the Network for Public Health Law, from January 2021 to May 2022, a total of 185 laws were enacted to limit local public health authority. These laws include those that impact the authority of local health officials, address mask requirements, vaccines, and emergency measures, or shift authority between the state and local health officials. [14]

THE CENTER FOR PUBLIC HEALTH LAW NOTES THAT SINCE THEN, FROM MAY 2022 TO OCTOBER 2023[15]:

Out of 22 jurisdictions that have enacted a law to address authority to respond to public health emergencies, ***9 of those limit public health authority.***

7 states have also enacted laws that limit local health officials' authority *regarding public health emergency orders.*

Only ***4 jurisdictions*** *have enacted legislation to strengthen public health authority.*

Approximately 70 percent of all local health departments are county-based, and another eight percent that serve multiple counties

CHAPTER 3

COUNTY PUBLIC HEALTH IN ACTION

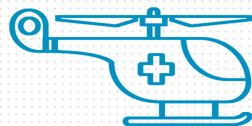
Snapshot: The Role of Local Public Health in Preparedness, Response and Recovery

Counties are on the frontlines of crises, working alongside state and federal partners to respond to natural disasters and public health threats. Emergency preparedness is a critical aspect of local public health. Disasters have broad consequences on the health and well-being of communities, often having downstream impacts to water quality, food security, environmental hazard exposures, increased flooding or extreme weather, loss of shelter, power outages, contact with animals and insects, increased injury or illness and more.[16]

During a disaster response, local public health is involved in various activities such as managing and communicating information, administering medical countermeasures (MCM) and personal protective equipment (PPE), managing surges, ensuring continuity of normal public health programs, conducting ongoing disease surveillance, and protecting vulnerable or at-risk populations.

At the federal level, the U.S. Department of Health and Human Services (HHS) has the legal authority for responding to public health emergencies. Within HHS is Office of the Assistant Secretary for Preparedness and Response (ASPR), created post-Hurricane Katrina, to adverse health effects of public health emergencies and disasters. Within ASPR, the Office of Emergency Management (OEM) provides resources and expertise to state and local communities to help them prepare for public health and medical emergencies.

*Since January of 2020, there have been **50 declarations of a public health emergency (PHE)** enacted by the U.S. Secretary of Health and Human Services, ranging from responding to COVID-19, wildfires, the opioid crisis, hurricanes, Monkey Pox, typhoons and severe storms.*[17]



*Since January 1, 2022, there have been **198 disasters declared**, most frequently for fires, severe storms, and flooding.*[18]

See below for an expanded list of critical functions of local public health entities in preparing for, responding to and recovering from disasters and other public health emergencies.[19, 20]

Preparedness

- Continued disease surveillance
- Creation and maintenance of a critical supply stockpile.
- Facilitate training for local residents, and employees
- Volunteer recruitment and training
- Communication on public health threats
- Plan response protocols
- Evaluate and test preparedness and response capacity
- General system maintenance and repairs
- Execute community health and hazard vulnerability assessments

Response

- Communicate and collaborate across sectors and jurisdictions
- Co-respond with other local emergency response agencies
- Communicate public health information to residents
- Support emergency shelters
- Distribute critical supplies
- Direct volunteer responders
- Participate in incident management through the EOC
- Care for vulnerable and at-risk population

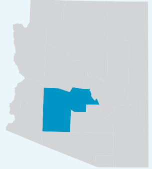
Recovery

- Create and facilitate recovery plan
- Address resident and responder behavioral health needs
- Build future preparedness plans based on lessons learned
- Find gaps and pain points in response infrastructure
- Develop policies and partnerships to address identified gaps

Local public health and health departments often serve as the coordinating body of multiple systems to prepare and respond, convening emergency management, hospitals, emergency operation centers, and more. In this way, local public health is involved with a number of partners, not only to plan responses, but to enact response and recovery actions alongside local hospital system, emergency management teams and medical services, and other multi-sector partners.

