DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Friday, December 20, 2013
1:30 pm – 5:00 pm

1:30-2:00 INTRODUCTIONS AND OPENING COMMENTS

2:00-2:05 QUESTIONS COMMON TO ALL DEPARTMENTS

1. **Please describe how the Department responds to inquiries that are made to the Department. How does the Department ensure that all inquiries receive a timely and accurate response?**

   Response: The Department receives a wide variety of inquiries every day, from complaints about hospitals and nursing homes to questions about testing well water. Each division has program staff who are responsible for responding to customer inquiries. In addition, each division has a "must answer line" that responds to customer calls during regular business hours. The Department also has a "Governor's advocate" who is responsible for processing telephone and email inquiries and ensuring they get to a person capable of responding to the customers' needs. Several times a year Department representatives meet with customer groups to seek input on Department programs and processes which include responsiveness. The Department uses this information to make improvements to its customer service. In addition, over the last few years, the Department has spent considerable effort using customer focused lean tools to improve efficiency, effectiveness and customer responsiveness. These efforts are focused on ensuring that customers get timely and useful responses from Department staff. The Department is committed to continuing to examine processes and make changes that improve the customer experience.

   The Department's budget and legislative staff coordinate responses to inquiries from legislators and legislative staff. This coordination ensures that responses are timely and are reviewed carefully. Programmatic subject matter experts draft responses to inquiries. Responses are then vetted through budget/legislative staff and executive leadership. The goal of this multi-layered review process is to ensure that the information being provided is accurate.

2:05-2:25 MEDICAL MARIJUANA REGISTRY

2. **Please provide a short primer on what research exists on what conditions should be added to the allowable use category for medical marijuana, and what work has been done to expand the existing list of allowed conditions.**

   Response: The Department uses a medical model for evaluating new conditions proposed for medical marijuana. The current process is as follows: The CDPHE Chief Medical Officer (CMO) reviews the existing medical literature to ascertain the safety and effectiveness of

marijuana for a proposed condition as well as the availability of alternative approved medications. If the CMO considers the evidence to be sufficient, then s/he convenes a panel of experts to review the evidence and provide guidance. Based on this feedback, a recommendation may be forwarded to the Board of Health, which has the authority to make the final decision as to which new conditions will be added to the list for medical marijuana use.

Since the original list of medical marijuana conditions was created in 2000, no additional conditions have been added to the list due to the lack of sufficient research available. The last condition considered by the CDPHE CMO was Post-Traumatic Stress Disorder (PTSD), where only two studies were available, both of which were conducted outside the United States and did not provide a sufficient level of evidence deemed necessary to add PTSD to the list of allowable medical marijuana conditions.

3. **Please discuss the Department's opinion of the JBC staff legislative option for the marijuana health research request discussed on page 19 of the December 13, 2013 briefing.**

   Response: The Department understands the proposal for legislation and agrees that having clear guidelines for the project would be valuable**.**

4. **Please discuss the reasoning behind the historically slow response to adjusting the fee for the medical marijuana application**.

   Response: Starting in 2009, a significant and unforeseen number of patients began to send applications to the Medical Marijuana Registry (MMR) in comparison to previous years (over an 800% increase in 2009 in comparison to applications submitted in 2008). The volatile climate surrounding medical marijuana use in the state of Colorado, in addition to the state budget shortfall at this point in time, led many decision-makers to move cautiously regarding a significant decrease to the MMR application fee. Many decision makers questioned whether the registry would continue to see a sustained increase in patient applications and if there was a need to reserve funding should the need arise to change the model for resourcing the registry. It has become clear that patient interest in the registry has continued to increase and the funding for the registry is more than sustainable. Each time a fee adjustment has been proposed to the Board of Health, the Board has acted on the department’s recommendation.

5. **Please discuss why the fees are the same for a new medical marijuana card application and renewal medical marijuana card applications**.

   Response: Since registrants have to resubmit all their application materials including doctor certifications each year, the workload involved in processing renewal applications is approximately the same as the workload for processing new registrants**.**

6. **Please discuss and, provide if available, the Department's projection for the number of medical marijuana applications after the legalization of marijuana**.

Response: The Department has no way of predicting the impact that marijuana legalization will have on the Medical Marijuana Registry. However, through November 2013, the program has not seen a decrease in the number of applications, even though recreational marijuana will be available starting January 2014. There are many variables that may affect the number of medical marijuana patients after January 2014:

1. Patients that stay in the registry due to medical necessity.
2. Patients that stay in the registry because of the protection provided against Federal prosecution as indicated in the Ogden Memorandum of October 19, 2009, and the Cole Memorandum of August 29, 2013.
3. Medical use for minors; recreational marijuana only serves those individuals over the age of 21 and minor use continues to increase due to recent media coverage.
4. Registry patients are permitted to have more product than those using recreational marijuana.
5. The price of the card, if low enough, might keep people in the registry to avoid additional A64 excise taxes.

The registry is currently at 112,000 active patients. The program believes that it is unlikely that the number of registrants would decline substantially.

7. Please discuss the Department's opinion of the staff recommendation to have the State Board of Health set the fee every six months for two years, and annually thereafter (the recommendation is on page 19 of the December 13, 2013 JBC staff briefing document).

Response: The Department supports the current regulatory requirement to review the fee annually and to propose changes to the Board of Health and will put processes in place to ensure this occurs moving forward. The Board of Health approved a fee decrease from $35 per application to $15 per application on Wednesday, December 18th. The Department will be going back to the BOH in August 2014 to provide an update on the number of applications received since the legalization of recreational marijuana use and the current status of the cash fund reserve to determine if an additional fee decrease is warranted. Reviewing the fee every six months, and potentially changing it, could create constant fluctuations and inequities in the fee; which patients want to avoid per recent feedback to the Department. This could create a situation where it becomes difficult for patients to track the current fee, leading to a need to either refund fees or reject applications for those patients that provided payment in an amount that is more or less than the current fee structure in place

2:25-3:10 STATE LABORATORY

8. *This question applies to both the Department of Public Health and Environment and the Department of Public Safety.* Please provide information on the groups that would not come back to a state run Toxicology Unit if one was reopened.

