



**BOARD OF DIRECTORS
MEETING
April 6, 2010**

**Health District Building
Conference Room**

MINUTES

BOARD MEMBERS PRESENT: Joe D. Hendrickson, President
Celeste Holder Kling, Vice President
Bernard J. Birnbaum, Secretary
Steven J. Thorson, Treasurer
Lee Thielen, PVHS Board Liaison

STAFF PRESENT: Carol Plock, Executive Director
Cheryl Asmus, Evaluation Specialist
Jim Becker, Resource Development Coordinator
Bruce Cooper, M.D., Medical Director
Carrie Cortiglio, Policy Analyst
Richard Cox, Communication Director
Rebecca Gonzalez-Rogers, Finance Accountant
Lorraine Haywood, Finance Director
Sue Hewitt, Evaluation Coordinator
John Newman, Clinical Services Director
Dianne Moeller, RD, Nutritionist
Chris Sheafor, Support Services Director
Nancy Stirling, Assistant to Executive Director
Lin Wilder, CI & HP Director
Ernie Williamson, M.D., Preventive Medicine Resident

CALL TO ORDER; INTRODUCTIONS; APPROVAL OF AGENDA

President Joe Hendrickson called the meeting to order at 6:05 p.m. Staff and Board Members introduced themselves to the group. No changes were offered for the meeting agenda.

MOTION: To approve the agenda as presented.
Motion/Seconded/Carried Unanimously

PUBLIC COMMENT

None.

PRESENTATION & DISCUSSION

Nutrition/Weight Management

Ms. Plock introduced the topic, noting that this evening's presentation, the third and final on the topic of obesity, would be an overview of the nutrition and weight management services currently provided by the Health District, followed by a brief review of some of the key points from previous obesity presentations. The issues of obesity, nutrition, and weight management arose at last year's board retreat, and with this information, the board should be ready to discuss the issue, see where they are on the "placemat" decision process, and determine whether they are ready to make a decision or to ask for more information.

Ms. Wilder and Dr. Cooper presented the overview of the Health District's nutrition and weight management services, which began in the early stages of the current Health District. In 1995/6, as the board looked at results from the first community health survey, the national obesity rate was 33% and the topic of weight management was one of the many identified issues the board was considering. As the Health District was served with the injunction which required that we offer our own direct health care services in our own facilities, one of the board's decisions was to establish a wellness and health promotion facility targeting services most likely to increase the health of the community. The community wellness center was called Health Bridge, and it was established in partnership with PVHS, which set up the community health library side of Health Bridge. The Health District's services at Health Bridge provided health risk assessments, a variety of clinical preventive screenings, and services for smoking cessation, nutrition/weight management, and increasing physical activity.

A registered dietician was hired and began the planning and designing of the Healthy Weighs program, which was started in 1998. The program at that time was a 12-week program that de-emphasized weight loss and focused on healthier lifestyle. Services included group presentations and cooking classes. Several other programs began as pilots when the Healthy Weighs program was begun, including: grocery store tours (talked about specific nutritional meals, showed how to shop for healthier foods), participation in local health fairs (including 9 Health), and Eat to Your Heart's Content (participants learned how to have a healthy heart diet, 2-hour sessions, 3 of them over 3 weeks, help people learn how to eat and prepare healthy foods). Some were discontinued for a variety of reasons: because their effectiveness was not able to be discerned, there was a drop off of attendance to these classes, or lack of staff time. Another program, Health District on the Move, which encouraged people to increase the number of steps they take each day, operated under grant funding for three years. One of the newest offerings is the Food Bank classes where our dietician use foods that can be found at the Food Bank to create healthy food options which are prepared for and tasted by Food Bank clients, with recipes given during distribution days.

When the Top Ten Health Burdens in the Health District from the last 3 community health surveys are reviewed, about half of them relate to overweight and obesity. The Health District has, through time, been concerned about overweight and obesity because they cause an enormous amount of health burden through increased morbidity and mortality. For example, a 40 year old woman who is overweight may lose about three years of life; one who is obese, seven years of life. Intentional weight reduction has been proven to reduce metabolic disturbances and risk for adverse consequences (i.e., diabetes, heart disease, breast and prostate cancer, and all-cause mortality), and the benefits accrue with even modest weight loss (5-10% of body weight).

