Health District
OF NORTHERN LARIMER COUNTY

# BOARD OF DIRECTORS MEETING
**April 26, 2011**

**Health District Office Building**
**120 Bristlecone Drive, Fort Collins**

**MINUTES**

**BOARD MEMBERS PRESENT:** Celeste Holder Kling, President
Bernard J. Birnbaum, MD, Vice President
Timothy S. O'Neill, Secretary
Steven J. Thorson, MD, Treasurer
Joe D. Hendrickson, Liaison to PVHS Board

**STAFF PRESENT:** Carol Plock, Executive Director
Cynthia Beyer, Health Care Matters Project Coordinator
Dee Colombini, MH Connections Program Coordinator
Bruce Cooper, M.D., Medical Director
Richard Cox, Communications Director
Rosie Duran, Medicaid/CHP+ Outreach Coordinator
Lorraine Haywood, Finance Director
Sue Hewitt, Evaluation Coordinator
Marty Janssen, Policy/Research Assistant
Ann Martin, Prescription Assistance Advocate
Samantha Murphy, MHSA Partnership Manager
John Newman, Medical Services Director
Chris Sheafor, Support Services Director
Nancy Stirling, Assistant to Executive Director
Lin Wilder, Community Impact/Health Promotion Director
Kristan Williams, Health Promotion Coordinator

## CALL TO ORDER; APPROVAL OF AGENDA

President Celeste Kling called the meeting to order at 6:03 p.m. Several staff members were introduced, including the Health District's newest employee, Ms. Cynthia Beyer, who is the Coordinator for the Health Care Matters Project. No changes were made to the agenda.

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

## PUBLIC COMMENTS

**None.**

## PRESENTATIONS

Updates on Health District programs continue tonight; the goal is to be sure that the Board has heard from all programs within the last couple of years prior to the June board retreat. Ms. Plock and Ms. Kling will be working together to draft an agenda for the retreat. If any Board member would like to suggest specific agenda items, they were asked to let them know.

### Community Dual Disorders Treatment Program (CDDT): Second Year Results and Plans for Serving More People

Ms. Samantha Murphy, Community Organizer and Manager for the Mental Health and Substance Abuse Partnership, provided on overview of the Community Dual Disorders Treatment Program (CDDT). The presentation included an overview of CDDT services, results from the third year of the program, lessons learned, and where the program is headed.

The CDDT program is an evidence-based initiative stemming from the MHSA Partnership that assists people with a dual diagnosis of severe mental illness and substance use disorders in securing housing and managing their MHSA issues. The program is unique in the country in that it is a collaborative effort between Larimer Center for Mental Health, the Fort Collins Housing Authority, and the Health District, with each entity providing staffing and/or funding/resources to the program. The program takes into consideration that these disorders are chronic diseases, that recovery takes time, and that clients will move forward and backward along the recovery continuum and, therefore, is not time-limited for the clients. The CDDT program just completed its third year as of March 31. Some highlights of program results (outcomes compared to before individuals joined the program) include:

- 62% reduction in overall services usage
- 75% reduction in total services cost per client
- 96% reduction in Emergency Department visits
- 83% reduction in ER/Ambulance usage
- 81% reduction in In-patient psychiatric days
- The average annual cost per client for community services (outside of the cost of the program) decreased considerably from $35,000 per client (before entering the program) to about $10,000.

The program experienced some fluctuations in some of the measurements when data is reviewed over the three years. For example, in Year 2, there was an increase in hospitalization and in-patient treatment days; this is a common occurrence in CDDT programs in the second year as individuals begin to better understand their illnesses and seek intensive treatment for their diseases, move back and forth during recovery, and experience relapses. In Year 3, the number of medical inpatient nights did not drop from Year 2. This was in part because clients who hadn't yet addressed specific medical issues, such as surgery, diabetes, etc., sought those services in Year 3. Also it was noted that while arrests gradually declined, nights in jail/prison increased for some people. This was attributed in part to the fact that clients with legal issues (warrants, time to serve) were taking responsibility for those obligations and volunteering to serve their time.

