Colorado's Public Health System:

History, Structure, and Future

Revised in 2021

To understand how Colorado's public health system functions, it is important to know our history and how our system has developed over time. This brief history adapts material from the 1969 publication "Health in Colorado: The First One Hundred Years," and then describes our current and constantly evolving system of public health. It highlights both modernizing efforts like the Public Health Act of 2008 and the Public Health Transformation movement (2015 – the present), as well as challenges like the COVID-19 pandemic and chronic underfunding.

Colorado State Board of Health

The nine-member State Board of Health was established in 1877 by act of Colorado's First General Assembly. The responsibilities of the first State Board of Health mirrored the public health issues of the time. The Board was charged with the collection and study of vital statistics as a means of determining the causes of illness and death, the control of epidemics and contagious disease, and advice on proper sources of water supplies and places of sewage disposal.

Leading causes of death in Colorado	
1877	**2017**
Tuberculosis (24.7%)	Cancer (28%)
Diphtheria (7.8%)	Heart Disease (25%)
Scarlet Fever & Pneumonia (5.4%)	Accidents (11%)
Heart Disease (5%)	Chronic Lower Respiratory Diseases (9.3%)

The Board's first official vital statistics report showed that communicable disease and waterborne illness were Colorado's leading causes of death. Over the years, public health laws evolved and the legislature gave additional authority to the State Board to enact and enforce public health rules and regulations.

Currently, State Board of Health members are appointed to staggered, four-year terms by the Governor. One member is appointed from each of Colorado's seven Congressional districts and two members are from the state at-large. One of the board members must be a county commissioner and no more than five members can be from the same political party.

The primary duties of the State Board of Health, established by state law, are to:

- Adopt or revise standards, rules, and regulations to administer the public health laws of the state.

- Determine general policies to be followed in administering and enforcing the public health laws, standards, rules, and regulations.
- Act in an advisory capacity to the executive director of the state public health department on matters pertaining to public health.
- Establish and appoint special advisory committees when necessary to advise and confer with the board concerning the public health aspects of any business, profession, or industry within the state.
- Approve grants to local public health agencies and community-based organizations for a variety of public health efforts.

The Public Health Act of 2008 added the following components to the authority and duties of the State Board of Health in law (Colorado Revised Statutes[CRS] 25-1-503):

- Establish core public health services that each county and district public health agency must provide or arrange for the provision of said services (6 Colorado Code of Regulations [CCR] 1014-7).
- Establish minimum quality standards for public health services (6 CCR 1014-9).
- Establish minimum qualifications for county and district public health directors and medical officers.
- Ensure the development and implementation of a comprehensive, statewide public health improvement plan.
- Review all county and district public health agency public health plans.

In addition to the Board of Health, a variety of other state boards and commissions related to public health have been established by Colorado statute. Examples of these boards and commissions include the Air Quality Control Commission, Colorado HIV and AIDS Prevention Grant Program Advisory Committee, Minority Health Advisory Commission, State Emergency Medical Services and Trauma Advisory Council, and the Water Quality Control Commission.

State Health Department

Throughout the early 1900s, new public health responsibilities, including food inspection and licensing of hospitals, were given to the Board of Health which was not distinct from the state health department at that time. In 1941, the Division of Public Health became a division of the executive branch of government under the direct supervision of the governor. In 1947, the legislature created a Department of Public Health, taking it from the executive branch of state government and establishing two divisions -- the State Board of Health as the advisory, consultative and judiciary branch, and an executive division consisting of the state health officer and staff. This was the result of one of the seven “Sabin bills” that were passed in the 1947 legislative session because of Dr. Florence Sabin’s campaign for public health in Colorado.

The state health department, renamed the Colorado Department of Public Health and Environment (CDPHE) in 1994, currently includes a main campus in Glendale as well as regional offices in Grand Junction and Pueblo, a state laboratory in Denver, and a branch laboratory in Grand Junction. Environmental concerns including water, sewage, air, food, naturally occurring radioactivity, and the impacts of mining have greatly influenced the evolution of the public health system in Colorado. The combination of both public (human) and environmental health in one state agency, as exists in Colorado, is uncommon across the nation.

