DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
FY 2012-13 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, November 29, 2011
9:00 am – 12:00 pm

9:00-9:30 INTRODUCTIONS AND OPENING COMMENTS

9:30-9:50 QUESTIONS COMMON TO ALL DEPARTMENTS

A. PERFORMANCE-BASED GOALS AND BUDGET REQUEST

1. Please describe the process the Department used to develop its strategic plan.

Response: CDPHE began working on the current strategic plan in the summer of 2011. We began by reviewing the elements of the SMART Act to ensure that the plan would have all the necessary elements. We then worked with Department employees and other stakeholders including local public health agencies, industry groups, legislators and other organizations to identify strengths and opportunities. Department leadership then worked with TSI consulting to develop the central challenge, goals and objectives included in the strategic map. We returned to employees and other stakeholders with the draft map and incorporated their input in the final strategic plan that was included in the November 1st budget submission.

B. OTHER QUESTIONS COMMON TO ALL DEPARTMENTS

2. ***ONLY for those departments with an Appendix D (SAO Audit Recommendations Not Entirely Implemented):*** Please explain why the Department has audit recommendations that have not been fully implemented after extended periods of time. What are the obstacles the Department has faced in implementing recommendations? How does it plan to address outstanding audit findings? If applicable, please focus on those financial audit findings classified as "material weakness" or "significant deficiency".

Response: The Department does not have any issues on Appendix D.

3. How does the Department define FTE? Is the Department using more FTE than are appropriated to the Department in the Long Bill and Special Bills? How many vacant FTE does the Department have for FY 2009-10 and FY 2010-11?

Response: OSPB and DPA are working with all departments to provide quarterly reports on FTE usage to the JBC. These reports will ensure that all departments are employing the same definition of FTE. This definition comprises a backward-looking assessment of total hours worked by department employees to determine the total full-time equivalent staffing over a specific period. We intend for these reports to provide the JBC with a more clear linkage between employee head-count and FTE consumption. As it

concerns FTE usage in excess of Long Bill 'authorizations,' departments will continue to manage hiring practices in order to provide the most efficient and effective service to Colorado's citizens within the appropriations given by the General Assembly.

The CDPHE is currently utilizing more FTE than appropriated in the Long Bill, for the Medical Marijuana Program (please see question 7 for more information).

For FY 2009-10, the Department had the equivalent of 120.3 vacant FTE and 36.2 vacant FTE in FY 2010-11. Reasons for vacancies vary from year to year depending on federal funding levels, staff turn-over, retirements, and various programmatic changes.

FY 2009-10 utilized 5 furlough days – or essentially one week per employee. The Department had 68,874 furlough hours in the fiscal year which is then equivalent to 33.1 FTE that were not used during that fiscal year.

Furthermore, FY 2009-10 was the end of the hiring freeze that started in October of 2008. The Department was very diligent at the beginning of FY 2009-10 to hold positions vacant as a result of the economic conditions unless a specific exemption from the freeze had been obtained.

9:50-10:20 GENERAL DEPARTMENT QUESTIONS

4. Does the Department know what the timeline is for changes to the federal funds received by the Department that will result from federal actions on the federal budget?

Response: The Department does not know what the timeline is for changes to federal funds. The timeline is dependent on several factors and the ability of Congress to continue current year funding using continuing resolutions.

5. What fiscal year is the federal Super Committee looking at? How does this impact the Department's budget?

Response: It's not clear which fiscal year the Super Committee is reviewing. The legislation states FY 2012-2021. When using only one year to represent the fiscal year – the state references the last year – for example FY 2012 references FY 2011-12. However, the federal government may use nomenclature that refers to the first year when describing a fiscal year – for example FY 2012 would then represent FY 2012-13. Because of the Super Committees' failure to present deficit reduction options, current law states that automatic sequestration (reductions) in federal programs will be implemented in each of the next ten years. (Again, we are unsure if the next ten years starts with the current fiscal year or FY 2012-13) The reduction amount will be approximately $110 billion per year (for a total of $1.2 trillion); half will be applied

to military programs and half to domestic programs, including environmental protection, and public health programs. It is unclear at this point how the cuts will be implemented, or if there will be changes offered at the congressional level in the coming months to resolve the issue.