CDPHE and CDPS Combined Response: In the absence of complaints on the level of service and costs at private labs, CDPHE made projections about the groups that would not return to using the CDPHE toxicology laboratory, if reopened, based on dynamic variables:

1. Informal discussions between CDPHE Toxicology laboratory staff and law enforcement from multiple jurisdictions suggested that in the absence of a qualified Toxicologist to provide testimony about the effects of drugs/alcohol, testing would be sent to private laboratories able to provide this service
2. Colorado Springs, which accounted for 12% of the CDPHE toxicology laboratory total annual revenue, moved all testing to a private laboratory approximately1-2 months prior to the suspension of testing in the CDPHE laboratory. Informal discussions suggested that Colorado Springs would not return.
3. Due to the loss of toxicology staff during the suspension of testing, a timeline to recertification and resumption of testing for the CDPHE toxicology laboratory was projected to be at least 6 months. It was assumed that during that time customers would find alternative laboratories and, potentially, not return to the CDPHE toxicology laboratory should it reopen.
4. While testing was suspended, submitters were forced to identify alternative laboratories and entered into contracts with private laboratories for DUI/DUID testing. It is assumed that at least a portion of them would not return to the CDPHE toxicology laboratory.

9. Please provide clarification on the following differences between a state run Toxicology Unit and a private laboratory doing toxicology testing:

a. Types and cost differences of testimony;
b. Requirements for analysts to testify;
c. **Requirements for the provision of expert testimony**.

Response: Differences between a state run toxicology laboratory and a private laboratory include:

a. ***Cost of testimony***: While the CDPHE toxicology laboratory was operating laboratory analyst testimony for routine cases was offered at no cost. Expert testimony did result in additional fees based on a per hour rate that was lower than the private sector.
b. ***Requirements for analysts to testify:*** United States Supreme Court-*Bullcoming v. New Mexico*, No. 09-10876 (June 23, 2011), requires the prosecution to produce the actual author of the test result (the analyst) and ruled that a "surrogate" witness did not meet the constitutional requirements of the Confrontation Clause. This applies to both public and private toxicology laboratories. The CDPHE toxicology laboratory did not charge a separate fee for analyst testimony, but instead

incorporated costs into the testing fee. Some laboratories include costs for analyst testimony in their testing fees while other laboratories charge a separate fee.

c. ***Requirements for the provision of expert testimony in the differences covered in the response:*** The roles of the laboratory analyst who performs or supervises the analysis of drugs/alcohol in biological fluids are distinct from those of forensic toxicologists, who have the training and experience that qualifies them to interpret the results. Not all analysts are qualified to go to court and provide interpretation (expert testimony) of analytical results in impaired driving cases. Laboratories are not required to provide expert testimony. Expert testimony services can be obtained, at a fee, through consulting firms, private laboratories, etc. Laboratories offering both testing and expert testimony provide "one-stop shopping" for law-enforcement and other submitters.

10. Please discuss what situations required the Department to provide expert testimony, and if there is a threshold which triggers the requirement for expert testimony.

Response: There is no threshold in law which triggers a requirement for expert testimony. The decision on whether or not to include expert testimony is made by the prosecutors and defense.

11. Please provide an update on how the following:

a. How the laboratory space is being used;
b. What is being done with the equipment;
c. What other entities could use the equipment; and
d. **What discussions the Department has had with the El Paso County Corner for use of the mass spectrometer**.

Response:

a. Currently the CDPHE toxicology lab space has been either left vacant or is being temporarily utilized by the CDPHE Chemistry program.
b. Equipment (listed below) has been inventoried and placed into one of 4 categories:
    - Can be used by another CDPHE / LSD program
    - Can be transferred if another state department chooses to provide toxicology testing
    - Leased equipment will be transferred to another State Department if they are interested in taking over the payments / lease. If another state department does not want the instrument, it may be returned to the lessor / owner.

- Any instrumentation that cannot be utilized at the CDPHE Lab or transferred to another State agency will be discarded through the state surplus process.

State Owned Toxicology Equipment List:
(1) Shimadzu GC Autosampler
(3) 6890N Gas Chromatograph (model G1540N)
(1) 7890N Gas Chromatograph
(1) Teledyne HT3 Headspace
(1) 5975 MS with standard turbo pump (model 1372A)
(2) 7683 Injector (Model G2913A)
(2) 7683 Tray (model G2614A)
(1) 5973N MS with High performance turbo (model G2579A)
(1) 6890N GC with EPC
(1) 5973 MS
(1) 7373B Injector (model 18596B)
(1) 7673C Tray (model 18596C)
(1) Turbo Pump
(1) 5890 GC with EPC
(1) 5971 MS
(1) 7673B Tray (model 18596B)
(1) 7673B Controller (model 18594B)
(1) Freedom EV075 Base unit Liquid arm

Leased equipment:*
(1) 6420 Triple Quadrupole LC/MS (Lease @ $11,246.13 quarterly or $44,984.52 annually)
*The CDPHE Lab does not intend to continue using this instrument. If a State agency would like to take over payments the CDPHE Lab would gladly assist in negotiations with the lessor to transfer the instrument and payment responsibilities.

c. The executive branch is reviewing the options for how best to utilize the lab space and for how best to ensure toxicology services are provided.
d. CDPHE has heard that the El Paso County Coroner may be interested in toxicology instrumentation but direct discussions between the CDPHE laboratory and the Coroner's office have not occurred. Executive branch departments have been discussing the best approach for handling the toxicology equipment.

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12. Of the equipment purchased/leased over the last five years, what specific equipment was for the Toxicology Unit?

Response: Only the following pieces of equipment have been leased/purchased for

Toxicology in the past 5 years:

- 6420 Triple Quadrupole LC/MS = Lease @ $11,246.13 quarterly or $44,984.52 annually. (not owned): Acquired for Toxicology lab.
- Freedom EV075 Base unit Liquid arm (final payment was made December of 2013. CDPHE Lab will have title of ownership as of January/2014)

13. ***Note this question applies to both the Department of Public Health and Environment and the Department of Public Safety.*** **Please provide the plan for closing down the Toxicology Unit in the Department of Public Health. Please provide the plan, if toxicology testing is transitioned to the Colorado Bureau of Investigation. Please include the following:**

a. How a transition from the Department of Public Health and Environment to the Department of Public Safety will work;
b. What statutory changes are required;
c. Specific steps that would be required; and
d. **Recommendations on how to implement the plan**.

