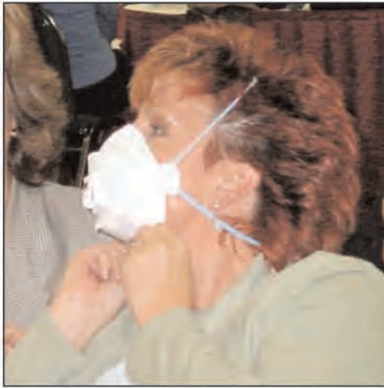
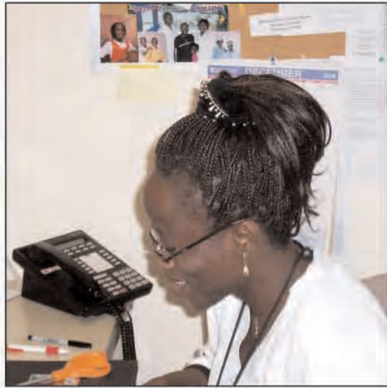
TRI-COUNTY HEALTH DEPARTMENT

Nursing Division Annual Report 2006

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THE DIRECTOR'S REMARKS
2006

The Nursing Division had a very busy and exciting year in 2006. These program summaries for 2006 highlight the successes and challenges that face public health nursing. As a division, the staff continued to find innovative ways better serve the population of Adams, Arapahoe and Douglas County. Some of the major highlights for the year were:

• The Cardiovascular Disease Screening program received funding to begin implementation of chronic disease screening, education and treatment referrals for women age 40 and older.

• The Immunization program worked with the Environmental Health Division to implement a program to review the immunization records of children attending licensed child care facilities prior to inspection by an EH specialist.

• The Division converted our electronic patient care management software to a Windows based format called "Insight".

• Nursing case management programs were moved to the expanded spaced in the Iliff office to relieve overcrowding in the Aurora and Englewood offices.

The Nursing Division will continue to address public health needs and challenges and anticipates the following for 2007:

• Expand programs to include a greater emphasis on chronic disease identification and prevention.

• Respond to the increasing demands and continual changes to the state's immunization requirements for school attendance.

• Continue to increase the overall level of comfort and competency of all Nursing Division staff related to emergency preparedness by participating in trainings and a mass point of distribution exercise.

The division and the agency receive a great deal of financial and collaborative support from many community partners. These partners and their commitment to Tri-County Health Department are critical to the success of our programs and to the overall health of this community.

The dedicated public health nursing staff that work so diligently to directly deliver these programs make this a safer and healthier community. I wish to thank you for all of your hard work and commitment.

Jeanne North, MS, RN
Director of Nursing

CORE NURSING PROGRAM

The Core Nursing Program at Tri-County Health Department (TCHD) represents a team of nurses who are cross-trained to work in a variety of programs. Several programs are assigned specifically to this team, including the Special Infant Project (SIP), the Tuberculosis Treatment program (TB), and the clinical scholar program. Core nurses work with the Health Care Program for Children with Special Needs (HCP), including managing a caseload of clients with Traumatic Brain Injury (TBI). Core nurses teach classes at area high schools that include information about birth control and TCHD services, are critical in staffing the child care immunization program, provide home visits for the Mother's First program, and help staff presumptive eligibility/first prenatal visits. The nurses provide disease control back-up, participate in county level multi-disciplinary teams, and do a variety of special projects as needs arise. The Core Nursing Program is funded by each county.

Special Infant Project (SIP) Program Description

The Special Infant Project (SIP) provides nurse home visits to families of infants who are at risk of developmental delay due to premature birth or other medical conditions that affect development. Infants are normally referred into this program at discharge from a neonatal intensive care unit. The program is based on Boston University's evidence-based program "Healthy Steps for Young Children" as well as a current literature review of best practices. Interventions include education and anticipatory guidance on growth and development and referrals to outside agencies and resources where appropriate. The program measures outcomes by assessing whether the family can verbalize understanding of the child's health condition and corrected age, can demonstrate to the nurse an understanding and sensitivity to the infant's cues, can verbalize an appropriate family planning method, and that the infant is demonstrating appropriate growth and development measured by a standardized growth chart and standardized developmental screens (Denver II and "Ages and Stages").

"The nurse helped me to know about my baby and how to take care of him"

- Special Infant Project Client

SIP Program 2006 Highlights

- A total of 137 referrals were received and thirty-eight percent of the newborns referred to this program were enrolled (Table 1).
- Of those families that received at least one home visit, 89% met two or more of the program objectives listed above.

Table 1. Special Infant Project Referrals and Results, TCHD, 2005-2006

	2005	2006
Referrals	136	137
Clients Enrolled	68	53
Total Home Visits	186	169
Average visits per Client	3	3.2

Data Source: CDPHE, Integrated Referral & Information System (IRIS)

Tuberculosis (TB) Treatment Program Description

The TB treatment program is a collaboration with the Denver Health TB program to provide TCHD TB clients with easier access to TB medication in an effort to increase compliance with TB treatment. Clients with a positive TB screening test are seen and evaluated at Denver Health, and then referred to the TCHD TB program if the client indicates that our office is more accessible to them. Clients are seen monthly by a public health nurse for medication and are evaluated for any side effects of the medication and any other questions or concerns. Denver Health provides TCHD with all client medications. Clients continue to be enrolled in medical care at the Denver Health TB Clinic.

124 new cases of TB were reported in Colorado in 2006, and 40 (32%) of those were in our three counties

- Colorado Department of Public Health and Environment

TB Treatment Program 2006 Highlights

- Of the 64 clients seen in 2006, 55 (86%) have completed or are continuing their treatment (Table 2).

Table 2. TB Program Activity, TCHD, 2005-2006

	2005	2006
New Clients	80	40
Active Clients at End of Year	51	24
Total Visits	491	300

Data Source: TCHD, Internal Program Data

Public Health Professional Nursing Education-Clinical Scholar Program Description

TCHD serves as a clinical placement site for baccalaureate nursing students and provides masters-prepared public health nurses to be clinical faculty for the students. Students are placed in several TCHD offices and receive a wide range of experiences in public health. TCHD has contracts for clinical faculty with schools of nursing from Regis University, University of Colorado and University of Northern Colorado.