The sequestering excludes Medicaid, Child Nutrition and other women's infants and children's programs (not specified – those may include Maternal and Child Health programs). It appears that homeland security/defense programs WILL be impacted, if no changes are made by Congress.

6. Please respond to the JBC staff concern about how the Department will work to prioritize the ten winnable battles so that the Department can address each winnable battle in a manner that is effective and enables the Department to attain each winnable battle's target.

Response: Each of the Department's 10 Winnable Battles has been assigned an internal champion. These champions will be responsible for determining the best approach to attain the target for each Battle. It should be noted that we are not starting from scratch. CDPHE has been involved to varying degrees on each of these issues for many years and existing strategies and partnerships will be utilized and strengthened. In some cases, CDPHE will hold more of a supportive role than a lead role. For instance, the Caring for Colorado Foundation has identified oral health as their main priority. CDPHE has been, and will continue to, work to support the Foundation's efforts on this Winnable Battle in a public-private partnership. In the case of mental health and substance abuse, CDPHE will support the efforts of HCPF and DHS as those departments have a leadership role around this Winnable Battle and CDPHE will identify a unique and substantial contribution to these efforts. Through tailoring our strategies for approaching each Winnable Battle, we will ensure appropriate contribution and effort while leveraging our partnerships to gain efficiencies.

10:20-10:40 DEPARTMENT FTE LEVELS

7. Please discuss the duties and responsibilities of the 23.0 FTE in the Medical Marijuana Program that were converted from temporary to permanent.

Response: These FTE are responsible for the review and approval of Medical Marijuana Registry applications. This includes opening mail, processing fee payments, ensuring applications are complete and that all the necessary documentation has been included, as well as verifying the authenticity of all documentation (i.e. identifying fraudulent identification, notarizations, or physician certifications).

The Department has requested this conversion to be effective for FY 2011-12 and has proceeded accordingly with OSPB's approval of our plan. It is important to note that the Department is not adding staff to the program. The intent of the conversion is to take existing temporary positions and convert them to permanent positions in order to increase efficiency and comply with state personnel rules.

8. Please provide by division and program the number of vacant FTE and the number of unfunded/unused FTE.

Response: The table in Appendix 1, details vacant positions as of November 18, 2011. The Department will not be able to calculate the number of unused FTE until after the end of the current fiscal year, as the FTE count is a backward-looking assessment and calculation of hours worked (see the response to question 3 above). It is important to clarify that just because a position is vacant at the current time that does not mean that an entire FTE will be unused at the end of the fiscal year. For example, if a position takes an average of 90 days to fill (60 days for the exam process and 30 days for interviews/notification to current job/etc) then for each position 0.25 FTE will be unused for the year and show as "reverted" or unused in the Department budget schedules.

The Department has identified two unfunded FTE for FY 2011-12.

9. Regarding the Amendment 35 FTE Funding Reduction decision item, is the request to reduce the FTE and utilize those personal services for Amendment 35 grants because the Department was successful in issuing grants with fewer FTE last year? If not, what is the reasoning for reducing the Amendment 35 funded FTE.

Response: In response to the questions and concerns expressed by the legislature regarding this issue and in keeping with the Department's focus on increased efficiency, effectiveness and LEAN. The Department is closely reviewing program activities and business processes. As a result the Department is making process improvements that will enable it to issue and administer these grants with fewer FTE (for example, aligning process and staff assignments for the three A35 grant programs). The Department is continuing to streamline processes and procedures, so that when the funding levels return to their full amounts for FY 2012-13 we will be able to process increased grant funds with the current number of employees. This request continues the base appropriation for FTE in FY 2011-12 and utilizes the unneeded personal services funding for grants. We appreciate the work done by the legislative members to protect the integrity of these programs and to ensure that we have the resources necessary to properly manage the programs.

10. What was the Department's reasoning and justification for the programs that are reduced by the Preventive Health Funding decision item? What was the Department's reasoning and justification for the programs being increased by the decision item?