The Public Health Act of 2008 prompted the development of the Office of Planning and Partnerships, within CDPHE, to coordinate many aspects of the implementation of the Act. This office, now the Office of Public Health Practice, Planning, & Local Partnerships (OPHP) drives strategic public health system improvement and distributes the only source of flexible state funding to LPHAs.

Local Boards of Health

In 1893, Colorado legislators passed a bill, drafted by physicians and concerned citizens, to create and empower local boards of health. Beyond that, there is not much discussion of local boards of health in the written history of Colorado public health. The Public Health Act of 2008 further formalized the structure and duties of local boards of health. The Act requires that each county or district board of health consist of at least five members, appointed by the board of county commissioners, to include county commissioners as well as county residents with expertise or interest in health and public health. In counties with populations of less than 100,000, a three-member board can be appointed and the board of county commissioners may designate itself, if there was not a board of health separate from the board of county commissioners prior to the 2008 Act.

The Act states that local board of health members shall be residents of the county and no business or professional group or governmental entity shall constitute a majority of the board. Local public health agencies serving multiple counties have district boards of health. District board of health members will be appointed by an appointments committee composed of one member of each of the boards of county commissioners of the counties comprising the district. The district board of health must have at least one member from each of the counties comprising the district.

To help ensure that board members have a basic understanding of public health practices, Colorado's public health system, and board members' roles, the state legislature passed HB-21-1115. This bill requires all local board of health members to attend annual public health, environmental health, and emergency management training.

Local boards of health provide administrative, policy, and financial oversight to the designated public health agency, and the duties defined within the Act (C.R.S. 25-1-508) include:

Administrative

- Select, advise, and evaluate the Public Health Director of the county or district public health agency.
- Determine the services and set priorities to carry out the public health laws and rules of the State Board of Health and CDPHE's environmental commissions according to the specific needs and resources available within the community and as set out in the state and local plans.
- Review and approve the local public health improvement plan and submit to the State Board of Health for review.

Policy

- Consider advice from the local public health agency regarding policy issues necessary to protect public health and the environment.
- Develop and promote the public policies needed to secure the conditions necessary for a healthy community.
- Determine general policies to be followed by the public health director in administering and enforcing public health laws, orders, and rules of the county or district board.

- Follow orders, rules, and standards of the State Board of Health.
- Issue orders and adopt rules not inconsistent with the public health laws of this state.

Financial

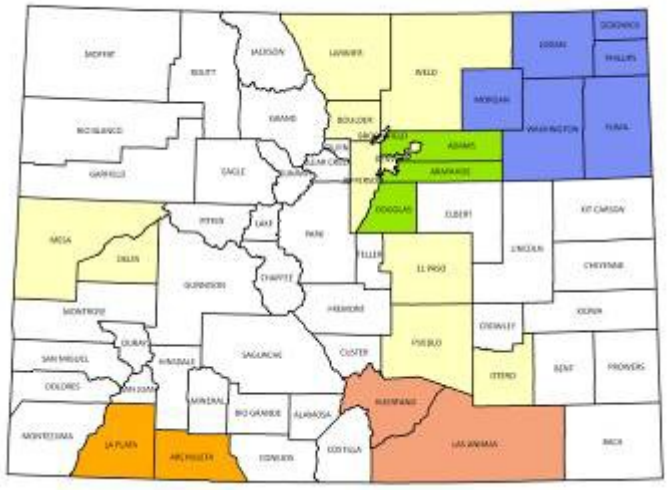
- Certify that claims or demands against the local public health agency fund shall be expended only for public health purposes.
- Annually estimate the total cost of maintaining the local public health agency for the ensuing year and submit a budget to the county commissioners.
- Provide for and assess fees to offset the actual, direct cost of environmental health services.
- Accept and, through the public health director, use, disburse, and administer all Federal and State aid or other property and services or money allotted to an agency for county or district public health functions.