CDPHE and CDPS Combined Response:

a. **Plan for transition to another state or private entity:** CDPHE continues to work closely with other state agencies to discuss the provision of State Toxicology testing activities. If a decision to transfer toxicology duties to another state agency is made, CDPHE will work closely with the identified state entity to transfer owned equipment to the new agency, to identify potential staff, and, if requested, to transfer the Triple Quadrupole LC/MS currently being leased by CDPHE. The CDPHE laboratory plans to maintain a State Toxicologist position to provide expertise to the Evidential Breath Alcohol Testing (EBAT) program, the Laboratory Certification program, and to support other Public Health-related events (e.g., synthetic marijuana outbreak, toxin-associated bioterrorism event, etc.).
b. **Statutory changes required:** The Department is currently reviewing what statutory changes would be required to transfer toxicology services to another state agency.
c. **Specific steps that would be required:** Business plan, Operating plan, Accreditation plan.
d. **Recommendations on how to implement the plan:** Implementation of the identified plan will require cooperation from the CDPHE; other impacted state agencies, the Legislature, stakeholders, the Governor's office, etc...

3:10-3:20 BREAK

3:20-3:30 WASTE TIRES

14. Please discuss the Department's work with stakeholders regarding changes to the Waste Tire Program.

Response: On July 10, 2013, The Hazardous Materials and Waste Management Division (the Division) initiated monthly stakeholders meetings to review and revise the existing waste tire statutes. The meetings are scheduled through February 2014. The goals were to remove barriers and reduce burdens associated with implementing the statutes, and improve fund utilization. The Division hoped to achieve this by updating the statutes based on the Division's and stakeholders' collective experience. The public stakeholder process was inclusive and the information was made available to all interested parties. The Division garnered wide representation in the process. Stakeholders included state representatives, waste tire haulers, processors, end users, and monofills. Stakeholders also included innovative technology companies seeking to use waste tires for power generation and recycling opportunities.

The Division is working with stakeholders on two primary categories of modifications. Those designed to: 1) increase fund utilization in alignment with the existing statutes and 2) improve the rebate and grant programs. Examples of improved alignment include: 1) allowing direct state contracting with waste tire cleanup contractors to eliminate the local government burden to pay first and then receive reimbursement (this will increase the number of waste tire cleanups and reduce the risks associated with illegal waste tire piles); 2) increasing the state's ability to contract with local enforcement organizations to improve the opportunity for local outreach, education and inspections (this will help protect the legitimate waste tire businesses and deter illegal waste tire operators), 3) transferring waste tire fee collection to the division, and 4) transferring the waste tire statutes to Title 30 to better incorporate existing solid waste enforcement authorities. Goals of improving the rebate structure include: 1) consistent and predictable monthly rebate rates, 2) providing sufficient funding to ensure grant effectiveness, and 3) encouraging broadening sustainable end use markets.

15. Please discuss why the Waste Tire Cleanup Fund was selected for a payback and the reasoning for the payback amount of $500,000.

Response: The Governor's Office based the restoration of cash funds that were swept during the economic crisis on the availability of funding and the desire to restore funds that had been negatively impacted by the recession.

3:30-3:40 MEDICAL INFLATION

16. Please discuss the merits of providing a medical inflation increase to specific Department programs in FY 2014-15.

Response: While the general purpose of the Department is not to provide direct medical care,

there are certain situations where department expenditures are related to medical care, and the costs of those services and activities increases along with the cost of general medical care. For example, the laboratory purchases reagents and laboratory supplies to test for medical conditions, such as newborn genetics conditions, sexually transmitted infections, tuberculosis, ECT. The necessary reagents and supplies (pipettes, beakers, culture medium, etc) costs increase each year. Additionally, the department provides funding to local health departments and community organizations to identify manage and treat diseases such as tuberculosis, AIDS and Cancer. Disease identification could include lab tests and other screening mechanisms. Treatment could include providing medications and performing testing. Screening and treatment can also include clinical personnel. All of these costs, medical supplies, testing and clinical personnel are impacted by the inflationary pressures on the health care sector. When state funding for medical service programs and activities does not keep pace with the rate of medical inflation, the result can be fewer services provided for a smaller number of patients. As medical costs increase but funding stays flat the Department and its partner organizations struggle to maintain service levels.

3:40-4:05 Implementation of Recent Legislation

House Bill 12-1041

17. Please provide an update on the status of the Electronic Death Registration System.

Response: CDPHE is currently in the design phase for the Electronic Death Reporting System (EDRS). CDPHE is conducting meetings with the vendor and stakeholders (funeral directors, physicians, coroners, local vital records offices) to design system functionality in order to modify the existing system (the death reporting system for the state of Georgia) to meet Colorado statutory requirements. CDPHE is on target for spending the appropriated funding for the purchase and design of EDRS and is on target to meet the system implementation date of January 1, 2015.

18. How often are death records updated?

Response: Death records are sent to Secretary of State (SOS) at the beginning of each month. Additional files are created more frequently prior to elections at the request of the Secretary of State's Office. In July 2013, CDPHE had conversations with SOS to modify the current interagency agreement with the Secretary of State to update the timeframe for which data is shared; specifying that death data could be provided once a month throughout the year and once each business day 30 days prior to a state election. This agreement is currently going through the SOS review and approval process.

19. Please discuss why is the Secretary of State's Office charged for electronic transfer of death records? Who else is charged a fee for this service?

Response: The fee that is charged for providing death records to the Secretary of State's (SOS) Office is to cover personnel time required to manually download and process the

records as well as to support the maintenance of the system. CDPHE currently charges Secretary of State $180 a month to provide the monthly death file. This fee was based on an estimate of 4 hours of work each month. Although a file is transmitted electronically, the current system requires a manual process rather than an automated one.

Other state and federal agencies, healthcare organizations, and researchers are charged a fee based primarily on the time required to complete requests for record-level vital record data, matching of patient or subject records to birth and/or death records, or other administrative or research purposes. These fees cover personnel time required to create the data sets as well as support the system for data collection and maintenance of databases. The Vital Records program receives no General Fund, so the fees need to cover all costs. Vital Records fees are collected under the authority of Section 25-2-117, C.R.S.

20. Please discuss how the Department works with the Secretary of State's Office to purge deceased voters from the voting rolls.

Response: The Department provides new and updated death records to the Secretary of State's Office (SOS). CDPHE personnel select limited identifiers, compare the data with what has been previously sent to the SOS, and create a new data set containing new records, voided records, and any previously received records that have been modified since the last data file was received. The data output is in the form of a text file that is transferred via FTP to the SOS. Once the SOS receives the file, they purge the deceased voters from their system.