KEY COUNTY PARTNERS IN PREPARDNESS AND RESPONSE AND THEIR RESPECTIVE ROLES:

PARTNERS	PARTNERSHIP ROLE AND IMPORTANCE
Emergency Management Services (EMS, emergency managers, etc.)	EMS - First responders on the scene and trained to provide critical, rapid medical care in a variety of diisaster scenarios Emergency Managers - coordinate response efforts, public communications, various sector involvment, etc.
Medical Reserve Corps (MRC)	Recruits and trains volunteer network to respond during disasters and public health emergencies Led by an MRC unit coordinator and matched to community needs, supporting a variety of public health preparedness and response functions locally
Local Health Departments or Agencies	Collaborate with other sectors to mobilize a public health response Engage in disease surveillance, stockpile management and distribution, community preparedness and risk communication Assist alongside first responders and serve in the Emergency Operation Center (EOC).
Hospitals & Medical Personnel	Provide rapid and essential medical care to communities Assist in providing care to injured or adversely impacted individuals during and following emergencies
Emergency Operation Centers (EOCs)	Central location for coordinating emergency response and management Collects, analyzes, and shares information with responders and the public Supports resource procurement and allocation and policy decisions
Community Emergency Response Teams (CERTs)	Educates volunteers on disaster preparedness Teaches basic response skills (ex. fire safety, search and rescue, medical operations, etc.)



MARICOPA COUNTY, ARIZ.: MEDICAL RESERVE CORPS EXPANSION[21]

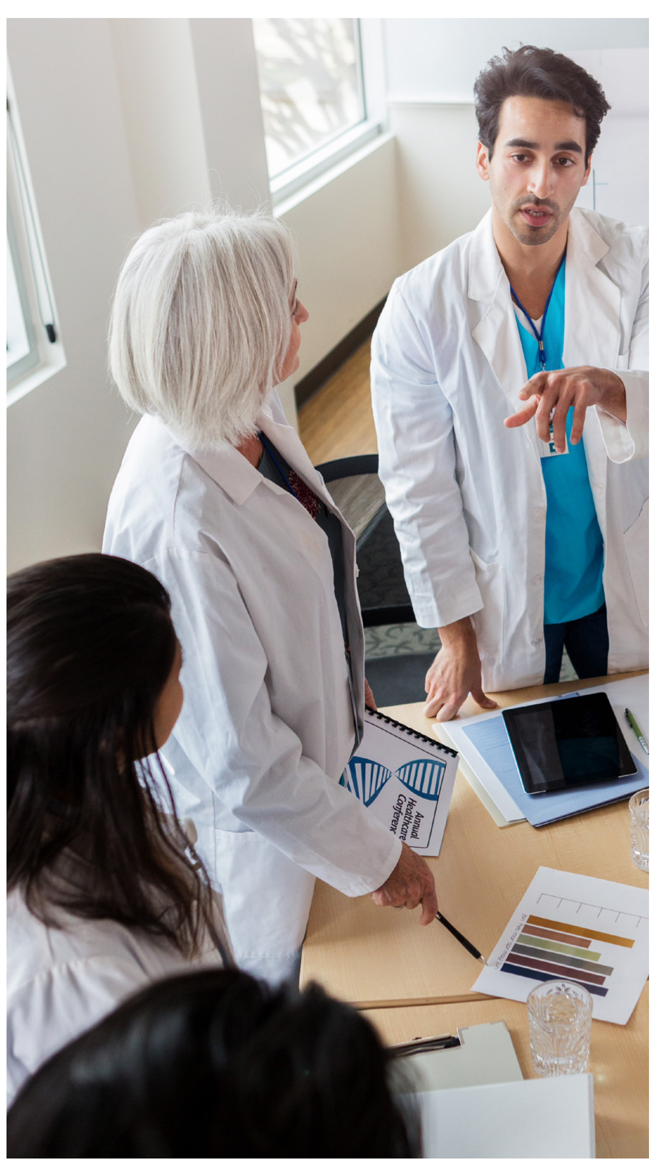
At the start of the COVID-19 pandemic, Maricopa County Department of Public Health (MCDPH) was experiencing an urgent demand for volunteers to respond to community needs from 2020-2022. To address this shortage of volunteers, the MCDPH Medical Reserve Corps (MRC) recruited and expanded their workforce from only 200 volunteers to over 27,000 at the peak in 2021. To date, the MCDPH MRC has over 12,000 registered volunteers in 2023, that consist of roughly half medical and half non-medical, demonstrating a continued high number of registered volunteers.