The “Stepped Model of Care” for clinical management of overweight and obesity is familiar to most physicians and consists of levels of interventions to address overweight/obesity for various target populations. For the general population, intervention starts with population education and awareness raising, and prevention efforts. For those considered overweight/obese, lifestyle interventions such as individual/group education and skills training and behavior modification techniques may be applied. Those with more severe overweight/obesity issues may require such interventions as medical treatment or, if necessary, bariatric surgery.

Behavior modification or therapy has had some success in addressing overweight/obesity issues. It used to be thought that being overweight was largely due to maladaptive behavior that could be changed. We now know that other factors can have significant impact on overweight/obesity, such as genetics and the environment. But behavior therapy can still make a difference, when used intensively, including: motivational interviewing, goal setting, self-monitoring, problem solving, cognitive restructuring, social support, stimulus control, and reward strategies. There is some strong evidence that motivational interviewing and self-monitoring can be successful. The Healthy Weighs program incorporates each of these methods.

Today’s Healthy Weighs program consists of 12 weeks of group meetings and support, plus 6 extra sessions with a registered dietician and/or a physical activity counselor. The program includes a baseline, end-of-course, and 6-month review of participant blood pressure and blood lipids screenings but does not include any formal maintenance program (which is part of evidence-based practice). The program has a “non-dieting” approach to weight management, focusing on a positive lifestyle vs. diet, on process rather than weight loss, and on moderating unrealistic expectations. Weight tracking is optional. The program consistently receives “high satisfaction” responses from clients on surveys. When compared with other community programs that address overweight/obesity, the Healthy Weighs program is the least expensive for participants and is the only program available in the community that offers a sliding fee. Dr. Cooper reviewed the demographics and outcomes of program participants.

Participants in Healthy Weighs experience significant increases in the following indicators at both the end of class and followup (six months later): percentage of people reporting eating recommended daily servings of vegetables, fruit, and water; knowledge and attitudes regarding using food labels to make better choices, and the importance of eating fruits and vegetables; reaching physical activity goals; and average energy expended in physical activity. Average weight loss was modest, at about 4-5 lbs at the end of class; less at the followup. By the followup, 32% had experienced at least a 5% weight loss; 14% of those had experienced a weight loss of 10% or more. While at baseline 47% of participants’ weight was classified as “obese,” by followup, only 36% had weight in the “obese” range. Changes in blood lipid levels and blood pressure and blood glucose were also measured. While the most recent three-year period did not show a significant sustained desirable change in blood lipid levels from baseline to followup (though triglycerides decreased 5 mg/dl), there were modest but significant decreases in systolic blood pressure (down 4 mm/hg).

In summary, the Healthy Weighs program produces modest weight loss sufficient to reduce risk for about a third of participants, has shown evidence of knowledge, behavior and health improvements in clients that are sustained over 6 months, and is an approach that aims for long-term success in modifying lifestyle.

Staff also reviewed information concerning the other related services, including nutrition counseling, cooking classes, the Food Bank Outreach pilot, public education via the Compass newsletter (there have been 42 articles pertaining to nutrition, physical activity, and related obesity-prevention topics in the past 5 years) and HealthInfosource.com web site, and efforts to encourage policies such as offering healthy beverages in schools, which passed in 2008. The great majority of people who participated in individual nutrition counseling heard about it through our cardiovascular screening program; the great majority of those attending cooking classes heard about them from the Health District newsletter Compass, a friend, or a staff member. Also reviewed were the nutrition program costs, including staffing, budget, and net expense comparison with other Health District direct services programs. The cost of nutrition/weight management services is about \$245,000, with approximately \$130,000 of it being for recoverable direct expenses.

Ms. Thielen commented that two of her acquaintances had recently taken the Healthy Weighs class, experienced both weight loss and lowered cholesterol, and had gone out of their way to let her know that they were thrilled with the experience. As taxpayers, they thought that it was a service of great value from the Health District. Board members also noted that when people come to attend the cooking classes, more people benefit than those attending the classes: the recipes and dishes are shared among family, friends, and coworkers. A question about how many people who start Healthy Weighs complete it was answered in the context of a recent class, in which 53 started it and 47 completed the 12-week series.