Response: The Department is requesting to shift some General Fund appropriations to offset anticipated loss of federal Preventive Health Block Grant funding (PHBG) for the Communicable Disease, Environmental Epidemiology and Sexually Transmitted Infection Medication programs. The Department is requesting this

shift to protect these critical programs while recognizing the state's challenging General Fund situation. As evidenced by the recent Listeria outbreak, the Communicable Disease program is essential to protecting public health. The return on investment for the Sexually Transmitted Infection Medication program is extremely high in terms of health care cost savings and preventing the spread of disease. The Environmental Epidemiology program is critical to ensuring accurate and appropriate information and response to environmental concerns from organizations and citizens. These three programs are critical to public health and do not have alternative funding sources that are readily available.

The request proposes to offset anticipated federal PHBG reductions with General Fund increases for the three programs. The requested General Fund increases will be offset by commensurate General Fund decreases to two programs, The Immunization and Ryan White Aids Drug Assistance programs have alternative funding sources that will allow them to remain relatively intact subsequent to the General Fund reduction. Both the Immunization and Ryan White programs receive Master Settlement Tobacco funds, a secure funding source, and federal funds, which do not appear to be in immediate jeopardy of federal cuts as is the case with the Preventive Health Block Grant. Therefore the Department believes that the Immunization and Ryan White programs are better able to withstand loss in funding without significant impact to services than could the three programs discussed above.

10:40-11:15 AIR POLLUTION CONTROL DIVISION

11. Please explain the operational ways the Air Pollution Control Division has used to address the shortage of FTE (i.e. staggering work schedules to meet the peak demand rather than hiring additional FTE). If the Division has not used operational ways to address the FTE shortage, why not?

Response: The Division's FTE shortage is driven primarily by the rapid growth of Colorado's oil and gas industry, which has resulted in a substantial back log of permits awaiting processing. To address this issue, the Division, working with industry, has instituted a number of operational changes to improve permit processing efficiency. Specifically, the Division, working closely with industry, underwent an intensive process improvement analysis that resulted in a reduction in the number of steps necessary to process a permit. Additionally, where feasible the Division has developed a number of general permits for the oil and gas industry, which have dramatically reduced the time to issue a permit for qualifying sources. However, in light of the dramatic and continued growth in the oil and gas industry, efficiencies alone cannot address the Division's FTE shortage.

12. Please explain the relationship between the federal Environment Protection Agency (EPA) and the Division. What federal requirement is there that Colorado has an Air Pollution Control Division. Is the work done by the Air Pollution Control Division duplicative of work done by the EPA? Can Colorado decide not to have an Air Pollution Control Division? If so, who would do the work and what are the consequences to the State?

Response: The Clean Air Act establishes a dual role for EPA and the states. As a general matter, EPA sets air quality standards and the states implement these standards in ways that make the most sense in light of local circumstances. The Act provides states with some flexibility in deciding upon the relative roles of EPA and the state. Because of the way Colorado's program is structured, there is little, if any, duplication between the Division's work and that of EPA. If the EPA were to assume responsibility for implementing the state's air program, Colorado citizens and industry would have to deal directly with the federal EPA on Colorado air quality issues. This would result in the federal EPA mandating how to manage Colorado's air quality matters, seriously curtailing the opportunity for Businesses, environmental groups, public health officials and locally elected officials to have input into air quality management, regulation of emission and strategies for controlling air pollution.

13. How many of the additional FTE identified in the report, is driven by the current presidential administration's decisions on Environmental Protection Agency guidelines that have not been previously implemented? Additionally, how many of the additional FTE in the report is attributable to the passage of House Bill 10-1365 (Incentives Utilities to Convert to Natural Gas)?

Response: Most of the identified FTE needs are the result of the significant expansion of Colorado's oil and gas industry, and are unrelated to new federal requirements. The remaining FTE are driven in part by the EPA's adoption of Nitrogen Oxide and Sulfur Dioxide standards in 2010, existing standards that the Department is struggling to implement, as well as by community requests for increased monitoring.

None of the identified FTE needs are attributable to the passage of House Bill 10-1365.

11:15-11:40 SCHOOL-BASED HEALTH CENTERS

14. What are the impacts to the School-based Health Centers of the General Fund reduction being requested to the School-based Health Centers line item? Will any School-based Health Centers close because of this reduction? If so, where are the School-based Health Centers located that might close?