Local Public Health Departments and Agencies

Public health at the local level was strengthened by public health nursing in the late 1880s through the early 1900s. A variety of entities were involved in the evolution of public health nursing including the American Red Cross, the Visiting Nurse Association and the Colorado Tuberculosis Association. In 1922, the State Board of Health included a division of public health nursing.

In 1924, local public health departments began to develop in more populated areas. By 1948, following the passage of the Sabin bills, eight single or multiple county health units were providing basic public health services to 18 counties.

Prior to 2008 Act



Prior to passage of the Public Health Act of 2008, fifteen "Organized Health Departments," serving 24 counties and 85% of the state's population, had been formed. These agencies were responsible for the provision of a broad scope of public health services within their jurisdiction. This map indicates, with color, the location of the agencies formerly called "Organized Health Departments." The multi-county, or district, public health agencies are shown in unique color on the map.

In the remaining 40 counties, only those public health services deemed necessary by the local board of health (fulfilled by the board of county commissioners and one physician) and falling within the scope of the practice of nursing were required by statute (C.R.S. 25-1-601-repealed 2008). These counties are shown in white on the map.

Prior to 2008, whether a county had an organized health department, or a nursing service was based on history and did not necessarily reflect current needs or population size. This is evidenced by the fact that eight of the counties with former "Nursing Services" have populations larger than four of the counties with former "Organized Health Departments." The primary difference was the scope of public health

services provided. In at least ten of the counties formerly served by "Nursing Services," there was no direct provision of environmental health services.

The organized health departments followed different statutory requirements prior to the Act and were also encouraged through funding incentives to provide additional services outside of their jurisdiction to counties that did not provide the full range of public health services. Some of these relationships still exist today. This map depicts the local public health agencies formed by resolution of the respective boards of county commissioners by July 1, 2009.

After July 1, 2009

While the Public Health Act of 2008 established a uniform system of agencies and a minimum standard of services, building out this infrastructure is ongoing.

During the last few decades, with the state's population more than doubling and the growth of tourism, the population centers in the state have also changed accordingly. The following table identifies the year the "Organized Health Departments" were established along with the current population of the counties served.