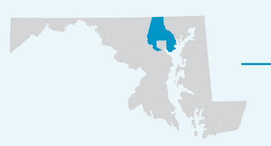
These MRC volunteers have filled critical needs with thousands of volunteer hours throughout the COVID-19 pandemic, including rapid response deployment to support vaccine clinics, tests and other clinical activities. The MRC volunteers were also used in response to the novel Monkeypox (MPXV) outbreak, supporting vaccine clinics as vaccinators and support staff to reach at-risk and underserved populations most effected by MPXV.

Overall, this unprecedented adaptation made by the MCDPH to expand the MRC volunteer workforce in response to needs identified during the COVID-19 pandemic response, have supported their continued response to new and emerging threats like MPXV and Dengue fever. Maricopa County, Ariz., as a result now has one of the largest MRC units that continues to support their response to a variety of public health and other emergencies.

Key Challenges in Public Health Preparedness and Response

- Lack of sustained and direct funding to local communities
- Outdated surveillance technology and data collection methods
- Siloed and outdated data systems
- Recruiting and retaining an adequate responder and public health workforce
- Building public trust and engaging at-risk stakeholders and vulnerable populations



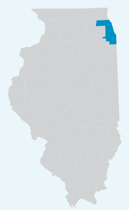


BALTIMORE COUNTY, MD.: COVID-19 MOBILE OPERATIONS OUTREACH VEHICLE (MOOV)[22]

Baltimore County's data team identified hot spots in the county down to the street level to increase vaccination rates for underserved areas. However, most of these locations were not suitable for a larger, mass-vaccination site. As a solution, Baltimore County created a small mobile strike team called "The MOOV" (Mobile Operations Outreach Vehicle) that could accommodate these locations. The Mobile Teams deployed a mechanism modeled after common practices used in the entertainment industry, such as live music, which allowed for greater numbers to be vaccinated in a shorter timeframe. All necessary materials, supplies, equipment, and even furniture were rapidly loaded into rolling work-box style road cases that allowed for an expeditiously coordinated mobilization. A small strike-team of staff quickly established a vaccination site in the hot spots and vaccinated up to 300 people over three hours with a skeletal crew dubbed Noah's Ark, which was comprised of two of each role including vaccinators, registrars, vaccine fillers, observation assistants, ushers, and logisticians who handled mobilization. Finally, a physician was added to help patients who had medical questions or other reasons for their hesitancy. Baltimore County anticipates that this unit will provide vaccines, testing, and other public health services to hard-to-reach demographics well beyond the COVID-19 response.

Snapshot: Impact of the Covid-19 Pandemic and Response

The COVID-19 pandemic posed a number of challenges for county public health resources and infrastructure. Despite the historically low investments in public health leading up to 2020, a dated infrastructure, and unpredictable resource allocations in response to disease outbreaks and disaster events, counties continued to actively innovate the way they deliver services and respond to a public health crisis.