30 out of 37 states reported public health nursing as the field that will be most affected by workforce shortages in the future

- Association of State and Territorial Health Officials

Clinical Scholar Program 2006 Highlights

- TCHD provided clinical placements to 109 bachelor of science nursing students in 2006 (Table 4).

Table 3. Total Number of Bachelor of Science Nursing Students, TCHD, 2001-2006

	2002	2003	2004	2005	2006
Regis University	24	20	40	47	48
University of Colorado	22	21	24	40	36
University of Northern Colorado	24	27	19	27	25
TOTAL	70	68	61	114	109

Data Source: TCHD, Internal Program Data

Traumatic Brain Injury (TBI) Program Description

The TBI Program provides nurse care coordination for families with a child who has suffered a TBI. Services are provided for one year and nurses provide education, appropriate referrals to community resources and assist families in applying for monetary assistance (up to $2000) from Colorado's TBI Trust Fund program. The program is currently administered under the Health Care Program for Children with Special Needs (HCP) and is funded through the TBI Trust Fund program.

Approximately 2% of the US population needs help or support with routine activities as a result of a TBI

- Centers for Disease Control and Prevention

TBI Program 2006 Highlights

- A total of 32 clients were served during 2006 (Table 4).
- Nurses conducted 78 home visits and hundreds of phone and email consultations

Table 4. Number of TBI clients by county of residence, TCHD, 2006

	2006
Adams	9
Arapahoe	15
Douglas	8
Total	32

Data Source: CDPHE, CHIRP system

ADAMS COUNTY TEMPORARY ASSISTANCE FOR NEEDY FAMILIES HOME VISITATION PROGRAMS

Since 1998, Adams County Social Services Department (ACSSD) has contracted with Tri-County Health Department's (TCHD) Nursing Division to provide case management services to families with young children enrolled in social services programs. This program focuses on enhancing family function, increasing positive parenting skills, and optimizing self-sufficiency, with the goal of decreasing the need for public assistance in the future. The programs are funded by Adam's County Social Services Department through the Temporary Assistance for Needy Families (TANF) program.

Mothers First Program Description

Mothers First is a long-term case management program for pregnant and parenting women, most of who receive TANF from ACSSD. Families may receive case management services for up to two years, depending on risk factors and needs of the family. The goal of the program is to enhance family function, expand parenting skills, increase self-sufficiency, and improve pregnancy outcomes. Families are referred to TCHD by ACSSD and ACSSD contractors (i.e., Community College of Aurora [CCA], One Stop, Goodwill, Center for Work, Education and Employment [CWEE]).

ACSSD holds the highest Federal Work Participation Rate (FWPR) in the State. Adams County FWPR for the 05/06 fiscal year was 53.3%, the State's average was 21.7%

- ACSSD Internal Data

Mothers First Program 2006 Highlights

- ACSSD began providing incentives to clients working with the nurses for meeting certain program guidelines.
- The Mothers First Program was presented at the Colorado Public Health Association Annual Conference.
- Mothers First almost doubled the number of clients served from 2005 to 2006 (Table1).

Table 1. Mothers First Program Referrals and Home Visits, TCHD, 2002-2006

	2002	2003	2004	2005	2006
Referrals	37	80	72	105	207
Home Visits	130	186	342	417	767
Clients	N/A	N/A	N/A	85	168

Data Source: TCHD, Internal Program Data

Brief Parenting Program Description

Brief Parenting allows for nursing case management of clients that do not qualify for the Mothers First Program, but are Adams County residents and in need of shorter term nursing case management. The goal of the program is to enhance family functioning, expand parenting skills, and increase health knowledge through education. The clients are referred to TCHD through ACSSD, ACSSD contractors, WIC, Adams County schools, and community providers.

ACSSD increased the number of full-time work placements by 37.3% over 2005 despite that the average county caseload decreased from 347 in 2005 to 232 in 2006.

- ACSSD Internal Data

Brief Parenting Program 2006 Highlights

- 30 mothers and their families were served in this program in 2006 (Table 3).

Table 2. Brief Parenting Referrals, Home Visits, and Clients, TCHD, 7/1/2005-2006

	7/1/2005-12/31/2005	2006
Referrals	66	41
Home Visits	142	204
Clients	45	30

Data Source: TCHD, Internal Program Data

Early Crisis Intervention Program Description

The Early Crisis Intervention Program is a unique collaboration between TCHD nursing case management services and ACSSD child welfare. Families who are involved with ACSSD child welfare are referred to TCHD for a four-month intervention that includes nurse home visits that are focused on parenting and health issues. The goal of the program is to keep children in the home, or, if removed, to expedite their return into the home. The program also works on expanding parenting skills and increasing health knowledge to decrease the likelihood of future ACSSD involvement.

"The clients appear to enjoy the in-home support given by a group of committed nurses that understand not only the complexities of health care but also of parenting."

- ACSSD Clinical Supervisor

Early Crisis Intervention Program 2006 Highlights

- Nursing services and child welfare successfully collaborated in an innovative new program designed to impact families in crisis.
- 8 mothers and their families were served in this program in from 7/1/2006-12/31/2006 (Table 3).

Table 3. Early Crisis Intervention Referrals, Home Visits, and Clients, 7/1/2006-12/31/2006

	7/1/2006-12/31/2006
Referrals	8
Home Visits	42
Clients	8

Data Source: TCHD, Internal Program Data

Health and Parenting Classes Program Description

A TCHD nurse provides health and parenting classes for ACSSD clients being served at ACSSD contractor sites. These sites include CCA, CWEE, One Stop and Goodwill, as well as Adams County schools and community sites. Education is offered in birth control, STIs, parenting, appropriate child development, and child safety.

Colorado has had a 26% drop in teen pregnancies from 1992-2000

- Centers for Disease Control and Prevention

Health and Parenting Classes 2006 Highlights

- TCHD performed quarterly orientations to TCHD services and appropriate screening and referrals for family planning for all new child welfare staff.
- TCHD offered a total of 176 health and parenting classes to the Adams County community (Table 4).