Response: The reduction equals a 4.5% decrease in the overall program which will be spread evenly to providers. This will reduce the awards to the 15 contractors, who represent 35 school-based health centers by 4.47% totaling $42,624. Additionally the reduction will reduce the amount allocated to program support by 5.1%, or $2,134.

This reduction would not lead to the closure of any school-based health centers. However, it is important to note that a few programs are already in vulnerable positions and have already reduced staffing and hours of operation. The majority of these vulnerable centers are located in Adams County.

15. Please explain the rationale behind the reduction to the School-based Health Centers line item. Is this reduction due to ability for the School-based Health Centers to receive private funds?

Response: The Department was asked to target a specific amount of General Fund to reduce. The Department made its reduction proposals based on the area's most able to absorb reductions with the least severe consequences to public health. Issues such as availability of other funding sources were a factor in the process. There were programs that were exempted from having any General Fund reduction.

16. What is the average School-based Health Center cost per visit? How does this cost compare to the cost of getting medical services through a Medicaid provider?

Response: In previous response to JBC staff, we noted that the average annual cost for a school based health center is $283,367. If we then take the average visits per CDPHE funded center (see table in question 17) (For 2010-2011 79,618 visits for 35 centers) that is an average of 2,275 visits per center. Dividing $283,367 by 2,275 visits = $124.55 per visit. Furthermore, Denver Health has done an analysis of their SBHC (they oversee 13 SBHCs) and it covers 8/09 – 5/10. Based on their analysis, the average cost per visit for their high school sites was $78.86 and for their middle school sites it was $79.67. It is important to note that the cost per visit will vary widely from site to site.

A 2010 study conducted by Guo et al. (School-Based Health Centers: Cost-Benefit Analysis and Impact on Health Care Disparities. Am J Pub Health. 2010; 100: 1617-1623) concluded that school-based health centers are cost beneficial to both the Medicaid system and society, and may close health care disparity gaps. Included in this study was a comparison of parents' out-of-pocket expenses for travel, lost work time and co-payments to have their children see a community provider.

The Department of Health Care Policy and Financing and CDPHE's School-Based Health Center Program have partnered with New Mexico on a federal quality demonstration grant which will include an evaluation of data on emergency room visits and visits to school-based health centers for students who are on Medicaid and have access to a school-based health center. It is anticipated that this information will be available mid-2012.

17. Please provide the following data for the past five school years:
    a. How many student visits there have been at all School-based Health Centers;
    b. The number of School-based Health Centers; and
    c. The average cost of per visit.

Response: The average cost per visit is $124.55. CDPHE's School-Based Health Center Program typically provides funding through a competitive grant application process to ensure efficient use of grant money. As a result of the competitive grants process, most but not all of the programs responsible for administering school-based health centers throughout the state receive some funding from CDPHE/ The data gathered by CDPHE and provided below is only for the programs funded by state grants.

School Year	Total # of SBHCs	# Funded by CDPHE	# of Visits for sites reporting to CDPHE
2006-2007	38	29	62,640
2007-2008	43	31	59,290
2008-2009	44	38	83,164
2009-2010	45	41	84,687
2010-2011	44	35	79,618
2011-2012	46	35	N/A

18. How does the average cost per visit compare to the cost of getting medical services through a Medicaid provider?

Response: As addressed under question 16, this information is not currently available. However research suggests that these programs produce a positive cost benefit result.

19. Please explain how the need for and the location of a School-based Health Center is determined. Are services provided at a School-based Health Center available to any student enrolled at the school? How are co-pays for services determined?

Response: Interested citizens, schools, local health agencies and other community organizations initiate creation of a school-based health center. The first step is generally to conduct a needs assessment to determine if a school based health center would be valuable. The needs assessment generally looks at the number of students qualifying for Free and Reduced School Lunch rate since students who qualify for free or reduced lunches are often medically underserved. Another aspect of the assessment is to identify the medical and behavioral health care that is available within the community for medically underserved children and youth. Exploring these factors give communities a sense of the need for and potential utilization of a school-based health center.