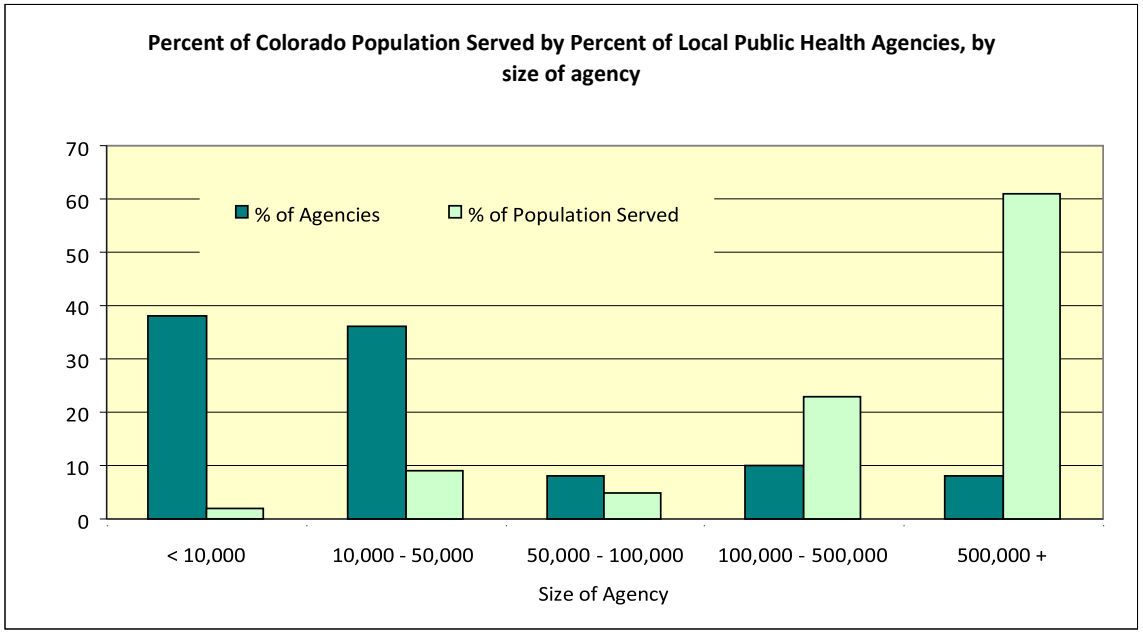
Formation of Colorado's Health Department's Prior to the 2008 Act	**YEAR ESTABLISHED**	**POPULATION SERVED** (2020 estimate)
Otero (re-established in 1938)	1924	18,690
Weld	1938	328,981
El Paso	1939	730,395
Denver	1939	715,522
Huerfano/Las Animas[1]	1951	21,375
Tri County [2](Adams, Arapahoe and Douglas)	1948	1,532,620
Mesa	1948	155,703
Northeast (Logan, Morgan, Phillips, Sedgwick, Washington, Yuma)	1948	72,378
San Juan Basin[3] (La Plata and Archuleta)	1948	67,413
Pueblo	1952	164,982
Boulder	1954	298,822
Jefferson	1958	550,046
Larimer	1968	299,040
Delta	1981	34,200
Broomfield	2001	51,970

[1] Las Animas first formed a health department in 1944.

[2] Tri-County originally served Adams, Arapahoe and Jefferson Counties. Jefferson County formed their health department in 1958. Douglas County joined Tri-County in 1966. Tri-County Health Department dissolved in 2022, after Douglas and Adams counties split due to COVID-19 political ramifications

[3] San Juan, Dolores and Montezuma counties were previously part of San Juan Basin Health Unit.

The following graph shows that 38% of all agencies serve populations of less than 10,000 people; taken together, these agencies serve less than five percent of the total population. Conversely, less than 10 percent of local public health agencies serve populations with size greater than 500,000 people, yet together these agencies serve over 60 percent of the total population. The geography and distribution of population in Colorado has added complexity to the delivery of public health services across the state throughout history and is still a concern today.



Public Health Laws

As this brief history illustrates, there has been an ongoing evolution of public health laws that impact the structure of the public health system and public health services. However, there are two significant events in history that have considerably impacted Colorado public health. The first was passage of the Sabin Health Laws of 1947 that were supported by data provided in the Buck Report of 1946. These laws reorganized the state health department and State Board of Health, authorized local public health agencies and appropriated funding for public health services. At the time, this set of laws brought the Colorado public health system up to meet the needs of the day. The second significant event in history was the passing of the Public Health Act of 2008. Not since 1947 had the legislature passed an equally comprehensive law to position the Colorado public health system to be able to effectively meet the needs of today and the future.