Table 4. Health and Parenting Classes, TCHD, July 1, 2004-2006

	7/1/2004-12/31/2004	2005	2006
Classes Offered	76	167	176

Data Source: TCHD, Internal Program Data

Family Success in Adams County Program Description

TCHD, CSU Cooperative Extension, and Alternatives to Family Violence have partnered together on a five-year project to strengthen the families of Adams County. The project focuses on parenting, relationship building, anger management and budgeting education. The project was currently focused on internal staff training in these areas.

Approximately 43% of families spend more than they earn each year

- US Federal Reserve

Family Success in Adams County Program 2006 Highlights

- TCHD Mothers First nurses were trained in multiple research based curricula:
    - Making Parenting a Pleasure
    - Spend Some, Save Some, Share Some
    - Love U2
    - Rethink

Home Visit Compliance Program Description
Previously the Adams County Sanction Prevention Program

The Home Visit Compliance Program is targeted to families who are in jeopardy of losing their TANF benefits. Nurses evaluate the family's home situation, health status, and their need for community resources. The goal of this short-term nursing home visitation program is to educate families on available resources and to assist families in complying with TANF requirements. The nurse makes referrals and coordinates with the ACSSD Job Transition Specialists to assist families in retaining TANF benefits.

One of the goals of TANF is to reduce dependency by promoting job readiness, employment, and marriage
- Department of Health and Human Services

Home Visit Compliance Program 2006 Highlights
- 102 clients received home visits, and another 157 received nursing services via telephone contact (Table 5).

Table 5. Home Visit Compliance Program Referrals, Home Visits, and Clients, TCHD, 2002-2006

	2002	2003	2004	2005	2006
Referrals	290	360	371	369	328
Home visits	116	119	165	336	145
Clients	203	239	268	351	259

Data Source: TCHD, Internal Program Data

FETAL ALCOHOL SYNDROME – PREVENTION ACTIVTIES, CHOICES AND EMPOWERMENT PROGRAM

The Fetal Alcohol Syndrome - Prevention Activities, Choices and Empowerment (FAS-PACE) program targets Adams County females of childbearing age (aged 12 to 44 years) who have ineffective contraception use and use alcohol at risk levels (4 or more drinks per occasion, 8 or more drinks per week, or any use if pregnant). Clients are recruited internally through Tri-County Health Department's (TCHD) nurse home visiting programs, the Family Planning program, and the Women, Infants and Children (WIC) program. Externally, TCHD receives referrals from medical care providers, mental health providers, alcohol treatment programs, domestic violence shelters, Social Services, schools, correctional institutions, and other local agencies. Depending on client need, a nurse can provide a brief intervention with two face-to-face sessions, ongoing sessions for up to six months, long-term case management for up to 3 years, and/or group sessions. Sessions include education, self-evaluation, goal setting and support. The FAS-PACE program is funded as a cooperative project from the Centers for Disease Control and Prevention through Colorado Department of Public Health and Environment and University of Colorado Health Science Center with TCHD, Larimer County Health Department, Denver Health Medical Center and Jefferson County Department of Health and Environment.

Drinking increases the risk that a woman will be assaulted physically or sexually
- National Institutes of Health

FAS-PACE Program 2006 Highlights

- The theme of the program changed to Party WISE, which focuses on making choices about sex and alcohol.
- TCHD's nurse-interventionist trained two interventionists from two counties.
- 440 women were screened for eligibility for the program.
- FAS-PACE increased the number of individual clients served by over 300% (Table 1).

Table 1. FAS-PACE New Clients Served, TCHD, 2005-2006

	2005	**2006**
Individual Clients	13	55
Group Clients	77	90
Education Only Clients	N/A	29
Total	90	174

Data Source: TCHD, Internal Program Data

The Health Care Program for Children with Special Needs (HCP) is a program that serves families of children, birth to twenty-one years of age, who have medical, developmental, mental health, or behavioral needs. The HCP program provides care coordination for families to assist with enrolling their children in a health insurance program, finding a primary care provider, and utilizing other community support systems, such as early intervention programs and disability advocacy organizations. Tri-County Health Department's (TCHD) HCP program provides a multidisciplinary team that includes public health nurses, a social worker, a nutritionist, a physical therapist, a family coordinator, and an administrative support staff person. In addition, HCP has a regional audiology coordinator. The HCP program is a component of the Maternal Child Health (MCH) block grant funding and the program has additional state and county funding support.

Autism affects approximately 1 child in every 150.

- Centers for Disease Control and Prevention

HCP Program 2006 Highlights

- TCHD HCP assisted in the planning and start up of a second respite program for families of children with special needs in the Denver Metro area.
- The lead agency for Part C Early Intervention system, the state's system for coordinating services for children with disabilities, transitioned from the Colorado Department of Education to the Department of Human Services, disability services. TCHD HCP provided education to our local community partners on this change.
- The State HCP program started electronically transferring data to local HCP offices from the CRCSN (Colorado Responds to Children with Special Needs) system about children who are at risk for developmental delays living TCHD's three counties.
- The HCP program had a decrease of 29% in total caseload numbers from 2005 to 2006 (Table 1). This decrease may be due to decreased referrals to the HCP program and closure of inactive cases.

Table 1. Health Care Program for Children with Special Needs Clients Served by County, TCHD, 2002-2006

	2002	2003	2004	2005	2006
Adams	521	438	673	578	455
Arapahoe	690	531	736	577	412
Douglas	76	64	188	277	107
Other	21	10	0	15	49
Total	1308	1043	1597	1447	1023

Data Sources: IRIS Report # 01, Total Caseload with Diagnoses
CHIRP data request, CDPHE, HCP, 04/07

The Nurse Family Partnership (NFP) is a research-based primary prevention nursing case management program targeting first-time pregnant, low- income women. NFP is one of only a few social programs that has scientifically shown positive outcomes through randomized controlled trials. NFP has demonstrated positive multi-generational outcomes that not only benefit the participating clients, but society as a whole. This program has three direct goals: to improve pregnancy outcomes, to improve children's health and development, and to improve economic self-sufficiency of the family. Clients are enrolled during pregnancy and receive nurse home visits weekly or bi-monthly until their child's second birthday. NFP is a comprehensive program that uses multiple intervention strategies to assist participants in developing increased knowledge, skills and self-efficacy to improve pregnancy outcomes, child health, and development. NFP is primarily funded by the Colorado Department of Public Health and Environment (CDPHE), which administers a portion of the state's tobacco settlement dollars and is supplemented by Medicaid reimbursement.