Ms. Cortiglio then provided a brief review of highlights from previous obesity presentations. The social-ecological model shows that our genetic predisposition, combined with a changing world, is causing nearly all groups to gain weight – some more than others.

Drivers of the overweight/obesity epidemic:

- *Social networking* – while overweight and obesity appears to be connected to our social network, it may be possible to harness the same social influence to slow its spread...health improvements in one person might spread to others (i.e., family members, friends, co-workers, neighbors, etc.)
- *Food producers* - drive individual's desire for "unhealthy" food by offering/pushing bigger portions, concentrating on ingredients that people crave (i.e., salt, fat, sugar), offering an abundance of variety, and having aggressive marketing strategies
- *Government policy* - on commodity subsidies has influenced the development of unhealthy foods – for example, the increase of sugars in food products came from a cycle of corn subsidies, which developed corn syrup, which created sugars that are easy and cheap to produce and make money
- *Economic change* – there has been a dramatic increase in two-earner families which leads to greater reliance on take-out, prepared, and convenience foods.
- *Food environment* – changes in the food environment have swamped our ability to compensate with increased physical activity. In particular:
 - *Portion sizes* – "super-sized" meals; we have forgotten what a healthy portion looks like
 - *Sugar-sweetened beverages* – more sugar, greater sizes
- *Physical activity* – likely been a decrease in overall activity, but is not as well documented and has been outpaced by changes in the food environment

What does prevention look like?

It looks different than other interventions such as for tobacco, where if you can stop someone from starting until they are 21, they are unlikely to become addicted; or for communicable diseases for which there is a shot. Preventing overweight and obesity requires that we arrest the progression of the epidemic at all levels, focusing on both kids and adults, to:

- 1) keep kids at a healthy weigh, and
- 2) slow weight gain over the lifespan

What interventions are most likely to impact the drivers of overweight and obesity in our community?

In determining what the Health District might do to most effectively address overweight and obesity in our community, the following questions were considered:

Who's at risk in our community?

What could we be doing?

Of those, what are potentially the most impactful strategies?

What is already being done in our community?

The 3 areas that rose to the top of the 24 CDC and IOM community strategies to address overweight/obesity that are not currently being addressed in our community and which have direct connections to the key drivers of obesity include:

school foods – improving the quality of school meals and increasing participation

portion size – education & interventions to reduce the size of meals while out or at home

sugar-sweetened beverages (SSBs) - education & interventions to reduce the consumption of SSBs by children and adults

More detail on possible interventions and challenges for each of these areas were outlined.

Board members wondered whether the Governor's plan to raise taxes on candy and soda [actually, to eliminate the tax exemption] might have an impact on this issue; Ms. Cortiglio noted that although it looks like that is happening, it is unlikely to have much of an impact because the cost increase will be so low.

Prior to the board discussion on what the Health District should be doing about the overweight/obesity epidemic, and about its current nutrition/weight management services, Ms. Plock provided some grounding, reminding them that this discussion emanated from the last board retreat. At that time (just prior to H1N1's emergence), board members ranked several health topics; some into a category where "strong focus is indicated," and others into a category described as "areas where further consideration is indicated" – areas where the board determined that they would like to learn more and then deliberate. Since obesity fell into the second category, the board has been learning about the issue prior to its deliberations and decisions.

In reviewing the "Process for Board Consideration of Ideas, Issues, Programs and Policies" document, President Hendrickson noted that this process appeared to be approaching Stage 8: Termination/Continuation. At this stage, the Board's responsibility is to: review and discuss staff reports; request additional information from the Executive Director as needed; determine whether the District should continue, amend, or terminate this policy/program; determine the costs/consequences of each option, etc.

Board Discussion

The Board launched into a significant discussion of the issue.

A comment acknowledged staff members for creating a program that has high client satisfaction, promotes healthy lifestyles for the long term, and is available to individuals of all income levels.

One question was whether the Health District should introduce a maintenance program, since that is an evidence-based practice not currently included in our services. It may be that it would enhance outcomes, and although it didn't look like people were slipping much at 6 months, it might be good to also measure at a year.

It was noted that when the risk factors for health are added together, diet and obesity become a very big issue, and that if we should choose to go forward in working on the issue, there is likely to be outside funding available, since so many organizations nationally have this as a priority.