School-based health centers operate under the guiding philosophy that all students will be offered care,

regardless of their ability to pay.

HB11-1019 exempts school-based health centers from collecting co-payments. As the majority of students served through school-based health centers have Medicaid, CHP+ or no payer source, the number of students capable of paying (as well as potential revenue collected from these students) is limited. Additionally, guidance from the Title V Maternal Child Health Block Grant prohibits charging a woman or child whose household income is 100% or below the Federal Poverty Level for any services provided through these funds. Below is the current guidance provided to the school-based health center contractors regarding a sliding fee scale:

If any charges are imposed for services to patients whose family incomes are above 100% of the poverty level, such charges must be on a sliding scale which takes into account the patient's family size, income and resources. These charges and the sliding fee scale must be made available to the general public and to all patients and must be based on the agency's usual and customary cost for the service. **Patients and their parents/guardians must understand they will not be denied services for inability to pay any of the sliding fee charges.**

Some school-based health centers have a nominal one-time enrollment fee (generally not more than $20 per student). As noted earlier, these fees are waived for students whose family income is 100% or below the Federal Poverty Level.

11:40-12:00 DISSOLVABLE TOBACCO PRODUCTS AND THE LISTERIA OUTBREAK

20. Are dissolvable tobacco products inspected by the Food and Drug Administration? Why or why not? How are these products distributed in Colorado (i.e. like candy and mints or similar to cigarettes)?

Response: The FDA has jurisdiction over all Tobacco products. However, they do not currently have regulatory standards for dissolvable products, thus they are not regulated. The FDA has convened the Tobacco Product Scientific Advisory Committee. The committee is expected to make recommendations regarding dissolvable tobacco products in 2012.

The only regulation that relates to Dissolvable tobacco products in Colorado statute is HB 11-1016. This legislation was passed during the 2011 session and prohibits sales of dissolvable products to minors. Other than the prohibition against sales to minors, there is no regulation of dissolvables either as tobacco products or as food; thus there are no specifications regarding where dissolvable products can be distributed, sold or where they can be placed; E.G. next to Candy.

Dissolvable tobacco products are received either directly from the manufacturer or through a distributor.

21. Please discuss the Listeria outbreak and where the bacteria infected the cantaloupe. Please provide any pictures the Department has that illustrate where the problems existed.

Response: CDPHE played a major role in the initial phases of the listeria outbreak: Identifying unusual frequency of the disease, overseeing the investigation to detect cantaloupe as source of the outbreak, coordinating with CDC to share information nationally, and coordinating recall and trace back activities and information dissemination. Once this outbreak involved multiple states, FDA assumed primary responsibility for identifying the source of the contamination and recommending actions to prevent future incidents. With CDPHE's assistance the FDA determined that listeria contamination likely occurred during the cleaning and storage of cantaloupe after harvest. The soil itself was not the source of contamination. Issues around cleaning equipment and work surfaces such as floors, as well as storage temperature were determined, by the FDA, to be the likely causes of the contamination. We would defer the photograph request to the FDA since they were the lead on that aspect of the investigation

22. What is the gestation period of Listeria? Has that timeframe passed?

Response: For Listeria the incubation period (that is, the time between when a person consumes a contaminated food until the time the person becomes ill) is thought to be 3-70 days, however, it is usually about one month or less. For the recent listeria outbreak that time frame has not passed yet (the recall was issued Sept 14), however new cases have slowed considerably and we are unlikely to see many more cases. In Colorado our last case was reported October 28.

Cantaloupes associated with Listeria illness have been recalled (removed from stores) as of September 14th. In addition, warnings were issued to discard cantaloupes purchased before September 14. Cantaloupes purchased after September 14 are safe to eat.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

1. What is the Department's entire Information Technology (IT) budget for FY 2011-12 and FY 2012-13? Does the Office of Information Technology (OIT) manage the Department's entire IT budget? If not, what IT activities is the Department managing separate from OIT and what percentage is that of the entire IT budget for the Department for FY 2011-12 and FY 2012-13? Of the IT activities the Department still manages outside of OIT, what could be moved to OIT?