"I couldn't have made it this far without my nurse"

- Nurse Family Partnership Client

NFP Program 2006 Highlights

- TCHD NFP generated $290,959 in Medicaid revenue for the fiscal year 2006.
- The majority (50%) of clients served in 2006 resided in Adams County (Table 1).
- The number of clients served decreased by 13% from 2005 to 2006 (Table 2). This may be due to a large turnover of nurse home visitors.

Table 1. Nurse Family Partnership Enrollment by County, TCHD, 2005-2006

	2005	2006
Adams County	138 (46%)	129 (50%)
Arapahoe County	149 (50%)	117 (46%)
Douglas County	10 (4%)	11 (4%)
Total	297	257

Data Source: Clinical Information System (CIS) – National Center for Children, Families and Communities

Table 2. Nurse Family Partnership Referrals, Home Visits, and Clients Served, TCHD, 2002-2006

	2002	2003	2004	2005	2006
Referrals	648	486	533	397	1452
Home Visits	1978	2661	2486	3388	2757
Clients Served	164	206	358	297	257

Data Source: Clinical Information System (CIS) – National Center for Children, Families and Communities

PRENATAL PLUS PROGRAM

Tri-County Health Department (TCHD) became a Prenatal Plus (PN+) Provider in 1995 and is one of many Prenatal Plus Providers in Colorado. Prenatal Plus, overseen by the Colorado Department of Public Health and Environment (CDPHE), provides case management services to Medicaid-eligible pregnant women in Colorado who meet high risk criteria for delivering a low birth weight baby. A team of registered nurses, licensed mental health professionals and registered dieticians provide education and counseling that complements medical prenatal care to address the lifestyle, behavioral and psychosocial factors that can adversely affect pregnancy. Counseling includes information on appropriate weight gain, smoking, drug or alcohol use, preventing preterm labor, prenatal education, parenting, depression, and domestic violence. Community resources are provided to those needing physical assistance such as housing and food, mental health resources, parenting classes and many others. The goal is to meet the client monthly until two months post partum to complete a model package of service (10 or more visits). Prenatal Plus is funded through Medicaid.

Over 98% of clients surveyed reported that Prenatal Plus had been helpful during their pregnancy

- 2006 Prenatal Plus Client Satisfaction Survey

PN+ Program 2006 Highlights

- Prenatal Plus Care Coordinators reported 1,858 visits with PN+ participants.
- The total number of clients enrolled in PN+ increased 3% from 2005-2006 (Table 1).
- Partial Package (1-9 visits) participants had a 23% decrease in the percentage of low birth weight deliveries from 17.2% in 2005 to 13.3% in 2006.
- Clients that delivered at term (>37 weeks gestation) in the PN+ Program reported a low birth weight rate of 6.6%. *Data Source: 2006 CDPHE, Integrated Referral and Information System (IRIS)*

Table 1. Total Number of Prenatal Plus Clients by Year, TCHD, 2002-2006

	2002	2003	2004	2005	2006
Model Care Packages (10 visits or more completed)	126 (36%)	97 (35%)	130 (41%)	124 (45%)	122(43%)
Partial and Partial Plus Packages (1 - 9 visits completed)	223 (64%)	178 (65%)	184 (59%)	150 (55%)	160(57%)
Total Number Enrolled	349(100%)	275(100%)	314(100%)	274(100%)	282(100%)

Data Source: 2006 CDPHE, Integrated Referral and Information System (IRIS)

Table 2: Low Birth Weight Rates for Singleton and Multiple Births, TCHD Prenatal Plus Program, Compared to Statewide Rate and National Goals

	National goal, Healthy People 2010	Colorado 2005	TCHD Model Package 2006	TCHD Partial Package 2006
Low Birth Weight Rate	5.0%	9.3%	13.8%	13.3%

Data Source: 2006 CDPHE, Integrated Referral and Information System (IRIS)

CARDIOVASCULAR DISEASE PREVENTION PROGRAM

Tri-County Health Department (TCHD) was awarded a three year grant from the Colorado Department of Public Health and Environment (CDPHE) to establish a cardiovascular disease (CVD) screening program in Adams, Arapahoe and Douglas Counties. The program is based on WISEWOMAN, a best-practices model established by the Centers for Disease Control and Prevention (CDC) that provides low-income, under-insured and uninsured women aged 40–64 years with chronic disease risk factor screening, lifestyle intervention, and referral services. The program is intended to reduce the incidence of disease and death by screening for important risk factors such as high cholesterol, hypertension, diabetes, tobacco use, obesity, and physical inactivity. In addition, the CVD prevention program aims to engage women in positive lifestyle changes through partnership and ongoing support for those at risk for CVD. Medical referrals to partnering primary care providers are offered for treatment and follow up for those clients who present with medical abnormalities.

These new CVD services were bundled with existing family planning and cancer screening services to create a more comprehensive program for eligible women. These bundled services were named the Peak Wellness program. The CVD program is funded by CDPHE.

Nearly 39 percent of all female deaths in America occur from cardiovascular disease
- US Department of Health and Human Services

CVD Program 2006 Highlights

- In September 2006, TCHD began offering Peak Wellness appointments in three TCHD clinic sites.
- A total of 187 women were screened for cardiovascular disease.
- 27 (14.4%) had 2 abnormal blood pressure readings.
- Of the 122 women screened for a fasting blood glucose, 17 (9.1%) were in the diabetic range.