21. Please discuss the options for getting physicians to submit death records electronically, and what barriers exist to accomplishing this.

Response: In order for physicians to submit death records electronically, the Electronic Death Records System (EDRS) must first be in place; the target date for system implementation is January 2015. There is some physician resistance to participating in an electronic death reporting system due to perceived time constraints (physicians feel they are busy treating live patients and do not always have time to complete death certificates) and resistance to new technology (many physicians do not find themselves sitting at a computer during their normal practice and are not accustomed to using electronic systems). Many physicians only complete a small number of death certificates in a given year and so there are concerns from these physicians that they may not remember how to use the electronic system due to infrequent use. Physicians may designate someone within their practice to submit death certificates on their behalf. There will be a transition period after the implementation of the system by which paper records will still be accepted until physicians are fully trained on system use. CDPHE is reaching out to the medical community as well as using lessons learned from other states and the system vendor to identify ways to streamline the electronic system processes and make the system as user-friendly as possible. The vendor is building in an electronic "help" feature and other system prompts to help physicians easily navigate the required fields.

22. Is there a charge for electronic death record as opposed to a paper record? Please discuss if the cost is the same, or different for both types of records and why.

Response: Once the Electronic Death Records System (EDRS) is implemented, the fee for the exchange of electronic death data will be reduced, but there will still be a fee for the exchange of data in order to support ongoing maintenance of the electronic system. The future fee will be set by the State Registrar. The amount of the decrease will depend on how much the EDRS vendor will charge for on-going maintenance. Currently, certified copies of death certificates cost $20, verifications of death cost $20 and confirmations of death for research purposes cost $12. Fees for electronic files created for research requests are charged based on the personnel time required to complete the request.

House Bill 12-1294

23. Please provide an update on the PACE discussions as they relate to the implementation of H.B. 12-1294.

Response: House Bill 12-1294 established that Program for All inclusive Care for the Elderly (PACE) providers shall only be regulated consistent with the three-way agreement between the provider, the federal Centers for Medicare and Medicaid Services (CMS), and the Department of Health Care Policy and Financing (HCPF) (see C.R.S. 25-27.5-104 (1)). This paragraph also notes that the department may require additional information from the provider with regard to reporting instances of abuse.

Both HCPF and CDPHE have oversight roles over Program for All inclusive Care for the Elderly (PACE) functions. HCPF's oversight is broad, since they monitor the overall delivery of the care provided to PACE participants. CDPHE's oversight is narrower, with jurisdiction only over health care services subject to licensure, such as home care. The two agencies have conducted discussions throughout the past year regarding the appropriate oversight responsibilities for each agency. The Departments have done comparative analyses to identify the overlap between the two departments. The two agencies have scheduled a joint Lean event for December 30, 31 2013 to outline their respective roles regarding PACE oversight. While one of the main objectives of the event is to ensure that oversight is not duplicated, it is also designed to ensure that there are no gaps in oversight that would make the protections available to PACE participants less than those of consumers of other licensed home care agencies.

It is the Department's understanding that a bill regarding PACE may be introduced during the 2014 session.

24. Please provide an update on the Department's required review of rules which govern the relationship between mental health centers and primary care.

Response: The language in House Bill 12-1294 regarding the required review is under Section 25-1.5-103 (1) (c) (II), C.R.S. and reads as follows "The department of public health

and environment has primary responsibility for the licensure of community mental health centers and acute treatment units. The department of human services has primary responsibility for program approval at these facilities. In performing their respective responsibilities pursuant to this subparagraph (II), both departments shall take into account changes in health care policy and practice incorporating the concept and practice of integration of services and the development of a system that commingles and integrates health care services."

The rules for community clinics were revised in November 2012. Community clinics are not required, under statute, to be licensed. However, if they are licensed, they must meet applicable regulatory standards, to include life safety code. Mental health issues were not considered in this review.

The only concern that the Department is aware of in terms of the relationship between mental health centers and primary care is service co-location and the implications for fire code oversight. Specifically, stakeholders expressed concerns regarding the cost of requisite fire walls. However, the Department no longer has jurisdiction over this issue since House Bill 12-1268 transferred the responsibility of fire code oversight from CDPHE to the Department of Public Safety

H.B. 13-1326

25. Please provide an overview of the status of the Old Age Pension Dental Program and how the Program will align with other oral health programs in the State.

Overview

The Old Age Pension Dental Assistance Program (DAP) is a state grant program to provide preventive and restorative oral health care services to very low income Coloradans over the age of 60. After a three year suspension, funding for the DAP was restored at a much higher level (six-fold) during the 2012 legislative session.

Status

Program grantees provide or arrange for oral health care services to eligible seniors in all 64 Colorado counties. State FY 2012-13 marked the first year when this statewide reach was achieved.

There were 19 DAP grantees in FY 2012-13. There are 32 DAP grantees for FY 2013-14. An additional four contracts are forthcoming.

$2,144,670 of a $3,202,743 appropriation was expended in FY 2012-13. The unspent amount was rolled forward into FY 2013-14. The department is on track to spend the full FY 2013-14 appropriation.

In five months of operation during FY 2012-13, the DAP funded care for 1,360 eligible seniors. Of seniors who were served in FY 2012-13, 98% were qualified under Old Age Pension eligibility criteria (Section 26-2-111 (2), C.R.S.). The remaining 2% of DAP

beneficiaries in FY 2012-13 were qualified under an expanded eligibility definition created in statute in 2012 (Section 25.5-5-101 (1) (l), C.R.S.).

The average program cost per beneficiary in FY 2012-13 was $1,050. Grantees are permitted under statute to collect a copayment from the beneficiary. All grantees waived or reduced the copayment charged to seniors in order to lower cost barriers to program beneficiaries. All grantees are allowed to bill the state for up to 10% of care costs for administrative services. One grantee declined to bill the state for the allowable administrative fee in order to extend resources available for care. Four grantees requested reimbursement, per procedure, at rates lower than those allowable under Board of Health program rules in order to extend resources available for care.