Response: Nearly all IT-related personnel appropriations have been consolidated into the Governor's Office of Information Technology. IT-related professional services and operating expense budgets continue to reside in Departments' individual appropriations, and have not been consolidated into OIT. At this time,

it is expected that budgets for IT professional services and operating expenses will remain in the Departments' individual appropriations. However, during this fiscal year, all IT procurements will be centralized through the Office of Information Technology (the OIT Storefront). For FY 2012-13, the Executive Branch believes this represents the most efficient division of IT-related appropriations to ensure that Departments maintain appropriate discretion in making technology and program decisions. The Executive Branch will consider further consolidation of IT appropriations in future fiscal years.

Fiscal Year	Total IT Budget	OIT Managed Appropriations	Department managed expenditures	Department managed percentage
FY 2009-10	$10,840,135	$342,929	$10,497,206	96.8%
FY 2010-11	$11,971,752	$5,911,074	$6,060,678	50.6%
FY 2011-12	$12,903,492	$6,842,814	$6,060,678	46.9%
FY 2012-13	$12,653,726	$6,593,048	$6,060,678	47.8%

FY 2009-10 and FY 2010-11 are actual expenditures, and FY 2011-12 are Appropriations (OIT managed) and estimates (Department managed). FY 2009-10 actuals include personal services managed by the Department and FY 2010-11 has those personal services expenses under OIT control.

The operating costs associated with information technology items are included in the program operating lines. The tables above show the ESTIMATED IT operating budget for FY 2011-12 and for FY 2012-13. Actual expenditures will depend on changing circumstances that the programs must respond to on a day to day basis.

The Department has two Interagency Agreements (IAA) with OIT. The Water Quality Control Division has one for an employee to pay him a higher salary. The Prevention Services Division has one for an employee that was not included in the OIT Transfer Decision Item. This will be corrected through the regular budget process.

2. What hardware/software systems, if any, is the Department purchasing independently of the Office of Information Technology (OIT)? If the Department is making such purchases, explain why these purchases are being made outside of OIT?

Response: The Department receives OIT approval for purchases over $10,000. The Department does not purchase hardware that is not consistent with OIT standards. Software is sometimes purchased if the dollar amount is small and is for a specific purpose. An example would be the laboratory wants to purchase a software package off the shelf to read bar codes for their consumable inventory. It will cost around $3,000 and it would not go to OIT for approval.

3. Please list and briefly describe any programs that the Department administers or services that the Department provides that directly benefit public schools (e.g., school based health clinics, educator preparation programs, interest-free cash flow loan program, etc.).

Response:

Division	Program	Budgeted amount for K-12	Description
CPD/DEHS	School Chemistry	$122,770	Inspection of chemistry laboratories and inventories in middle and high schools in 10 counties.
PSD	School based health centers	$993,619 General Fund	Provide medical services to children in school based health center
PSD	Family Planning	Cannot identify exact funding as these decisions are made at the local level.	Two Title X agencies provide family planning services in school-based health centers as sub-site. Other agencies around the state do presentations in their local schools as part of their family planning outreach activities.
PSD	Coordinated School Health	We receive $100,000 from the Colorado Department of Education (through CDC funding) for the Coordinated School Health Initiative.	This initiative creates and supports school health teams who coordinate messages, programs and funding to create healthy schools so that kids can learn better.
PSD	Tobacco prevention and control	$100,000	The Not On Tobacco youth tobacco cessation program is administered by the American Lung Association via a contract and is conducted in schools and community based organizations throughout the state. This year, the program is in about 65 schools.
PSD	TGYS	$2,016,388 goes to K-12 programming	Before and After School Programs, Mentoring, Restorative Justice, Tutoring, Life Skill classes
PSD	Oral Health	$38,000	Kids in Need of Dentistry – application of sealants and fluoride varnish to students in schools with a high % of Free and Reduced Lunch kids
	Total	$3,370,477	

Appendix 1 – Vacancy list. This list was pulled on 11/18/2011 and has been modified to eliminate positions where the position has been filled or a job offer made and accepted. Furthermore, positions that will be abolished have also been removed.