In addition to the data gathering, the program has recently undergone a fidelity review. Some of the findings from both reviews include:

- The approach works! – it makes a big difference on both the lives of the participants, and the costs of services provided by the community

- Ongoing staff training is needed – intensive training for new clinical staff, and refresher trainings for ongoing staff. Because the program has a very specific approach, and the team is so small (4 people), loss of just one team member has a large impact on the program.
- It is important to do good client selection and screening. This approach is evidence-based developed for those with severe MI and SUD. While it is not always possible to tell if both will be chronic disorders as treatment starts, it works best for that population.
- Now that we have experience, staff will proactively address the issues that tend to arise between 12 and 24 months in the program, where participants tend to need more services
- Interventions, not just interviewing, need to match clients' stage of change – staff are learning to create appropriate interventions that meet the client where they are. While staff have developed remarkable skills in motivational interviewing, it has been harder to learn to craft interventions that are appropriate and effective for different levels of the stages of change.

As the program moves forward, staff are working on plans to: increase the number of people being served (expand to 30 clients in 12-18 months); partner with Homeward 2020 and be part of the 2020 community plan; consider providing community outreach; determine whether housing options for clients can be increased (ranging from independent living apartments with little or no client management, to communal living, short-term crisis supportive housing, on up to inpatient psychiatric); and enhance the evaluation process of the program.

The Board expressed their appreciation to staff for the information presented and asked that they please convey to the Partnership the Board's approval and appreciation for the program.

**Connections Program (Mental Health and Substance Use Disorders) - Update**
Ms. Dee Colombini, Program Manager, provided an update on the Mental Health Connections program. The program is a partnership between the Health District and Larimer Center for Mental Health, and its mission is to "improve our community's mental health status by helping clients access mental health and substance abuse services."

MH Connections offers mental health and substance abuse information and referrals, help during times of crisis, assistance with coordinating care, and help finding affordable counseling and medication. Staffing includes a client advocate, a program manager, an administrative assistant, and several mental health specialists. Services are provided to anyone seeking information, experiencing symptoms or addressing a specific crisis or situation. In First Quarter 2011, MH Connections served 1,035 individuals in 2,152 contacts with 3,179 services. Although the number of clients served has gradually declined - about 100 per year for the last 5 years - the number of contacts has gone up. This has been attributed to increased staff contact time as well as the clients' need for enhanced (intensive) service facilitation. For example, 106 clients participated in 377 brief therapy sessions, the greatest amount since this service started.

Challenges for the program include: client medication needs, a lack of Medicare/Medicaid psychiatric providers in the community, and Medicare providers who are not accepting new clients.

Dr. Birnbaum proposed the idea of a possible partnership with primary care physicians as is currently being done with the Pro Bono program's relationship with mental health providers, since family doctors are now able to do much of what a psychiatrist can do. He noted the potential to build relationships between mental health providers and primary care providers, particularly with good case management processes.

**Prescription Assistance Program - Update**

Mr. John Newman, Clinical Services Director, provided an overview of the Prescription Assistance (PA) Program, including: the program's vision, community need, who we serve, how we help people obtain medications, value of services provided, and program challenges and opportunities.

The PA program began in 1995 and assists individuals who cannot otherwise afford needed medications. The 2010 Community Health Survey reported that 41% of responding adults who had low incomes and no insurance (which would translate to approximately 6,500 people in the District) were *unable to fill* prescriptions in the previous two years due to cost. Also, 67% of adults in the District with low income and no insurance (approximately 10,700 people) reported *skipping* medications or treatments during the past two years due to cost.

Increasingly, staff find that individuals utilizing PA services are not only the homeless and the "working poor" (families where one or both income earners have jobs, but their incomes are low and there is no health insurance), but also individuals and families who have recently lost employment (and therefore lost their health coverage, as well as used up their personal savings) and have never had to use such services before.

The PA program helps individuals (with income levels up to 200% of Federal Poverty Level) obtain needed medications in two ways: through vouchers, and through helping them access manufacturers' prescription assistance programs (MPAPs). Vouchers are given when there is no MPAP available to the client, or to fill the gap until an MPAP might become available. Depending on Health District resources, vouchers per client are limited. Eligible clients take the voucher to a participating pharmacy, and pay a copay based on their income level. Pharmacies later bill the Health District at a discounted rate for prescriptions filled by clients. Many pharmaceutical manufacturers have their own prescription assistance programs that provide medications for free or reduced cost. PA staff assist clients by helping them complete and submit applications to the MPAPs, and by monitoring the status of submitted applications and facilitating the process with both the physician and MPAP organizations, often advocating for the client when issues or concerns arise. MPAP medications are delivered by the manufacturer to the client's physician for pick-up by the client.

In 2010, PA staff assisted over 1,500 people in obtaining medications valued at over $2.5 million (values of MPAPs and discounted vouchers). It was noted that there was a drop in the number of clients in 2006 when the Health District lost a number of clients due to the Medicare Part D program that was initiated at that time. Since then, client numbers have been steadily increasing and are now almost back to previous levels.