The board pondered the value of individual interventions and the value of population public health interventions, and wondered about the importance of continuing a program that is available to those of all incomes.

Another comment was that while the Healthy Weighs program was extraordinarily developed, the ultimate outcomes of weight loss and changes in lipids and blood pressure appear to be negligible. In particular, much better outcomes can be achieved through medications for lipid and blood pressure control. If we have served 700 people in ten years, might the return on investment have been better by hiring a physician to prescribe medications? (It was noted that we may not have captured all the benefit in this single report; that this report was based on the last 3 years and that prior years had had slightly better outcomes – though still not what could have been gained in lipid and blood pressure control, though that is not the only aim of the program; and that some of the participants have not wanted to access medical interventions; while acknowledging that outcomes are not as high as desired.)

Attention moved to the possibility of developing a public health approach, for example on impacting the issue of sugar-sweetened beverages, or foods in the schools, and whether the money might have a bigger impact if spent in that way. Staff noted that it is, unfortunately, impossible to determine that, since the health impact of both those interventions has not been measured (and would be very difficult to measure).

In other comments, board members noted that: the obesity issue is a much bigger problem than many other health challenges in our community, and it isn't going to go away; our role is to help our community have a comprehensive strategy; we need to "be in the game;" intensive work with individuals is part of a comprehensive strategy – it wasn't meant to solve the whole problem, but be a piece of the solution, and individuals of all incomes need an option (our services fill a gap for people with low incomes who don't have other options); things are interrelated, so if you stop one thing, it impacts others (e.g., cardiovascular screening clients using individual nutrition counseling); we need to play a role in helping to push things toward the tipping point to interrupt this epidemic (e.g., finding effective interventions that stop the "drivers"); we can probably get the word out to more people through more mass media outlets (e.g., TV and videos, including possibly putting them in our waiting rooms).

The Board's discussion shifted to their desire to look into a broader strategy for impacting the growing problem of overweight and obesity in our community, which would have three components:

- 1) Develop a concrete plan to focus on the issue of sugar-sweetened beverages, with appropriate outcomes measures, and determine whether outside funding could be secured (and potential sources);
- 2) Increase effectiveness in the services we currently provide, focusing on: increased outcomes (perhaps participants will have to agree to set goals, and to measure weight), more MD and other complementary referrals (leading to increased use of meds for those with risky blood pressure and cholesterol levels), integration of services (or at least improved communication back and forth between physicians and staff), increased use of the media (especially TV), and the possibility of adding a maintenance portion to the program; and
- 3) Look more closely at the possibilities in expanding the impact of positive social networking to address the issue of overweight and obesity.

MOTION: To direct staff to develop an overall strategy for how we can better impact overweight and obesity in our community, with particular analysis on 1) improving outcomes for interventions at the individual level; and 2) creating effective macro-level interventions targeted at reducing the consumption of sugar-sweetened beverages – such interventions to be funded by outside sources in order to add this intervention despite current budget constraints.
Motion/Seconded/Carried Unanimously

POLICY UPDATES & DISCUSSION

Senate Bill 109, concerning medical marijuana and the physician/patient relationship, passed each house with some small differences. The Senate sponsor of the bill has asked for a conference committee and will address the issue of tighter restrictions on how people under the age of 23 access the medical marijuana program.

House Bill 1284 has come out of the Judiciary Committee. Ms. Cortiglio drafted a letter to the Larimer County delegation outlining the Board's position on this bill, and may also be able to meet with some of them. As the bill stands now, it does not meet the standards outlined by the Health District board. Board President Joe Hendrickson was asked by staff for permission to do some limited grassroots lobbying by calling a few other partners and asking them to weigh in with legislators on the bill. The Board clarified that their position is not in opposition to HB 1284 – that instead, their position is that there should be the tightest possible regulations, that they would like to see all of the specific issues they have outlined addressed in a bill, and that, no matter what, something needs to pass this session to tighten up regulations and restrict access. An important piece of HB 1284 that has been taken out, but may be added back in, is a provision allowing municipalities to enact tighter regulations than what is in the state bill, including banning dispensaries altogether.