Alignment

Medicaid: With the expansion of Medicaid, CDPHE is not certain that there is a need for the OAP dental program because these same clients will be served by Medicaid through HCPF. In order to be effective, efficient and elegant, CDPHE and HCPF are working with stakeholders to determine how to best use state resources to serve this population. Whether OAP dental goes away entirely, or is re-purposed as a different type of benefit is still being discussed between CDPHE and HCPF who has expertise in benefit eligibility and administration. **Statute changes will need to be made if the program, or the Dental Advisory Committee which advises the program, are to be modified, transferred or eliminated.**

Older Americans Act Dental Benefit (OAA): This program is funded by the federal government and administered by the Department of Human Services. These program funds are to be used as a last resort for eligible seniors; therefore, an individual must be deemed ineligible for DAP before they may access OAA. Department staff and DHS are in regular contact regarding clinical, administrative, policy and contractor issues.

4:05-4:15 School-Based Health Centers

26. Please discuss what the role of School-Based Health Centers will be in light of the Affordable Care Act and Medicaid expansion.

Response: With the implementation of the Affordable Care Act (ACA) and Medicaid expansion, the Department anticipates more children will be covered by Medicaid. Department staff regularly shares ACA and Connect for Health Colorado information, including opportunities for training, with School-Based Health Centers (SBHCs) to encourage enrollment as well as Medicaid and third-party payer billing.

Despite the Medicaid expansion, there will remain a population of children and youth who will not be eligible for coverage. Along with federally-qualified and rural health centers, school-based health centers are safety net providers; they are expected to serve otherwise unserved populations. SBHCs already serve as medical homes for children and youth;

nevertheless, the delivery and billing of services such as oral and behavioral health services continues to be challenging. Additionally, there are a number of services that SBHCs provide that are not reimbursable by insurance. The role of SBHCs will to continue to reduce barriers to access to these vital services.

27. *This question is for the Department of Health Care Policy and Financing.* Would the new Medicaid management system be able to track services that are provided at a School-based Health Center? Why or why not?

Health Care Policy and Financing Response: The Medicaid Management Information System (MMIS) is the health care claims processing and payment system for programs administered by the Department of Health Care Policy and Financing, including Medicaid, the Child Health Plan *Plus* (CHP+), and the Old Age Pension Health and Medical Program. If the School-based Health Center bills HCPF for a service, then the MMIS would have information on the services provided. However, if the School-based Health Center does not bill HCPF for services, then HCPF may only have a limited ability to track services. Through HCPF's November 1, 2013 R-5 Budget Request, "Medicaid Health Information Exchange", HCPF has requested funds to link the Department to the Colorado Regional Health Information Organization (CORHIO), which may contain additional information on the services provided if the School-based Health Center used an Electric Health Record that is connected to CORHIO. Finally, HCPF would not have the authority to gain information on clients who are not covered under one of the Department's programs.

28. Please discuss the process used to grant out the $5.3 million appropriated for School-based Health Centers. Please include a discussion of how the Department involved stakeholders in these discussions.

Response: In FY13-14, the department released two Requests for Applications (RFAs): the annual RFA to distribute the annual appropriation in March, 2013, and an expansion RFA for the additional funding in September, 2013.

The Department met multiple times with staff from both the Colorado Association of School Based Health Centers (CASBHC) and The Colorado Health Foundation to develop a plan for spending the additional funding. According to the plan, the department surveyed all SBHC contractors to determine their needs and developed the expansion RFA based on the results of that survey.

The expansion RFA had two categories: (1) Service Expansion funding to expand the type and number of SBHC services and/or to increase the number of patients served by SBHCs, and (2) One-time Center Enhancement funding to enhance center facilities. Each RFA process had a the applications based on the RFA criteria as well as the applicant's known historical and current performance.

Current funding supports 15 contractors to operate 47 centers throughout the state and the

building of a 48th center. The Department created the SBHC Investment and Sustainability Advisory Committee to advise the Department on the best investments for the SBHC funds to support and expand current service capacity statewide and to ensure the program's growth is sustainable with local level efforts. The Committee has members from local SBHCs as well as representatives from the CASBHC, The Colorado Health Foundation, and Caring for Colorado Foundation, and the Colorado Health Institute.

29. Please supply a detailed FY 2013-14 budget for the School-Based Health Centers Program including the amount budgeted for Department personnel, grants, and the amount anticipated to remain unexpended.

Response:

FY14 SBHC APPROPRIATION	**$5,260,817**
SBHC Personnel (salary and benefits): 2.9 FTE • Program management • Program coordination and technical assistance • Fiscal staff • Contracts staff • Project evaluation	$222,309
SBHC-related Operational Costs: (no indirect costs) • Start-up costs including computers and software • Site visits including travel and training related to contract compliance, health reform, Medicaid billing, etc. • Supplies • Miscellaneous costs, such as mail and phone	$101,948
Clinical TA Contract • Dr. Maureen Daly provides TA related to compliance of clinical standards.	$44,000
Data System (January – June 2014)	$50,000
Data System Consultation (Apex)	$6,500
SBHC Pre-planning Grants	$20,000
SBHC Contracts (original plus expansion awards)	$3,648,793 *$1 million is anticipated to remain unspent due to the limited time allotted (December 1, 2013 – June 30, 2014) for expansion grants.*

Funds Remaining from the FY2013-14 Appropriation to be used for the FY2014-15 RFA scheduled for release in February/March 2014	$1,167,267
Total anticipated unspent in FY 2013-14	$2,167,267

30. How much of the total appropriation does the Department anticipate will not be expended by the end of FY 2013-14? Of this amount, how much will be funds were not award out through grants? Please discuss if the Department supports the roll-forward recommendation and why.

Response: The total anticipated unspent amount for FY13-14 is approximately $2,167,267. Of this amount, approximately $1,167,267 was not awarded through grants in FY13-14. The plan is to award this amount for FY14-15. $1 million is anticipated to remain unspent due to the limited time allotted (December 1, 2013 – June 30, 2014) for expansion grants. If needed, The Department anticipates requesting roll forward spending authority for any unspent funds through the OSPB SCO year end process.

31. Please discuss the Department's long range plan to support school-based health services including the mechanisms used to award grants, how the Department will measure success, and how the Department will ensure funds are being used appropriately.

Response: In collaboration with other known funders of the program such as The Colorado Health Foundation, the Department will continue to release an annual RFA to assure that communities have a source of funding for activities from planning through ongoing implementation.