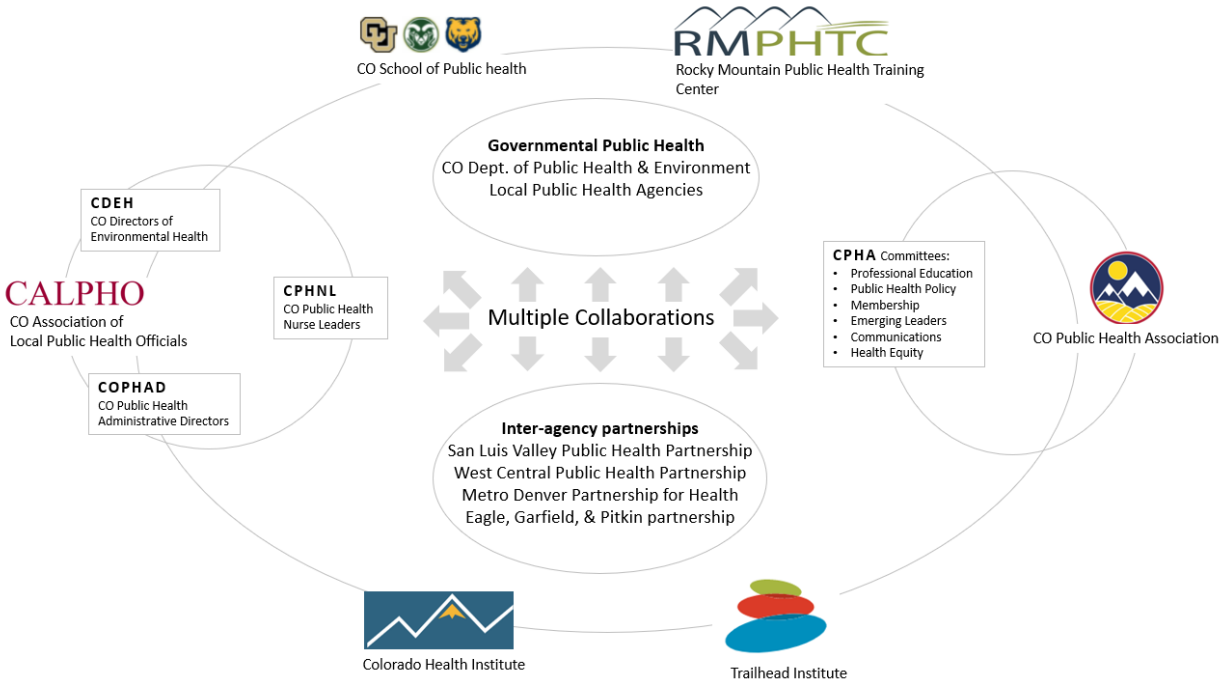
Public Health Organizations

The public health organizations in Colorado have an interesting history of their own. These professional associations and public health institutes provide education, advocacy, and professional development to strengthen the public health system and workforce. Currently, Colorado hosts several state affiliates of national associations

State Affiliates	National Organizations
Colorado Association of Local Public Health Officials (CALPHO)	*Affiliate of:* National Association of County and City Health Officials (NACCHO)
Colorado Environmental Health Association (CEHA)	*Affiliate of*: National Environmental Health Association (NEHA)
Colorado Public Health Association (CPHA)	*Affiliate of:* American Public Health Association
Trailhead Institute	*Part of the* National Network of Public Health Institutes (NNPHI)
Colorado Health Institute (CHI)	*Part of the* National Network of Public Health Institutes (NNPHI)

The associations also have affiliate organizations and committees of their own that represent different fields or concerns of public health, such as public health nursing, health equity advancement, and administration and finances. The longest running of these affiliate organizations is the Colorado Directors of Environmental Health (CDEH), currently an affiliate of CALPHO but founded in the 1970s (CALPHO was founded in 2006).

In 2007, these organizations came together under the umbrella of The Public Health Alliance of Colorado. The Alliance provided administrative support and worked to connect the organizations in pursuit of common goals. These organizations and the professionals within them were a key part of the initial implementation of the 2008 Public Health Act. The Public Health Alliance formally disbanded in 2015, but most of its member organizations are still active and collaborating.