Pos Nbr	Class Title	Class Code	Full/Part Time	Division
24	ENGR/PHYS SCI ASST I	D9B1IX	F	LSD
35	GENERAL PROFESSIONAL IV	H6G4XX	F	PSD
57	GENERAL PROFESSIONAL IV	H6G4XX	F	ADM
58	PROGRAM ASSISTANT II	H4R2XX	F	WQCD
66	HEALTH PROFESSIONAL V	C7C5XX	F	HF&EMS
95	HEALTH PROFESSIONAL IV	C7C4XX	F	HF&EMS
108	GENERAL PROFESSIONAL III	H6G3XX	F	PSD
119	GENERAL PROFESSIONAL V	H6G5XX	F	PSD
152	GENERAL PROFESSIONAL III	H6G3XX	F	CHEIS
182	HEALTH PROFESSIONAL III	C7C3XX	F	PSD
193	HEALTH PROFESSIONAL III	C7C3XX	F	HF&EMS
231	PROGRAM ASSISTANT I	H4R1XX	F	DCEED
237	ADMIN ASSISTANT III	G3A4XX	F	DCEED
240	Admin Asst. II	G3A3XX	F	CHEIS
250	HEALTH PROFESSIONAL III	C7C3XX	F	DCEED
312	HEALTH PROFESSIONAL IV	C7C4XX	P	DCEED
335	GENERAL PROFESSIONAL V	H6G5XX	F	PSD
353	ENGR/PHYS SCI ASST I	D9B1IX	F	LSD
458	ENVIRON PROTECT SPEC IV	I3A5*A	F	APCD
494	NURSE CONSULTANT	C7E1XX	F	DCEED
517	GENERAL PROFESSIONAL III	H6G3XX	F	EPRD
527	MANAGEMENT	H6G8XX	F	EPRD
534	PROGRAM ASSISTANT II	H4R2XX	F	PSD
541	PROGRAM ASSISTANT I	H4R1XX	F	DCEED
560	GENERAL PROFESSIONAL III	H6G3XX	F	EPRD
564	ADMIN ASSISTANT I	G3A2TX	P	CHEIS
579	PROFESSIONAL ENGINEER I	I2C4*C	F	WQCD
582	HEALTH PROFESSIONAL III	C7C3XX	F	HF&EMS
612	ENGINEER-IN-TRAINING I	I2C1IC	F	APCD
633	ENGR/PHYS SCI TECH I	I5D1*B	F	WQCD
646	TECHNICIAN III	H4M3XX	F	WQCD
867	HEALTH PROFESSIONAL III	C7C3XX	F	HF&EMS
885	ENVIRON PROTECT SPEC IV	I3A5*F	F	WQCD
935	HEALTH PROFESSIONAL I	C7C1IX	F	DCEED
957	ENGR/PHYS SCI ASST I	D9B1IX	F	LSD