Success will be gauged by two factors:

1. An increased capacity of SBHCs (more operational SBHCs state-wide, more students served and/or more services provided)
2. Assuring that all new centers receiving state funding meet the *Quality Standards for Colorado School-Based Health Centers* and are involved in Colorado's health information exchange network, enrolled in the Regional Care Collaborative Organizations, and are billing Medicaid and third-party payers. The Department will continue to assure appropriate use of state funds through its fiscal and program monitoring and compliance procedures in alignment and collaboration with the Colorado Association of School Based Health Centers (CASBHC).

4:15-4:25 Grants Management System

32. ***The Office of Information Technology should provide a response to this question in addition to the Department's response*.** **Please discuss why work on the Grants Management System has not progressed, the barriers preventing the expansion of the System, and when the General Assembly can expect to have a Grants Management System in the Department of Public Health and Environment**.

CDPHE Response: At this time, there are outstanding statewide system conversions that have delayed selection of an appropriate grants management system for the Department. The COFRS conversion to CORE is the largest outstanding variable in the decision about Grants Management Software. CORE does have Grants Management modules and the Department will explore using them to interface with the State's financial systems to provide the most cost effective business flow capabilities.

It is the intent of the Department to find a cost effective solution that best meets the needs of the grant making process from the application for funding through cost reimbursement payments. Previously piloted systems did not allow for electronic grants processing throughout the entire business process, causing the Department to revert back to paper and manual processing procedures during contracting and payment phases. In addition, previously piloted systems did not prove to be cost effective and were not projected to interface with the new financial system.

It is the Department's desire to find a solution that will provide the most efficient customer service to its grantees. The Department will continue grants management software discussions after the COFRS conversion in July of 2014.

OIT Response: Previously, several divisions within CDPHE were involved in OIT's effort on the Colorado Grants Management System (COGMS), other state agencies utilizing this service include the Department of Education and the Department of Public Safety in FY2013-14. For a variety of reasons CDPHE decided to opt out of this system prior to the completion of functionality. At the time of the CDPHE decision work was progressing in the Prevention Services Division on three major grant programs. A contributing factor may have been that OIT was considering ending this service but present expectations are that it will continue so long as departments wish to utilize it.

4:40-5:00 VARIOUS ENVIRONMENTAL DIVISION QUESTIONS

33. Please discuss what reasoning was used to select the $10.0 million repayment figure to the Hazardous Substance Response Fund, instead of a percent of the total amount transferred in FY 2008-09 and FY 2009-10. Additionally, please discuss the Department options for addressing the issue of the balance cap of the Hazardous Substance Response Fund if the General Assembly decides to repay the Fund.

Response: The Governor's office based the restoration of cash funds that were swept during the economic crisis on the availability of funding and the desire to restore funds that had been negatively impacted by the reduction.
The Hazardous Substance Response fund (HSRF) provides funding for the state match money for participation in the federal Superfund program and funding for the state Brownfields program. Long term, the funds in the HSRF will support the state's on-going responsibility for future operation and maintenance costs associated with the cleanups at Superfund sites after the 10 year federal participation in those activities ends. To address the issue of the current balance cap on the HSRF and provide the funding to meet the state's long term and on-going obligations the Department proposes that the $10 million payback be placed in a special fund or account similar to the funds that provide financial assurance and surety for cleanup activities at non Superfund and radiation sites. The moneys in this special fund or account could only be used to supplement the HSRF to fund the State's long term obligations at Superfund sites and could not be transferred or used for any other purpose. Current projections reflect the state's obligation for on-going costs will increase by 300% in FY2024-25 when the HSRF will bear all of the costs associated with the operation of the Summitville water treatment plant. At the projected fee levels the HSRF will be in deficit three years later.

34. Please provide an update on the Suncor spill.

Response: In late 2011, a plume of contamination from Suncor's property migrated across Metro Wastewater Reclamation District's (Metro's) property and was discharged into Sand Creek. A large amount of work has been done in the last two years to protect the creek, cleanup Metro's property, and contain the contamination at Suncor's property boundary. By February 2014, the installation of all planned remedial systems for the Metro Wastewater Reclamation District (Metro) property will be completed. These systems are intended to complete cleanup of the plume on Metro's property which will also help to keep contamination from reaching Sand Creek and the South Platte River. Metro is continuing with the planned construction on their property that requires groundwater to be pumped out so that facilities can be built below the normal ground water level. Suncor has constructed a waste water treatment system on Metro's property to deal with any contaminated water removed from the subsurface during the construction activities so that these activities are not affected by the groundwater contamination.

The flood event and heavy rains in September 2013 destroyed one of the operating remediation systems located parallel to Sand Creek. This system will be replaced in the future as necessary. Other operating remedial systems located on and offsite of the refinery were only slightly damaged, have been repaired, and are operating again. The flooding and rain increased groundwater levels in the general area of the refinery by 3-4 feet, which caused a slight shift in the groundwater contaminant plume. Groundwater and surface water monitoring in the area has been increased and adjusted to closely monitor the present status of the plume. As of December 9, 2013, the concentration of benzene in Sand Creek, at its confluence with the South Platte River, was 6.68 micro grams per liter (ug/l). The standard for benzene is (5 ug/l). Groundwater levels are expected to return to normal within a few months and the contaminant plume should once again stabilize. Once stabilized, the need for

additional remedial systems to protect Sand Creek and the South Platte River will be evaluated.

There is a remedial system installed and operating along Suncor's property boundary designed to contain the plume to its property. This system has stopped the offsite flow of free phase hydrocarbon but at this time dissolved phase hydrocarbon is continuing to migrate offsite onto Metro's property. Containment of dissolved phase hydrocarbon at Suncor's property boundary will continue to be evaluated and enhanced as Metro's property is remediated.

35. Where does the revenue from air enforcement fines go?

Response: All penalty dollars are directed to the general fund, with the exception of money directed to Supplemental Environmental Projects (SEPs). SEPS are penalties that the violator pays, but that are used to benefit the community where the violation occurred. These funds are kept in a separate cash fund specifically for this purpose. SEP funds are not comingled with the program cash funds.

See data below for all enforcement actions completed for the last two fiscal years:

Fiscal Year	***Penalties***	***SEPs***	***Total Penalties***
FY 2011-2012	***$ 1,397,997***	***$ 1,944,858***	***$ 3,342,855***
FY 2012-2013	***$ 1,507,618***	***$ 346,950***	***$ 1,854,568***

See data below for Oil & Gas Penalties for the last two fiscal years:

Fiscal Year	***Penalties***	***SEPs***	***Total Penalties***
FY 2011-2012	***$ 1,069,244***	***$ 972,240***	***$ 2,041,484***
FY 2012-2013	***$ 1,258,299***	***$ 196,280***	***$ 1,454,579***

36. Please provide the following information on Air Pollution Enforcement actions for the past two years:

a. How many days the violation lasted; and

b. Additional detail of how the fine was calculated.