COOK COUNTY, ILL.: HOUSING IS HEALTH: PARTNERING TO ESTABLISH A MEDICAL RESPITE CENTER[24]

Medical respite is defined as acute and post-acute medical care for persons experiencing homelessness who are too ill to recover on the streets, but not ill enough to be in a hospital.[25] Cook County Health (CCH) partnered to design, implement, and operate two Medical Respite Centers (MRCs) to address the needs of housing insecure patients, including COVID-19 positive individuals. The first MRC (MRC-SSY) was a partnership between CCH and the City of Chicago which served housing insecure COVID-19 positive adults who required a safe space for isolation. CCH designed and implemented the facility's infection control policies, a team-based approach with on-site and remote clinicians, and technology for data management, integration, and telehealth and the program successfully housed 51 clients for their full COVID-19 isolation period. In partnership with Housing Forward, CCH opened a second MRC (MRC-OP) in December 2020 which provides clinical oversight and operational support to 18-beds for post-acute care discharges. As of December 20, the MRC-OP accepted 15 of 17 referrals from health care partners, including CCH's Stroger Hospital, demonstrating the low-barrier for program entry.

Snapshot: Local Public Health and Health Equity

Counties are making concerted efforts to invest and improve health equity in their communities through their public health initiatives that aim to address the social determinants of health (SDOH). Counties are uniquely positioned to target SDOH with their access to data, connections to local leaders and decisionmakers, partnerships with other local services and community groups, convening power, and more[23]. These initiatives can include projects that target housing supports, programs that address health disparities, partnerships with community-based organizations and community health workers and more.

CHAPTER 4

KEY FEDERAL PROGRAMS AND POLICY RECOMMENDATIONS THAT SUPPORT LOCAL PUBLIC HEALTH

Counties support investments that enhance the local public health system's capacity to provide health promotion and injury and disease prevention services. Healthy communities depend upon a full array of interrelated county services and programs- which include access to healthy foods, community development plans, disaster preparedness and response and public works infrastructure projects that promote healthy living and access to affordable housing and shelter. Intergovernmental investments such as those recommended below, are the building blocks of better health outcomes, increased productivity and a reduction of disease related expenses for local governments.

1. PROVIDE FUNDING AND INCENTIVES TO RECRUIT AND RETAIN A DIVERSE PUBLIC HEALTH WORKFORCE.

Since 2008, LHDs have lost 21% of their workforce capacity and the COVID-19 pandemic has only exacerbated this decrease.[2] Many public health professionals have left the field due to burnout, low compensation, high levels of stress, and harassment from the public due to the COVID-19 response. For LHDs to continue to administer critical services to residents, continued funding and capacity building through workforce recruitment and retention must be supported. Unpredictable and insufficient federal investments, coupled with the stress of the COVID-19 pandemic response and the ongoing substance use crisis, have strained counties' ability to sustain core public health operations that keep residents healthy and safe. Local health departments which are underfunded and understaffed are less likely to be able to prepare and mobilize effectively, leaving our communities incredibly vulnerable. A strong workforce and consistent federal investments are essential to the overall health care infrastructure and ensure that our public health system operates efficiently and effectively.

2. PROTECT FUNDING FOR CORE LOCAL PUBLIC HEALTH SERVICES AND PREVENTION PROGRAMS.

Federal investments are responsible for nearly 25 percent of local health departments' revenue. Dedicated funding sources such as the Prevention and Public Health Fund (PPHF) are critical to helping counties support core local public health programs such as immunizations and chronic disease prevention. PPHF also invests in new and innovative programs tailored to the unique health problems facing our communities, including the underlying social determinants of health. Since the inception of the PPHF in FY 2010, new public health threats have emerged- such as substance use disorders and suicide epidemic, infectious disease outbreaks and increases in chronic illnesses- and federal resources have not kept pace. Despite funding essential public health work, the PPHF has already been cut by over $11.85 billion from FY 2013 – FY 2027. Further cutting PPHF funding, especially without increasing funding for local public health programs through regular appropriations, would negatively impact local public health departments already strained by having to respond to illness outbreaks like the current COVID-19 pandemic and the ongoing opioid crisis while maintaining core operations to keep residents healthy and safe.