Pos Nbr	Class Title	Class Code	Full/Part Time	Division
982	GENERAL PROFESSIONAL III	H6G3XX	F	EPRD
1021	GENERAL PROFESSIONAL III	H6G3XX	F	EPRD
1025	GENERAL PROFESSIONAL III	H6G3XX	F	PSD
1026	GENERAL PROFESSIONAL III	H6G3XX	F	ADM
1037	HEALTH PROFESSIONAL III	C7C3XX	F	HF&EMS
1063	HEALTH PROFESSIONAL IV	C7C4XX	F	HF&EMS
1074	GENERAL PROFESSIONAL III	H6G3XX	F	PSD
1080	ENVIRON PROTECT SPEC I	I3A2TD	F	HMWMD
1144	NURSE CONSULTANT	C7E1XX	F	DCEED
1152	MANAGEMENT	H6G8XX	P	HF&EMS
1196	GENERAL PROFESSIONAL II	H6G2TX	F	PSD
1198	GENERAL PROFESSIONAL III	H6G3XX	F	PSD
1203	HEALTH PROFESSIONAL III	C7C3XX	F	HF&EMS
1204	TECHNICIAN III	H4M3XX	F	APCD
1208	ENVIRON PROTECT SPEC I	I3A2TA	F	APCD
1214	GENERAL PROFESSIONAL III	H6G3XX	F	CHEIS
1216	GENERAL PROFESSIONAL III	H6G3XX	F	CHEIS
1218	GENERAL PROFESSIONAL II	H6G2TX	F	CHEIS
1231	TECHNICIAN I	H4M1IX	F	CHEIS
1233	PHY SCI RES/SCIENTIST I	I3B2TG	F	LSD
1234	TECHNICIAN I	H4M1IX	F	CHEIS
1250	TECHNICIAN I	H4M1IX	F	CHEIS
1251	TECHNICIAN I	H4M1IX	F	CHEIS
1252	TECHNICIAN I	H4M1IX	F	CHEIS
1270	GENERAL PROFESSIONAL II	H6G2TX	F	PSD
1271	TECHNICIAN III	H4M3XX	F	WQCD
1272	ENVIRON PROTECT SPEC I	I3A2TB	F	DEHSD
1273	HEALTH PROFESSIONAL III	C7C3XX	F	PSD
1279	ENGINEER-IN-TRAINING I	I2C1IC	F	APCD
1282	PROGRAM ASSISTANT II	H4R2XX	F	ADM
1285	GENERAL PROFESSIONAL III	H6G3XX	F	PSD
1286	GENERAL PROFESSIONAL II	H6G2TX	P	PSD
1288	TECHNICIAN I	H4M1IX	F	CHEIS
1299	ENVIRON PROTECT SPEC IV	I3A5*F	F	WQCD
1546	ENVIRON PROTECT SPEC I	I3A2TE	F	HMWMD
1663	PHY SCI RES/SCIENTIST I	I3B2TD	F	WQCD
1730	TECHNICIAN III	H4M3XX	F	HF&EMS
1731	HEALTH PROFESSIONAL III	C7C3XX	F	DCEED
1752	ENVIRON PROTECT SPEC III	I3A4*A	F	APCD

Pos Nbr	Class Title	Class Code	Full/Part Time	Division
1754	PROFESSIONAL ENGINEER I	I2C4*C	F	WQCD
1790	ENVIRON PROTECT SPEC III	I3A4*A	F	APCD
1843	PHY SCI RES/SCIENTIST IV	I3B5*F	P	APCD
1871	HEALTH PROFESSIONAL IV	C7C4XX	F	PSD
1873	HEALTH PROFESSIONAL II	C7C2TX	F	PSD
1909	HEALTH PROFESSIONAL III	C7C3XX	F	DCEED
2031	ENVIRON PROTECT SPEC I	I3A2TA	F	APCD
2086	PROGRAM ASSISTANT I	H4R1XX	P	DCEED
2264	HEALTH PROFESSIONAL IV	C7C4XX	F	HF&EMS
2270	GENERAL PROFESSIONAL V	H6G5XX	F	DCEED
2299	HEALTH PROFESSIONAL III	C7C3XX	F	HF&EMS
2357	ADMIN ASSISTANT II	G3A3XX	F	WQCD
2445	HEALTH PROFESSIONAL I	C7C1IX	F	DCEED
2499	PROGRAM ASSISTANT I	H4R1XX	P	ADM
2518	HEALTH PROFESSIONAL III	C7C3XX	F	PSD
2578	ADMIN ASSISTANT I	G3A2TX	P	CHEIS
2618	ACCOUNTANT I	H8A1XX	F	ADM
2709	PHY SCI RES/SCIENTIST II	I3B3*G	F	DCEED
5040	GENERAL PROFESSIONAL I	H6G1IX	F	WQCD
5052	GENERAL PROFESSIONAL II	H6G2TX	F	PSD
5060	GENERAL PROFESSIONAL III	H6G3XX	F	PSD
5061	GENERAL PROFESSIONAL III	H6G3XX	F	PSD
5063	GENERAL PROFESSIONAL III	H6G3XX	F	PSD
55534	GENERAL PROFESSIONAL III	H6G3XX	F	PSD
55538	GENERAL PROFESSIONAL IV	H6G4XX	F	PSD
55825	LABORATORY TECHNOLOGY III	C8D3XX	F	LSD
55944	GENERAL PROFESSIONAL III	H6G3XX	F	DCEED
55978	HEALTH PROFESSIONAL III	C7C3XX	F	PSD