Ms. Cortiglio also testified at a City of Fort Collins City Council hearing on the local ordinance. City Council passed the ordinance, which includes location restrictions such as a 1,000 foot

separation from schools and 500 foot separation from other dispensaries. They have not yet addressed what to do with all the dispensaries that currently exist. It is the Board's position to advocate that the city not "grandfather in" these dispensaries, but instead require them to meet all the provisions of the City ordinance.

National: Health Care Reform

National health care reform was passed in late March. Ms. Plock distributed a document from the Commonwealth Fund which outlines the implementation timeline for specific pieces of health care reform. The next steps for us are to look at how health care reform will affect the work of the Health District, and to consider whether there is any role that the Health District might play in the rollout of health care reform.

DISCUSSION

Dental Health Partnership: Dental Connections Concept

A sub-group of the Dental Health Care Partnership has been working on a Dental Connections concept similar to the Mental Health Connections model. The group has been brainstorming all aspects of the model, including who would be eligible; pay schedules that would be reasonable for clients and providers; finding, staffing, and outfitting a facility; etc. In one meeting, the group brainstormed and analyzed 10 or so possible locations to house Dental Connections. They determined that the best choice, for a variety of reasons, would be to house the facility at the Health District. Staff will be researching how this might look and work and will be bringing more information to the Board at a later date. If we do pursue this approach, it has been made clear to the group that the Health District could not be the sole funder of this project, and they are working on what shared financial responsibility might look like. The Health District and the Women's Resource Center are the organizations most effected by this and will need to obtain approval from their respective boards before any plans are implemented.

UPDATES & REPORTS

MHSA & Oral Health Partnerships, ED Oral Report (Beacon?)

No word has come yet regarding the Beacon Community grant. Other reports were postponed due to how late in the evening it was.

PVHS Liaison Report

Ms. Thielen reported that the PVHS Board recently held a retreat in which a key topic was the changes likely to impact health systems in the future. One change is that the health system will need to assure that 51% of their board has members that are "independent," – that is, neither they nor their relatives have any financial ties to the health system. Since there will be three vacancies, they will need to be careful about who is chosen to fill them. In other discussions, there is a great deal of uncertainty about how health care reform will evolve, and even the experts are only able to share what they think might happen. A key quote was "the future will certainly be different than the past has been." A trend likely to continue is the trend towards physicians becoming employees of health systems. The move towards different payment mechanisms may lead to an increased focus on wellness and good care coordination, because systems may lose money if they don't help keep people well. She noted that the mission statement is being revised, and now includes the word "community," and in other wording changes, the term "clinical outcomes" was modified to "health outcomes," and they will be strengthening their approach in addressing not just healthcare but also wellness needs.

At the retreat, Ms. Thielen participated in a break-out group titled “Healthy Lifestyles, Healthy Communities”. She noted that per health care reform, hospitals will be required to conduct community health assessments. Since the Health District already does this, and the county health department will be required to do it as well, this may be an opportunity for collaboration between the three entities.

Ms. Thielen expressed her appreciation for being able to serve as Liaison and stated that she had learned a great deal from the experience. A replacement for Ms. Thielen will be appointed at the Board’s May board meeting.

CONSENT AGENDA

- Approval of the January 26, February 12, February 23, and March 12, 2010 Board Meeting Minutes
- Approval of the January 2010 Financial Statements

MOTION: To approve the consent agenda as presented.
Motion/Seconded/Carried Unanimously

Dr. Birnbaum stated that he will not be at the April 27 board meeting as he will be presenting at a conference in Vancouver.

ANNOUNCEMENTS

- April 7, 11:00 am to 1:00 pm – Annual Employees Appreciation Luncheon at the Northside Aztlan Community Center
- April 27, 5:30 pm – Health District Board of Directors Meeting
- May 25, 5:30 pm – Health District Board of Directors Meeting

ADJOURN

MOTION: To adjourn the meeting.
Moved/Seconded/Carried Unanimously

The meeting was adjourned at 9:12 p.m.

Respectfully submitted:

Nancy L. Stirling, Assistant Secretary

Joe D. Hendrickson, President

Celeste Holder Kling, Vice President

Bernard J. Birnbaum, Secretary

Steven J. Thorson, Treasurer

Lee Thielen, PVHS Board Liaison