3. EXPAND DIRECT TO COUNTY INVESTMENTS AND SUPPORT FOR BOLSTERING THEIR PUBLIC HEALTH PREPAREDNESS AND RESPONSE.

To meet the needs of residents, the local preparedness infrastructure must be upgraded as communities continue to face numerous environmental and natural disasters, alongside growing public health threats. Federal programs like the Centers for Disease Control and Prevention's Public Health Emergency Preparedness (PHEP) cooperative agreement program are essential in providing not only funding, but technical assistance and guidance, to help public health departments at all levels to better prepare and respond to public health threats and emergencies. In Fiscal Year (FY) 2022, the CDC awarded over $651.5 million in PHEP funding, primarily targeted at states. Given the significant role of counties in responding to disasters and emergencies, CDC and other federal agencies should ensure that local governments receive direct allocations or suballocations of PHEP resources to assist in the development of a more effective preparedness system in local communities, thereby strengthening the response capacity of our nation as a whole.

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Director's Report
August 2024

Recent & Upcoming Events:

- Emergency Management Disability Awareness Training, September 23-24 (Emergency Response Coordinator)
- Dine Bich'iiyaan Binaho'aah Halchita Event, September 24 (Health Promotion)
- Local Health Office Meeting (Vernal), September 19-20 (Public Health Director)
- Monticello Public Health and Safety Night, September 21 (USU Preschool Development Grant Community Health Workers)
- San Juan County Fall Festival, Blanding, September 14 (Health Promotion and USU Preschool Development Community Healthworkers)
- Utah Medical Reserve Corps Summit, Provo (Emergency Response Coordinator)
- Intermountain Leadership Institute (Murray), September 9-13 (Health Promotion Director)
- Intermountain Community Health Advisory Board (virtual), September 11 (Public Health Director)
- Intermountain Leadership Alumni Reunion (Park City), September 5-6 (Public Health Director)
- Mobile WIC/COVID: 2nd Wednesdays in Bluff and 3rd Wednesdays in Monticello
- SafeTalk, culturally tailored suicide prevention, Staff Training, September 5: Provided by Niki Olsen, UNHS Behavioral Health and San Juan County Zero Suicide Coalition
- White Mesa Bear Dance, August 30 - September 1
- Staff Training, August 29: Team Building, CPR & Stop the Bleed review
- National Association of Community Health Workers Virtual Conference, August 21-23
- Back to School Night events (Health Promotion and USU Preschool Development Community Healthworkers)
- County Janitor assigned to our building resigned on August 22: Staff taking turns fulfilling duties during recruitment and until the position is filled.
- National Diabetes Prevention Program Lifestyle Coach Training, August 14-15 (Health Promotion)
- Hozho'go Iina 365 Unifying Families Event (Health Promotion)
- San Juan Pool Inspection Training, August 12-13
- Bluff Elementary School Prevention Night, August 13
- San Juan County Fair, August 7-10 (Health Promotion, Breastfeeding, USU Preschool Development)

San Juan Public Health WIC Report for 2023 to June 2024

Month	% Benefited*	# of Participants with Benefits
January	79.2%	207
February	82.0%	205
March	82.4%	204
April	80.2%	207
May	80.0%	210
June	82.5%	211
July	95.9%	195
August	91.3%	219
September	92.1%	229
October	89.4%	236
November	91.2%	226
December	91.5%	224
January 2024	93.24%	222
February 2024	92.14%	229
March 2024	91.77%	231
April 2024	91.89%	222
May 2024	87.72%	228
June 2024	85.96%	228

* Percent of participants with benefits (WIC card activated). Those without benefits missed a mid-certification or education class (once every 3 months).