DENTAL PROGRAM

The Senior Dental program at Tri-County Health Department (TCHD) provides services for low-income senior residents who reside in Arapahoe County. The program provides free or low-cost dental care, including routine care, hygiene and some restorative treatment. TCHD dental clinic space in Commerce City is leased to Kids in Need of Dentistry (KIND) at a low cost to support dental care for children in Adams County. Dental care in Aurora is provided in cooperation with the Metro Community Provider Network (MCPN) in their dental clinic space.

Only 68% of adults visited the dentist or dental clinic within the past year for any reason
- Colorado Department of Public Health and Environment

Dental Program 2006 Highlights

- Dental program patients and client visits both decreased by 13%, from 2005-2006. This may be due to the loss of our half-time dentist for the 4th quarter of the year (Table 1).
- Dental hygiene services were provided to 150 (70%) of our 214 program clients in 2006.

Table 1. Senior Dental Care Program Clients and Visits, Arapahoe County, TCHD, 2003-2006

	2003	2004	2005	2006
Total Patients	274	288	246	214
Total Visits	933	1031	902	783

Data Source: TCHD, Internal Program Data

FAMILY PLANNING

The Tri-County Health Department (TCHD) Family Planning (FP) Program provides comprehensive reproductive healthcare to women and men in the Tri-County area. To be eligible for these services one must be fertile and seeking to prevent or delay pregnancy. There is no residency requirement and no income requirement. The program targets teens and clients with a household income less than 150% of the federal poverty level.

The FP program offers reproductive health exams, related counseling, contraceptive supplies, pregnancy testing, HIV testing, and sexually transmitted infection (STI) testing and treatment. In addition to clinic services, the FP program provides outreach education and presents information on both birth control and the prevention of sexually transmitted infections to local schools, individuals receiving social services, and parents of teens.

The Family Planning program is funded by and operates under the federal Title X grant guidelines and some aspects of the program are funded through the Centers for Disease Control and Prevention and the Colorado Department of Public Health and Environment. Additional funding includes client fees (on a sliding scale fee based on income), client donations, and county dollars.

In the United States, approximately 49% of pregnancies are unintended.
-Centers for Disease Control and Prevention

FP Program 2006 Highlights

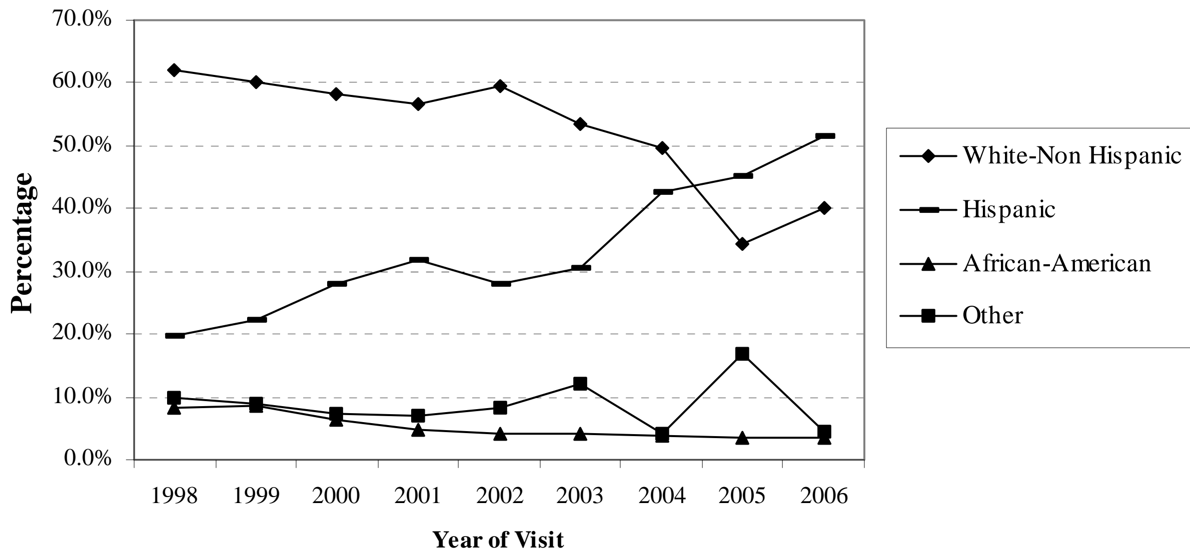
- Two clinic sites participated in a study to maintain or decrease weight in low-income, women with a BMI> 25 that were using DMPA injections as their primary form of birth control. (This method is associated with a slight weight gain in overweight women).
- The Family Planning staff taught a total of 179 birth control and STI prevention classes to middle school students (n=45), high school students (n= 179), and parent groups (n=7).
- Clients visited the clinic an average of 2.01 visits per year in 2006, maintaining a decrease for the third year in a row from a high of 3.29 visits per year in 2003 (Table 1).
- After several years of decline, from 1999 to 2002, the number of African-American clients receiving FP services has stabilized at 3.5%, from 2003 to 2006 (Figure 1).
- For the first time, the number of Hispanic clients served exceeded 50% in 2006 (Figure 1).
- 10% of clients served were teens less then 18 years of age and 94% of clients served were at or below 150% of poverty (Table 2).