Response:

a. The Air Pollution Control Division ("Division") has completed 250 enforcement actions in the past two years. Each action addresses anywhere from one (1) to thirty (30) violations per facility, with an average of five (5) violations. In addition, each individual violation addressed may have a different duration. Typically, each

violation has its own unique duration, ranging from 1 day (or portion thereof) to sometimes several years. Currently, the Division does not track the duration of each violation in our database. However, the duration of each violation is taken into account in assessing penalties associated with each enforcement action. The Division's primary goal in addressing any violation is to return the source to compliance as quickly as possible if they haven't already done so.

b. Each penalty calculation is unique to the circumstances of the case. The Division assesses penalties based on our statutory authority (Section 25-7-122, C.R.S.), including the consideration of both aggravating and mitigating factors. The duration of each violation is a key aggravating factor that is considered in penalty assessment. The Division has the authority to assess a penalty per violation for each day in violation. For some violations, penalties are assessed on a day per day basis. Often, violations that are longer in duration are assessed on a shorter duration than day per day, in order to manage the magnitude of the penalty. For example, a violation that occurred over the course of one year may be assessed as one day per year, one day per six months, one day per quarter or one day per month. The assessed duration can depend on many factors, including the serious nature of the violation, the source's compliance history, the source's response in addressing the violation, etc.

   The statutory penalty amounts are $15,000 per day for each violation (Section 25-7-122, C.R.S.). For all enforcement actions, the penalty range for the last two years is as follows:

Year	***Total Penalties***	***Median Penalty***	***Average Penalty***	***Range***
FY 2011-2012	***$ 3,342,855***	***$4,125***	***$49,160***	***$0 - $724,373***
FY 2012-2013	***$ 1,854,568***	***$5,250***	***$14,265***	***$0 - $226,800***

For Oil & Gas penalties, the penalty range for the last four years is as follows:

Year	***Total Penalties***	***Median Penalty***	***Average Penalty***	***Range***
FY 2011-2012	***$2,041,484***	***$15,441***	***$58,328***	***$0 - $681,914***
FY 2012-2013	***$1,454,579***	***$5,950***	***$14,918***	***$0 - $112,000***

Total penalties also include the economic benefit derived from non-compliance, as well as Supplemental Environmental Projects (SEPs) which help the local community and environment, and can be used to offset some of the cash penalty. All cash penalties go to the General Fund.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

1. Provide a list of any legislation that the Department has: (a) not implemented or (b) partially implemented. Explain why the Department has not implement or has partially implemented the legislation on this list.

Bill	Short Title	Implementation Status
HB07-1328	Educate Public Storm Water Quality	Effective upon gifts, grants and donations. To date, no donations have been received.
SB09-165	Drinking Water Wastewater Small Grants	This bill cleans up the two separate statutes that authorize the small community drinking water and waste water programs to allow for funding of small community grants when/if severance taxes become available.
HB 10-1284	Medical Marijuana Regulations: 24 Hour Access to Medical Marijuana Verifications for Law Enforcement	This bill was passed in the 2010 legislative session. Since that time, the Department has worked with our sister agency (DPS) to implement the bill. CDPHE's portion of the system is expected to launch in the first quarter of 2013. Delay was due to contracting issues.
HB 12-1294	CDPHE Authority Health Care Facilities	This bill had multiple sections. Most all of the bill has been implemented with a stakeholder process.
HB13-1063	Critical Care Endorsement for EMS Providers	There are rulemaking requirements before the Executive Director of CDPHE, adopting rules to implement the law by August 1, 2014. The Department has hired a contractor and is beginning research and stakeholder processes.

SB13-225	STEMI/Stroke Advisory Committees	Deliverables are due to the legislature starting in January 2014. Stakeholder processes are underway.
SB13-273	Concerning Incentives for the Beneficial Use of Forest Biomass.	
HB12-1041	Electronic Death Registry System	This system is nearing completion.
HB12-1268	Health Facility Safety Inspection Transfer To CDPS	This bill has been implemented. There will be a bill in 2014 to clean up some language from the initial bill.
HB 13-1044	Authorize Graywater	The stakeholder process for gray water regulations is underway. Draft regulations will be prepared in the next few months. A rulemaking hearing to adopt gray water rules by the Water Quality Control Commission has been scheduled for January 2015.
HB 13-1191	Nutrients Grant fund	Funds have been awarded to 21 grantees for 24 projects.
SB 13-222	Access to Childhood Immunizations	The Department is conducting a stakeholder process and is on track for implementation.
SB 13-232	Continue Tobacco Tax Medicaid Management Transfers	This transfer is continuing
SB 13-113	Natural Resource Damage Recovery Fund	Effective upon gifts, grants and donations. To date, no donations have been received.

2. Does Department have any outstanding high priority recommendations as identified in the "Annual Report of Audit Recommendations Not Fully Implemented" that was published by the State Auditor's Office on June 30, 2013? What is the Department doing to resolve the outstanding high priority recommendations?

http://www.leg.state.co.us/OSA/coauditor1.nsf/All/D36AE0269626A00B87257BF30051FF84/$FILE/1337S%20Annual%20Rec%20Database%20as%20of%2006302013.pdf

Response: The Department does not have any high priority outstanding recommendations from the audit report.

3. **Does the Department pay annual licensing fees for its state professional employees? If so, what professional employees does the Department have and from what funding source(s) does the Department pay the licensing fees? If the Department has professions that are required to pay licensing fees and the department does not pay the fees, are the individual professional employees responsible for paying the associated licensing fees?**

   Response: CDPHE has paid for individual professional license fees on a very limited basis. Department policy 9.2 related to dues, memberships and subscriptions is the guiding document on the issue of professional licenses. The policy states that "The cost of obtaining and maintaining a professional license is the responsibility of the individual and represents the individual's personal commitment to self-improvement and professional growth." The policy authorizes exceptions to be made in the case of compelling business reason and if it is beneficial to the Department. This exception is used infrequently and the funding source depends on which professional license is being issued to the employee.