WIC July 2024 Participant Report

Year & Month	**Enrolled Individuals**	
2024 June	228	
2024 May	228	
2024 April	222	
Quarterly number of participants by Area	**Dec 2023**	**Jul 2024**
Monticello and LaSal	33	39
Blanding	110	108
Bluff, MC, Aneth, MV, and Mexican Hat	73	77
Family Appointments by Type	**May 2024**	**June 2024**
Certification (New to WIC)	9	10
Recertification	16	20
Mid Certification	6	10
Education	16	13
High Risk Follow Up	1	1

- WIC Benefits
  - WIC participants have “benefits” when they complete appointments every 3 months
  - WIC provides a nutritious and colorful variety of foods for your family. We offer great tasting items like yogurt, whole wheat pasta, and fresh fruits and vegetables. We also provide name brand breakfast cereals, juice, peanut butter, and many other healthy foods.

- Families on WIC receive a card that works like a debit card to purchase WIC foods. The WIC card makes shopping convenient and discreet! Click here to learn more about the WIC card.

- State Expectations
  - The number of participants benefited to be at or above 84%. Our percent benefited for San Juan Public Health is at 91.8%

- Appointment Policies and WIC Locations
  - When Public Health was housed in Monticello, WIC was available M-F because it was by appointment only.
  - When the Public Health office moved to Blanding, shifting to walk-in appointments are more culturally appropriate
  - The amount of time spent on WIC was the same, but it is concentrated on on WIC walk-in days
  - Now that Monticello has a WIC day (2nd Wednesdays), those are mostly by appointment only to fit the culture of Monticello
  - We are able to have virtual WIC appointments as long as we have referral data from their healthcare provider. This means that they would not have to come into our office for their appointment.
  - We are going to be an online state starting in August. That means we will be able to load participants' cards without them having to come into our office.

- Why Monticello WIC
  - Helps address need in Monticello for families without gas money.
  - Mobile WIC unit is more discreet and helps reduce the stigma
  - Extended COVID funds (through 2026) cover StarLink internet access and cover time and other costs by also making COVID testing available

- Next Goals
  - Expand to Bluff
  - Have a meeting on August 5th with the Mayor of Bluff to set up a day for our Mobile Van to do WIC appointments and COVID testing one day a month.

- Additional Information
  - We have community breastfeeding classes every 1st Wednesday of the Month.
  - We have a “Dr. Yum” nutrition class every 4th Wednesday of the Month at the Library Story Hour to teach kids about the importance of fruits and vegetables.
  - We donate unopened cans of formula to our local women's shelter.
  - We order special formula from the state contracted pharmacy for children that

have severe allergies, prematurity, or other eating difficulties.
  - Screen every mother who comes in for WIC for Perinatal Anxiety and Depression and have partnered with the University of Utah Moms Mental Health Program to get mothers the help and resources they might need. .
  - We have 3 breastfeeding peer counselors that are reaching out to every pregnant and postpartum mother on WIC to see if they have any breastfeeding concerns or questions.
  - This year is the 50th Anniversary for the WIC program.
  - We partner with our local Clinics and hospitals to keep them up to date on our health department resources that we have to offer.
  - We are partnering with the San Juan School District and Root for Kids Head Start on referring children who need extra help with Speech and Developmental Delays.
  - We work closely with our local Vendors to make sure our WIC participants are getting the formula and foods that they are allowed on the WIC program. This was a big concern of ours when the formula shortage was going on in 2022 through 2023. We worked with the State WIC office during this time and they were able to send us formula that our stores were not able to get in during this time.
  - We also have two IBCLCs on our WIC staff. IBCLC stands for International Board Certified Lactation Consultant. They are able to help any mother with breastfeeding issues, not just WIC participants.
  - At every WIC appointment we discuss nutrition concerns or questions a parent might have.
- Additional funding
  - During every WIC appointment we print off their child's immunization record and talk to mom about how they are doing with this and if they have any questions about immunizations.
  - During every WIC appointment we also talk to moms and dads about the importance of Lead screening for their children and how to avoid lead exposure.
  - $38,945.76 in annual funding from the San Juan County Contribution