Table 1. Total Number Family Planning Clients, Visits, and Average Number of Visits per Client, TCHD, 2002-2006

	2002	2003	2004	2005	2006
Number of Clients	7474	7655	8193	8379	8020
Total Visits	16600	25861	16885	16712	16151
Average Number of Visits per Client	2.22	3.39	2.06	1.99	2.01

Data Source: Report #13, Visits and Patient Loads, CDPHE, WHS

Figure 1. Proportion of Clients by Race/Ethnicity and Year of Visit, TCHD, 1998-2006



Data Source: Insight

Table 2. Number of Clients by Age and Poverty Level, TCHD, 2006

	<100% of poverty	**100-150% of poverty**	**150-200% of poverty**	**>200% of poverty**	**Total**
< 18 years	769 (12%)	13 (1%)	1 (1%)	0	783 (10%)
18-39 years	5266 (84%)	1155 (93%)	308 (93%)	146 (90%)	6875 (86%)
> 40 years	257 (4%)	69 (6%)	21 (6%)	15 (10%)	362 (4%)
Total	6292	1237	330	161	8020

Data Source: Report # 12, Patients by Age, % poverty and type with Target, CDPHE, WHS

WOMEN'S CANCER SCREENING

The Women's Cancer Screening Program provides breast and cervical cancer screenings at no cost to women age 40 to 64 who are uninsured, have income at or below 250% of the federal poverty level, and reside in Adams, Arapahoe or Douglas County. In order to be enrolled in the state funded Colorado Women's Cancer Control Initiative (CWCCI) program, the client must also provide documentation of lawful presence in the United States. Annual screening exams include clinical breast exams, mammograms, pap smears, and pelvic exams. The program also provides follow up for cervical or breast abnormalities, including medical referrals for diagnostic procedures and case management with a registered nurse. The Cancer Screening Program is funded through the CWCCI administered through the Colorado Department of Health and Environment (CDPHE). Supplemental funding for breast cancer screening and diagnostic follow-up is provided by the Susan G. Komen for the Cure Denver Metropolitan Affiliate.

"This was my best visit to a clinic – ever!"
- Cancer Screening Program Client

Women's Cancer Screening 2006 Highlights

- 910 women were screened for breast and/or cervical cancer (Table 1).
- The majority or 62% of clients served were less than 50 years of age, 87% identified themselves as white and 36% as Hispanic (Tables 1-3).
- The Cancer Screening Program increased the number of clients served by 54% from 2005-2006 (Table 4).
- 7 women were diagnosed with either breast or cervical cancer (Table 5).

Table 1. Age Category of Cancer Screening Clients by County of Residence, TCHD, 2006

	Adams	Arapahoe	Douglas	Other	Total
< 50 years	213 (60%)	275 (65%)	41 (62%)	44 (67%)	573 (63%)
50-54 years	55 (16%)	66 (16%)	9 (14%)	9 (14%)	139 (15%)
55-59 years	50 (14%)	48 (11%)	7 (11%)	3 (5%)	108 (12%)
> 59 years	36 (10%)	35 (8%)	9 (13%)	10 (14%)	90 (10%)
Total	354 (100%)	424 (100%)	66 (100%)	66 (100%)	910 (100%)

Data Source: TCHD, Patient Care Management System

Table 2. Race of Cancer Screening Clients by County of Residence, TCHD, 2006

	Adams	Arapahoe	Douglas	Other	Total
White	325 (92%)	354 (83%)	58 (88%)	58 (88%)	795 (87%)
African-American	10 (3%)	39 (9%)	2 (3%)	3 (4.5%)	54 (6%)
Asian	10 (3%)	12 (3%)	3 (4.5%)	1 (1.5%)	26 (3%)
Other Race/Missing	9 (2%)	19 (5%)	3 (4.5%)	4 (6%)	35 (4%)
Total	354(100%)	424(100%)	66 (100%)	66 (100%)	910(100%)

Data Source: TCHD, Patient Care Management System

Table 3. Ethnicity of Cancer Screening Clients by County of Residence, TCHD, 2006

	Adams	Arapahoe	Douglas	Other	Total
Non-Hispanic	229 (65%)	251 (59%)	59 (89%)	38 (59%)	577 (63%)
Hispanic	125 (35%)	173 (41%)	7 (11%)	28 (41%)	333 (37%)
Total	354(100%)	424(100%)	66 (100%)	66 (100%)	910(100%)

Data Source: TCHD, Patient Care Management System

Table 4. Total Number of Cancer Screening Clients and Visits by Service, TCHD, 2002-2006

	2002	2003	2004	2005	2006
Total Number of Clients	NA	NA	299	589	910
Screening Mammograms	267	286	231	452	526
Clinical Breast Exams	211	224	302	377	760
Pelvic Exams	155	169	155	200	598
Pap Smears	152	167	153	200	540

Data Source: TCHD, Patient Care Management System

Table 5. Number of Cancers Detected, TCHD, 2002-2006

	2002	2003	2004	2005	2006
Breast Cancers Detected	1	1	5	12	5
Cervical/Uterine Cancers Detected	1	1	0	2	2

Data Source: TCHD, Internal Program Data

CHILD CARE IMMUNIZATION AUDIT PROGRAM

The Child Care Immunization Audit Program is a new interdisciplinary program created at Tri-County Health Department with Nursing, Environmental Health (EH), and Epidemiology. After an initial pilot period, the program began in April 2006. Nurses assess the immunization records of children aged 0-4 years attending childcare in Adams, Arapahoe and Douglas County that meet the EH criteria for an on-site inspection. The nurses work with the centers to meet set standards that include 95% of immunization certificates on file and 75% of children must have documentation to show that they are up-to-date (UTD) for age-appropriate immunizations. The program is funded by inspection fees paid by the childcare centers.

In 2001, 80% of children <6 years of age were in out-of-home child care an average of 40 hours per week

- Centers for Disease Control and Prevention

Child Care Immunization Audit Program 2006 Highlights

- 115 child care centers were assessed.
- 8349 children were impacted by the assessment.
- In one child care center, the percent of certificates on file increased by 78% (Table 1).
- For all child care centers, the median percent change for UTD records was 31% (Table 2).

Table 1: Median Percentage, Range and Percent Change of Certificates on File, Childcare Immunization Review Program, TCHD, 4/2006-12/2007

	Visit One	Last Visit*	% Change
% Certificates on file (median)	97%	97%	14%
% Certificates on file (Range)	54-100%	95-100%	1-78%

**if needed more than one visit and visit 1 was < 95%*
Data Source: TCHD, Internal Program Data

Table 2: Median Percentage, Range and Percent Change of Certificates Up-To-Date for age, Childcare Immunization Review Program, TCHD, 4/2006-12/2007

	Visit One	Last Visit*	% Change
% Certificates UTD (median)	78%	85%	31%
% Certificates UTD (Range)	39-100%	73-100%	2-126%

**if needed more than one visit*
Data Source: TCHD, Internal Program Data

INTERNATIONAL TRAVEL CLINIC

The International Travel Clinic (ITC) provides services for clients planning a trip overseas. Clients meet with a nurse to receive recommended immunizations, medications for malaria, and health and safety information specific to the client's destination country. ITC services are available at our main clinic location in the Lonetree office, and are also offered in our Aurora and Northglenn offices. Clients are charged a consultation fee in addition to the cost of the vaccines for visits that include health counseling. The ITC offers routine immunizations for adults in addition to travel vaccines and consultation. ITC is funded by client fees.