Vouchers are restricted by the resources we have available. A challenge has been to manage vouchers with the increasing costs of medications. In 1998, voucher's averaged $40; now they average about $72. At $72 per voucher and a budget of approximately $300,000, we could provide 4,166 vouchers. Staff is careful to monitor the distribution of vouchers and have, at times, based on estimated projections, implemented limitations (either on the dollar maximum per client or number of vouchers a client can receive) in order to serve most, if not all, clients needing our services. Staff also keeps informed of other resources clients can access in the community, such as low-cost prescription programs pharmacies, discount, or grocery stores, and now has a system that maximizes the use of generics, automatically using generic equivalents when available unless the physician orders differently. The Health District is also working on a process to educate physicians about generic alternatives in certain cases.

In 2012, Medicaid in Colorado is currently anticipated to be expanded to "adults without children" who have incomes up to 100% of FPL, although this is not a certainty. At this time, 72% of PA clients are at or below 100% FPL, which may cause a dip in the number of clients as some of them move to Medicaid. While there is uncertainty about how this may play out, in addition to uncertainty regarding health care reform changes, there are a variety of options for the program in the future, including reducing services, expanding eligibility to those with slightly higher incomes, and being able to provide more comprehensive help to the clients in real need.

## DISCUSSION AND ACTIONS

**Policy**

Marty Janssen, Policy/Research Assistant, provided an update on several bills of interest to the Board, including:

- **Senate Bill 2011-200,** which would create a Colorado Health Benefit Exchange, passed in Senate. One amendment was made to the bill since the last board meeting that states the Governor, who appoints five of the board members, can only appoint 3 members from their party. Amendments to require the state to opt out of national health care reform did not succeed. There is a sense of urgency to pass the bill in order to take advantage of significant federal funds that would help the state plan the exchange.
- **Senate Bill 2011-213** would establish monthly premiums for certain families whose children qualify for health coverage through CHP+. Monthly premiums existed several years ago in Colorado, however, they were replaced with an annual fee when it was deemed an "administrative nightmare" and a disincentive to get children covered. If this bill passes, it would institute a $20 minimum monthly premium for the first child for families with incomes between 205-250% FPL (this does NOT institute monthly premiums for all CHP families), plus $10 per month per additional child up to $50.

  For a family with 2 children (with income between 151-250% FPL) who currently pays $35 annually for two eligible children, under this bill they could pay up to $600 a year, a 1700% increase. This is a huge concern for families who, according to the self-sufficiency index, do not have enough extra money after essentials to be able to afford these kinds of costs. If the Senate does not agree to House amendments, it will go to Conference Committee where there may be an opportunity to inform people how this bill might impact already struggling families and have the issue.

  In the interim between Health District board meetings, Board President Celeste Kling authorized staff to convey to legislators a "strongly oppose" stance on SB 213, based on prior board stances on this issue; board members did not have any problem with that stance.
- **Senate Bill 2011-192** continues the Prescription Drug Monitoring Program (which is due to expire July 1, 2011) until July 1, 2021. This bill made it through the Senate with overwhelming support.
- **Senate Bill 2011-202**, which would amend the Hospital Transfer Act, died in committee today.

  **Senate Bill 2011-258** was filed just recently and would regulate locally grown foods and direct Boards of Health to create Registries of Growers. (See Legislative Bill Summary for details.) Currently, vendors who grow their own food and produce certain food products must have a Retail Food Establishment license and meet "certified" kitchen standards for their home kitchen. This bill would relax those standards and require instead that vendors meet certain criteria, such as: become certified in safe food handling, register with local board of health, label food in specified manner, etc. Opposition to this bill has been expressed by health departments due to concerns with potential food-borne illnesses, their authorities and restrictions, and lack of clear definitions. While the bill's intention (to get healthy food direct to the consumer) is good, several concerns remain with very little

time left in the session. The Board briefly discussed whether they wanted to voice any concerns about health implications. Given the lack of time to do a complete analysis, and the fact that the public health community is paying close attention to the bill, they asked staff to continue to monitor the bill and not take a position on this issue at this time.

- **House Bill 2011-1043** which clarifies a number of provisions in the Colorado Medical Marijuana Code had disappeared and now resurfaced and is sitting in the Senate Judiciary. An overview of current and proposed policy was distributed to the Board; it has changed significantly since first introduced.
- **House Bill 2011-1261,** which would set a limit on THC levels for driving, has been scuttled and will not be passed this year.
- **House Bill 2011-1250** concerning medical marijuana-infused foods or beverages has been whittled down to a labeling bill, where labels must state that product is unsafe for children to consume.