4. **Does the Department provide continuing education, or funds for continuing education, for professionals within the Department? If so, which professions does the Department provide continuing education for and how much does the Department spend on that? If the Department has professions that require continuing education and the Department does not pay for continuing education, does the employee have to pay the associated costs?**

   Response: The Department has a tuition reimbursement program which is available to all employees in the Department on a first come first served basis. In order to qualify for tuition assistance, classes must be from an accredited college or university, and the subject matter of the coursework must help support the mission and vision of CDPHE. In FY 2012-13 36 employees participated in the tuition reimbursement program with a total cost of $45,652.

5. **During the hiring process, how often does the number one choice pick candidate turn down a job offer from the department because the starting salary that is offered is not high enough?**

   Response: the Department conducted a quick informal survey of hiring managers to determine the reasons job offers were declined. Of the 66 responses
   - 24 or 36% were offered a higher salary by another employer
   - 14 or 21% had a better overall offer
   - 18 or 27% had another reason

- 10 or 15% didn’t know why the offer was declined.

The information gathered covered October 2012 to November 2013

6. What is the turnover rate for staff in the department?

Response: The Department of Personnel and Administration will provide a statewide report in response to this question during the Department of Personnel's hearing with the Joint Budget Committee.

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Friday, December 20, 2013
1:30 pm – 5:00 pm

1:30-2:00 INTRODUCTIONS AND OPENING COMMENTS

2:00-2:05 QUESTIONS COMMON TO ALL DEPARTMENTS

1. Please describe how the Department responds to inquiries that are made to the Department. How does the Department ensure that all inquiries receive a timely and accurate response?

2:05-2:25 MEDICAL MARIJUANA REGISTRY

2. Please provide a short primer on what research exists on what conditions should be added to the allowable use category for medical marijuana, and what work has been done to expand the existing list of allow conditions.

3. Please discuss the Department's opinion of the JBC staff legislative option for the marijuana health research request discussed on page 19 of the December 13, 2013 briefing.

4. Please discuss the reasoning behind the historically slow response to adjusting the fee for the medical marijuana application.

5. Please discuss why the fees are the same for a new medical marijuana card application and renewal medical marijuana card applications.

6. Please discuss and, provide if available, the Department's projection for the number of medical marijuana applications after the legalization of marijuana.

7. Please discuss the Department's opinion of the staff recommendation to have the State Board of Health set the fee every six months for two years, and annually thereafter (the recommendation is on page 19 of the December 13, 2013 JBC staff briefing document).

2:25-3:10 STATE LABORATORY

8. ***This question applies to both the Department of Public Health and Environment and the Department of Public Safety.*** Please provide information on the groups that would not come back to a state run Toxicology Unit if one was reopened.

9. Please provide clarification on the following differences between a state run Toxicology Unit and a private laboratory doing toxicology testing:
    a. Types and cost differences of testimony;
    b. Requirements for analysts to testify;
    c. Requirements for the provision of expert testimony.

10. Please discuss what situations required the Department to provide expert testimony, and if there is a threshold which triggers the requirement for expert testimony.

11. Please provide an update on how the following:
    a. How the laboratory space is being used;
    b. What is being done with the equipment;
    c. What other entities could use the equipment; and
    d. What discussions the Department has had with the El Paso County Corner for use of the mass spectrometer.

12. Of the equipment purchased/leased over the last five years, what specific equipment was for the Toxicology Unit?

13. ***Note this question applies to both the Department of Public Health and Environment and the Department of Public Safety.*** Please provide the plan for closing down the Toxicology Unit in the Department of Public Health. Please provide the plan, if toxicology testing is transitioned to the Colorado Bureau of Investigation. Please include the following:
    a. How a transition from the Department of Public Health and Environment to the Department of Public Safety will work;
    b. What statutory changes are required;
    c. Specific steps that would be required; and
    d. Recommendations on how to implement the plan.

3:10-3:20 BREAK

3:20-3:30 WASTE TIRES

14. Please discuss the Department's work with stakeholders regarding changes to the Waste Tire Program.

15. Please discuss why the Waste Tire Cleanup Fund was selected for a payback and the reasoning for the payback amount of $500,000.

3:30-3:40 MEDICAL INFLATION

16. Please discuss the merits of providing a medical inflation increase to specific Department programs in FY 2014-15.

3:40-4:05 Implementation of Recent Legislation

House Bill 12-1041

17. Please provide an update on the status of the Electronic Death Registration System.

18. How often are death records updated?

19. Please discuss why is the Secretary of State's Office charged for electronic transfer of death records? Who else is charged a fee for this service?

20. Please discuss how the Department works with the Secretary of State's Office to purge deceased voters from the voting rolls.

21. Please discuss the options for getting physicians to submit death records electronically, and what barriers exist to accomplishing this.

22. Is there a charge for electronic death record as opposed to a paper record? Please discuss if the cost is the same, or different for both types of records and why.

House Bill 12-1294

23. Please provide an update on the PACE discussions as they relate to the implementation of H.B. 12-1294.

24. Please provide an update on the Department's required review of rules which govern the relationship between mental health centers and primary care.

H.B. 13-1326

25. Please provide an overview of the status of the Old Age Pension Dental Program and how the Program will align with other oral health programs in the State.

4:05-4:15 School-Based Health Centers

26. Please discuss what the role of School-Based Health Centers will be in light of the Affordable Care Act and Medicaid expansion.

27. ***This question is for the Department of Health Care Policy and Financing.*** Would the new Medicaid management system be able to track services that are provided at a School-based Health Center? Why or why not?

28. Please discuss the process used to grant out the $5.3 million appropriated for School-based Health Centers. Please include a discussion of how the Department involved stakeholders in these discussions.

29. Please supply a detailed FY 2013-14 budget for the School-Based Health Centers Program including the amount budgeted for Department personnel, grants, and the amount anticipated to remain unexpended.

30. How much of the total appropriation does the Department anticipate will not be expended by the end of FY 2013-14? Of this amount, how much will be funds were not award out through grants? Please discuss if the Department supports the roll-forward recommendation and why.

31. Please discuss the Department's long range plan to support school-based health services including the mechanisms used to award grants, how the Department will measure success, and how the Department will ensure funds are being used appropriately.

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36. Please provide the following information on Air Pollution Enforcement actions for the past two years:
    a. How many days the violation lasted; and
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6. What is the turnover rate for staff in the department?