Environmental Health Director Update
September 12, 2024

- Continuous training has been held under Orion Rogers from Southeast Utah Health Department and Eric Larsen from Central Utah Health Department
- Environmental Health Scientist In-Training licensure has been obtained with the full licensure test being taken this fall
- Onsite Wastewater Specialist trainings and Certified Pool Operators course completed
- Streamlined the septic system process and made it available for the public
- Recruited 4-5 more business to become licensed wastewater designers in order to provide more options for home builders
- All septic systems are designed by licensed wastewater designers and reviewed by the EHD
- Implementation of a Septic Installation Permit in conjunction with San Juan Building Department
- Routine meetings are being conducted with San Juan County Planning and Zoning to ensure subdivisions are suitably sized for septic systems
- All public swimming pools/spas have been inspected in coordination with DHHS pool specialist Sarah Chesire
- Worked with Blanding City and Monticello City to implement a Temporary Food Establishment Permit checklist during community events
- Involved with San Juan County Business Department to ensure all new business licenses are reviewed for any environmental concerns

Septic System Process

Step 1: Apply for a permit at https://sanjuanpublichealth.org/ and make payment

Step 2: The septic system must be designed by a Certified Onsite Wastewater Professional.

The list of local and state-wide septic professionals are listed below

1. Sam Long (in Monticello) (801) 891-5513
2. Taylor Hall (Moab Geotech in Moab) (435) 210-8282
3. Jared Berrett (in Blanding) (801) 592-1045
4. The list of certified onsite professionals (Level 1 can do soil evaluation and percolation testing; Level 2 can design conventional onsite systems; and Level 3 can design alternative onsite systems) is available online at https://documents.deq.utah.gov/water-quality/laserfiche/DWQ-2017-000801.pdf

The plans will be submitted by the designer to the Environmental Health Director at dshumway@sanjuancounty.org and reviewed by the Health Department. If the plans require changes, they will be sent back to the designer for updates and resubmitted for review. When the design is approved, an installation permit will be sent via email and the septic system can be installed. The San Juan County building inspector will also receive a copy of the permit.

The following conditions must be followed during the installation process:

1. All installations meet the requirements of R317-4 of Utah Administrative Rule and approved design
2. If adjustments need to be made during installation, the Local Health Department will be contacted
3. Design plans need to be kept on-site to ensure systems are installed according to approved design
4. Septic tank and distribution box must to be filled with water at least 24 hours prior to final inspection
5. Prior to backfilling, the system must be inspected by the Local Health Department

Step 3: Set up a final septic inspection

Call Dennis Shumway to set up an appointment to inspect the septic system. After completion of the inspection, San Juan Public Health will create a final inspection report which will be filed as a county record.

Contacts:

Dennis Shumway, Environmental Health Director (435) 459-4357, dshumway@sanjuancounty.org

San Juan Public Health Department (435) 587-3838, publichealth@sanjuancounty.org

SEPTIC INSTALLATION PERMIT

To Install a
Conventional Septic System

This is to certify that
Byron and Emily Clarke
at the address of
2086 West Browns Canyon Road
Blanding, Utah 84511
Parcel ID: 37522E019004

is granted permission to install a conventional septic system as per design submission and under the following conditions:

(1) All installation meet the requirements of R317-4 of Utah Administrative Rule and approved design
(2) If adjustments to the approved design need to be made, the Local Health Department will be contacted
(3) Design plans need to be kept on site to ensure systems are installed according to plan
(4) Septic tank and distribution box need to be filled with water at least 24 hours prior to final inspection
(5) Prior to backfilling, the system must be inspected by the Health Department

Dennis Shumway EHD
Environmental Health Director

Permit # **01437**

735 S. 200 W. Suite 2 ◊ Blanding, UT 84511
www.sanjuanpublichealth.org
Telephone: (435) 587-3838 ◊ Fax: (435) 215-1893 ◊ Email: publichealth@sanjuancounty.org