Approximately 800 US travelers are diagnosed with malaria each year

- Centers for Disease Control and Prevention

2006 ITC Program Highlights

- ITC revenue per visit in 2006 was $95.38, up 12% from $84.77 in 2005 (Table 1).

Table 1. Total Number of ITC Immunizations, Clients, Revenue, and Total Clinics, TCHD, 2002-2006

	2002	2003	2004	2005	2006
Immunizations	4899	6417	6861	6603	6103
Client Visits	2578	3984	3789	3992	3202
Revenue	$230,189	$269,146	$322,113	$338,412	$334,894
Total Clinics	267	298	293	279	262

Data Source: TCHD, Internal Program Data

Table 2. Number of ITC Client Visits by County of Residence, TCHD, 2002-2006

	2002	2003	2004	2005	2006
Adams	277 (11%)	414 (10%)	361 (11%)	368 (9%)	249 (8%)
Arapahoe	1174 (46%)	1896 (48%)	1429 (43%)	1451 (36%)	1291 (40%)
Douglas	706 (27%)	1131 (28%)	1043 (32%)	1192 (30%)	1254 (39%)
Other	421 (16%)	543 (14%)	462 (14%)	981 (25%)	408 (13%)
Total	2578	3984	3295	3992	3202

Data Source: Insight

GIVE YOUR
CHILD
A SHOT
AT SUCCESS

Immunizations
Save Lives

IMMUNIZATION PROGRAM

Tri-County Health Department (TCHD) provides immunizations for vaccine preventable illnesses to clients of all ages. Both appointment and walk-in clinics are available, in addition to monthly Saturday clinics to increase access to immunization services. Immunization services are available in our Aurora, Castle Rock, Englewood and Northglenn offices, and are also provided at a variety of WIC offices and community locations. In addition to administering immunizations, program staff identify and contact the families of children 0-36 months of age who are not fully immunized using phone calls and post cards to encourage families to come for needed immunizations. For children, TCHD charges an administration fee of $15 per immunization that is waived for families who are unable to pay. Partial fees are accepted. The TCHD Immunization Program has a variety of funding sources, including grants from CDPHE, the Prevention Services Block Grant, and client fees.

In Colorado, 85.1% of kindergartners were up-to for age-appropriate immunizations for the 2005-2006 school year

- Colorado Department of Public Health and Environment

Immunization Program 2006 Highlights

- TCHD contracted with the Colorado Department of Public Health and Environment to participate in auditing randomly selected schools to determine an up-to-date rate of children attending kindergarten during the 2005-2006 school year.
- The total number of immunizations given in 2006 in our immunization clinics was 42,281 to a total of 13,306 clients (Tables 1, 2).
- The largest percentage (55%) of clients TCHD served was Hispanic (Table 3).
- The majority (86%) of clients TCHD served were 18 years of age or younger (Table 4).

Table 1. Total Number of Immunizations Given in Immunization Clinics to Children and Adults, TCHD, 2002-2006*

	2002	2003	2004	2005	2006
Children, ≤18 years	38656 (95%)	49107 (96%)	44246 (97%)	43797 (97%)	40189 (95%)
Adults, >18 years	2249 (5%)	1850 (4%)	1191 (3%)	1156 (3%)	2092 (5%)
Total Immunizations	40905(100%)	50957(100%)	45437(100%)	44953(100%)	42281(100%)

**Does not include vaccines given in International Travel Clinic*
Data Source: Insight

Table 2. Immunization Clients By County of Residence, TCHD, 2002-2006

	2002	2003	2004	2005	2006
Adams	3807 (27%)	4492 (28%)	3201 (23%)	3285 (23%)	2895 (22%)
Arapahoe	8007 (57%)	9403 (58%)	8789 (62%)	8153 (58%)	7805 (59%)
Douglas	1126 (8%)	1204 (7%)	1027 (7%)	1054 (8%)	889 (7%)
Other	1034 (8%)	1068 (7%)	1121 (8%)	1541 (11%)	1717 (12%)
Total	13974(100%)	16167(100%)	14138(100%)	14033(100%)	13306(100%)

Data Source: Insight

Table 3. Race/ethnicity of Immunization Clients by County of Residence, TCHD, 2006

	Adams	Arapahoe	Douglas	Other	Total
White, non-Hispanic	1227 (42%)	1975 (25%)	687 (77%)	478 (28%)	4367 (33%)
Hispanic, all races	1407 (49%)	4757 (61%)	135 (15%)	1008 (59%)	7307 (55%)
African-American	65 (2%)	651 (8%)	8 (1%)	110 (6%)	834 (6%)
Other Race	196 (7%)	422 (6%)	59 (7%)	121 (7%)	798 (6%)
Total	2895(100%)	7805(100%)	889(100%)	1717(100%)	13306(100%)

Data Source: Insight

Table 4. Age of Immunization Clients, TCHD, 2004-2006

	2004	2005	2006
Children, ≤18 years	12755 (90%)	12774 (81%)	11456 (86%)
Adult, >18 years	1383 (10%)	1259 (9%)	1850 (14%)
Total	14138(100%)	14033(100%)	13306(100%)

Data Source: Insight

CHILDREN'S ELIGIBILITY PROGRAM

The goal of the Children's Eligibility program is to increase enrollment of eligible children who in state funded health care coverage programs. Tri-County Health Department (TCHD) staff meets with families to help them apply for Colorado Medicaid or Colorado Child Health Plan Plus (CHP+) by reviewing applications for completeness, making copies of necessary documents, and screening for eligibility. Program staff then mail or deliver the application to the appropriate agency for processing. The Children's Eligibility program services are offered to clients referred from other agency programs such as WIC and immunizations, as well as from community agencies and social services. This program is funded by a Maternal Child Health block grant.