**Letter/Proclamation from the Colorado Drug Investigators Association**
Board President Celeste Kling received a letter from the Colorado Drug Investigators Association. A copy of the letter was included in the meeting packet for Board member's review and consideration. In the letter, the Association is seeking support for a proclamation against legalizing marijuana for recreational use.

**MOTION: To not sign the proclamation proposed by the Colorado Drug Investigators Association.**
***Motion/Seconded/Carried Unanimously***

**UPDATES & REPORTS**

**1st Quarter 2011 Program Summaries and Executive Director Report**
Board members noted that they read the quarterly report with "pride," and a sense that we are providing significant services with the resources that we have. One question to staff was how we serve those who speak a different language other than English or Spanish. Mr. Newman noted that there are several options: some individuals speak and understand enough English to get by; many bring a family member to the appointment to help with translation; we have a language line we can access by phone; and when needed, we can access translation services within the community.

The Board complimented staff on the "amazing" work they accomplish!

**Programs/Projects:**
- **Medicaid Accountable Care Collaborative Pilot Project** – The ACC project is in very detailed negotiations with the PVHS Foundation to take on the management of the Combined Community Care Coordination Team. Also, Karen Spink, a previous Health District Director, has been hired on a temporary basis to help establish the project. Challenges continue based on how fast all this has to happen. Rocky Mountain Health Plans has been surprised at how our community has come together so quickly in a partnership that pools dollars to accomplish something bigger than any one organization could accomplish on their own.
- **Homeward 2020 –** At the last meeting of the Homeward 2020 Key Leaders group, 3 to 4 priorities were identified, with a key priority being getting "supportive housing" structured and going. There is a possibility that the Fort Collins Housing Authority can provide funding for the facility and operational costs, but the community will need to figure out funding for supportive services.

- **Dental Connections / Dental Care Under General Anesthesia** – Ms. Sheryl Harrell has been hired to fill the Coordinator position for the Dental Connections project and she will be starting next Monday. Staff is working diligently to move the project forward in order to get the program up and running this summer. In April, two more General Anesthesia (GAP) clients received needed dental care. We are still in the pilot phase of this program to monitor how the process is working and address any issues. Everyone involved seems to be satisfied with what's being accomplished. Our staff (both dental and non-dental) has done a great job and are working well with the Foothills-Gateway care coordinators.
- **Health Care Matters Project** – Cynthia Beyer, who attends this meeting tonight, was recently hired as the Coordinator for this project. She has spent the past month absorbing the project and reading lots of information. A strategy team will be working on next steps and work plans and beginning to develop messages and recruit champions in preparation for the community conversations.

**PVHS Liaison Report**

Mr. Hendrickson, the Liaison to the PVHS Board of Directors, announced that the PVHS Board is having a board retreat this weekend in North Carolina. Focus of the retreat will be on exploring alternatives and options for the Greeley Medical Group's hospital privileges, and determining guidelines for how PVHS might change in the future in preparation for health reform and other changes (e.g., ought they to consider partnerships, affiliations, etc.). Mr. Hendrickson will also be attending the Governance Institute being held Sunday through Wednesday.

**CONSENT AGENDA**

- Approval of March 2011 Financial Statements
- Approval of the January 25, February 11, March 2, and March 29, 2011 Board Meeting Minutes.

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

**ANNOUNCEMENTS**

- May 24, 5:30 pm – Board of Directors Regular Meeting

Ms. Plock passed along to the Board invitations received concerning the Renewal Foundation, a new foundation being formed in memory of Mr. Joe Stern who passed away, for a meeting to gather information that will help determine what kind of foundation it might be.

Mr. O'Neill commented on the Staff Appreciation Luncheon held on April 6, noting that it was a nice event, that it was obvious that staff have a lot of fun together, and that teams are competitive and supportive of each other. He said it was nice to be a part of this great group of people.

**ADJOURN**

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

The meeting was adjourned at 8:45p.m.

Respectfully submitted:

Nancy L. Stirling, Assistant Secretary

Celeste Holder Kling, President

Bernard J. Birnbaum, MD, Vice President

Timothy S. O'Neill, Secretary

Steven J. Thorson, MD, Treasurer

Joe D. Hendrickson, PVHS Board Liaison