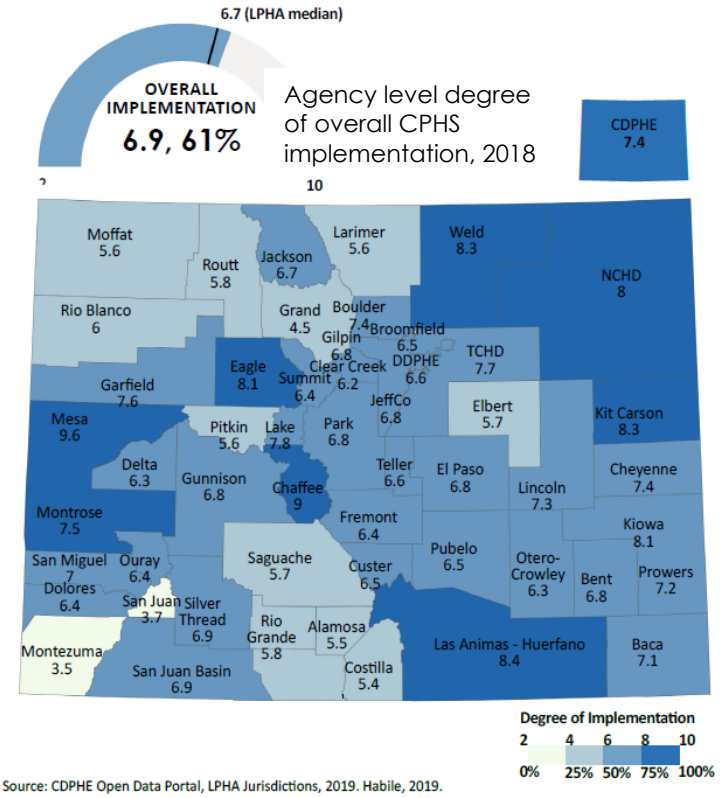
The Wider Public Health Ecosystem

While this history has focused primarily on the governmental public health and public health organizations, it is important to recognize that the public health system is much broader than these entities. For public health to work effectively, it must partner with and recognize the contributions of many other governmental entities, non-profit community-based organizations, private business, education sectors, faith communities, and many others. The health care sector is also a close partner. Many agencies regularly communicate and collaborate with local providers, and some develop joint community health assessments (CHA) and community health improvement plans (CHIP).

Continuing System Improvement: The Public Health Transformation Movement

The 2008 Public Health Act erected the frame for a strong and sustainable governmental public health system that could serve and protect all Coloradans equitably. The act spurred the formation of many new agencies that combined disparate public health nursing and environmental health services. It also mandated that each agency conduct a community health needs assessment and develop a public health improvement plan every five years. All agencies now meet this requirement, and many collaborate with their local non-profit hospital system on joint assessments and plans.

Some progress has been made towards implementing the minimum core services required by the Act. However, political and fiscal barriers in 2008 prevented the legislation from including any funding for the core services or assessment activities. These activities are required, but only "subject to available appropriations." This has resulted in a patchwork of service delivery across the state, with agencies relying mostly on unpredictable, short-term grants and disease-specific federal funding. There is still very little funding for core services and organizational infrastructure. This lack severely limits agencies' capacity for long-term planning, community trust building, and workforce development.



Source: CDPHE Open Data Portal, LPHA Jurisdictions, 2019. Habile, 2019.

In 2015, state and local public health leaders began exploring Colorado's public health funding and structure in the context of significant population growth and emerging public health priorities. Those initial efforts became a movement to simultaneously modernize the system and fund governmental public health predictably and sustainably. In 2019, CALPHO and the Colorado Department of Public Health and Environment (CDPHE) took a first step and updated Colorado's Core Public Health Services definitions to align them with emerging national standards and public health's

role in advancing equity. Then they conducted a comprehensive needs assessment to 1) understand current statewide implementation and spending on core public health services, and 2) estimate the cost to fully deliver core public health services statewide. The assessment revealed significant implementation gaps throughout the state, and an overall state-wide services implementation score of only 61%.

Further progress on modernizing and funding Colorado's public health system has been stalled by the COVID-19 pandemic. This unprecedented crisis has been devastating for the public health workforce and has eroded the state's already weak public health infrastructure. Once COVID-19 becomes endemic, rebuilding will necessarily become the primary focus of systems change efforts.

About this resource:
This history was first compiled by CALPHO staff in 2010 and revised by CALPHO staff in 2021-2022