A family of four making $3400 a month qualifies for CHP+

- Child Health Plan Plus eligibility requirements

Children's Eligibility Program 2006 Highlights:

- Children enrolled in Colorado Medicaid has decreased by 3% during 2006, but children enrolled in CHP+ has increased by 14% (Table 1, 2).
- During 2006 a change in application requirements was instated, requiring applicants to provide additional documentation of residency to receive services.
- Applications processed by TCHD staff increased in 2005, but decreased by 6% in 2006. This may be dues to difficulties surrounding the change in application requirements. (Table 3).

Table 1. Number of Children Enrolled in Medicaid, Colorado, 2005-2006

	2005	2006
Children Enrolled	210,394	204,273

Data Source: HCPF

Table 2. Number of Children Enrolled in CHP+, Colorado, 2005-2006

	2005	2006
Children Enrolled	42,672	48,481

Data Source: HCPF

Table 3. Number of CHP+ and Medicaid Applications Sent for Processing, TCHD, 2004-2006

	2004	2005	2006
CHP+	114	376	304
Medicaid	830	1463	1431

Data Source: TCHD, Internal Program Data

EARLY PERIODIC SCREENING AND DIAGNOSTIC TESTING

The Early Periodic Screening and Diagnostic Testing (EPSDT) program at Tri-County Health Department (TCHD) is a statewide program contracted through the Department of Health Care Policy and Financing (HCPF). Program staff work with clients who are enrolled in the Colorado Medicaid Program to ensure that they can access covered health care services. TCHD EPSDT is a regional program responsible for Medicaid (MK) enrollees in Adams, Arapahoe, Douglas and Elbert Counties. Clients are offered information about sources of health care, dental care, vision services, and community resources. EPSDT provides information to clients on the phone and by mail, during home visits, and face to face at the county human service offices. EPSDT staff also does outreach to physicians and dentists who provide care to clients covered by Medicaid. The EPSDT program is funded by HCPF.

Approximately 18% of persons living in the US have been uninsured at some time in the last 12 months
- National Center for Health Statistics (2005 data)

2006 EPSDT Program Highlights

- The number of people enrolled in Medicaid decreased overall 1.5% from 2005 to 2006. Children enrolled in Medicaid decreased 3% in the same period. (Table 1).
- Most client contacts (50%) were made by letter, with other contacts made by home visit or phone call (Table 2).
- In addition to client contacts, program staff made 834 contacts to providers who see MK clients to offer assistance and information, and made 1209 contacts to community agencies to keep an updated list of resources for clients (Table 3).

Table 1. Number of Medicaid Eligible Persons, Human Services, 2005-2006

	2005	2006
Colorado-Eligible Children	210,394	204,273
Colorado-All Enrollees	396,506	390,520

Data Source: HCPF

Table 2. Number of EPSDT client contacts by type, TCHD, 2006

	Home Visits	Phone Calls	Letters	Total
Total contacts	1187 (9%)	5504 (41%)	6691 (50%)	8417

Data Source: TCHD, Internal Program Data

Table 3. Number of Provider and Community EPSDT Contacts, TCHD, 2006

	Provider Contacts	Community Contacts
Total Contacts	834	1209

Data Source: TCHD, Internal Program Data

MEDICAID APPLICATION SERVICES FOR PRENATAL CARE AND FIRST PRENATAL VISITS

Since 1991, the Tri-County Health Department (TCHD) has provided low income, uninsured pregnant women the opportunity to apply for Medicaid benefits in Adams, Arapahoe and Douglas counties. This service is also available to women who do not qualify for Regular Medicaid, due to residency and citizenship requirements, but can receive Emergency Medicaid (EMK) to cover delivery costs.

Presumptive Eligibility provides 60 days of guaranteed coverage to eligible women while their application is being processed through the county Social Services for final determination of eligibility. TCHD Medicaid eligibility technicians provide valuable information, assistance and advocacy so that every client submits the most complete and accurate application possible. During the same application visit, a public health nurse performs a comprehensive prenatal assessment (First Prenatal Visit) and educates each woman on the importance of early prenatal care, substances that can harm the mother and fetus, pregnancy danger signs, folic acid and weight gain. Referrals are provided to local medical providers, smoking cessation programs, substance abuse programs, WIC, case management, and many others as needed. These services are funded by each county and Medicaid reimbursement.

"Thanks to Tri-County, the Medicaid application process was easy and not as complicated as I had feared "

- Medicaid Application Services Client

Medicaid Application Services 2006 Highlights

- Medicaid Technicians adapted to new proof of residency and citizenship requirements
- Regular Medicaid applications increased by 8% from 2005 (Table 1).

Table 1. Regular and Emergency Medicaid (EMK) Applications by Site, TCHD, 2002-2006

		2002	**2003**	**2004**	**2005**	**2006**
Northglenn	**Regular MK**	NA	503 (92%)	NA	421 (98%)	389 (100%)
	EMK	NA (<1%)	44 (8%)	NA (<1%)	9 (2%)	0
	Total	515	547	377	430	389
Aurora	**Regular MK**	806 (50%)	718 (47%)	555 (40%)	409 (36%)	492 (45%)
	EMK	806 (50%)	809 (53%)	832 (60%)	728 (64%)	594 (55%)
	Total	1612	1527	1387	1137	1086
Englewood	**Regular MK**	348 (75%)	401 (71%)	376 (79%)	205 (61%)	201 (72%)
	EMK	116 (25%)	164 (29%)	100 (21%)	130 (39%)	80 (18%)
	Total	464	565	476	335	281
ALL SITES	**Regular MK**	NA	1622	NA	1035	1082 (62%)
	EMK	NA	1017	NA	867	674 (38%)
	Total	**2591**	**2639**	**2240**	**1902**	**1756**

Data Source: TCHD, Internal Program Data