



**BOARD OF DIRECTORS  
MEETING  
May 24, 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  
Julie Abramoff, Cardiovascular Screening Nurse  
Bruce Cooper, M.D., Medical Director  
Richard Cox, Communications Director  
Lorraine Haywood, Finance Director  
Sue Hewitt, Evaluation Coordinator  
Marty Janssen, Policy/Research Assistant  
Laura Mai, Accountant  
Cheri Nichols, Health Promotion, Nurse Supervisor  
Kathryn Radtke, DDS, Family Dental Clinic  
Laura Schwartz, Coordinator, Integrated Care  
Chris Sheafor, Support Services Director  
Nancy Stirling, Assistant to Executive Director  
Lily Tellez-Garcia, Dental Clinic Manager  
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 6:14 pm. Introductions of all present were made. One item, concerning conferences for board members, was added to the Updates and Report section.

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

**PUBLIC COMMENTS**

None.

## **STAFF PRESENTATIONS**

### **Family Dental Clinic: Update**

The Lead Dentist for the Health District's family dental clinic, Dr. Kathryn Radtke, provided an overview of the clinic. The Clinic currently has 8 dentists (an FTE of around 4) and 2 hygienists, 9 dental assistants, and administrative and support staff who serve individuals and families of all ages who otherwise are unable to afford dental care. From the most recent community health survey we learned that 84% of adults in the Health District with low income and no insurance reported putting off going to a dentist because visits are too expensive – approximately 13,400 people. Also, 31% of children in the District whose parents are low income and have no insurance either skipped or delayed treatments over the past two years. The disparity between children and adults is attributed to the fact that there are more dental insurance options for children than there are for adults, since Medicaid covers general dental services for children but only emergency dental care for adults, and CHP+ also has dental coverage.

Over the years, the Family Dental Clinic has seen a gradual increase in the number of individuals treated. A slight dip in 2010, when compared to 2009, was noted and attributed to more complicated cases versus more clients. The number of RVUs (relative value units) has increased, particularly for rehabilitative RVUs, which include crowns, bridges, partials, and dentures, with some treatment plans taking approximately 8 visits to complete.

In addition to providing the usual dental services one would expect from any dental provider, including preventative, restorative, emergency, endodontic, root canals, oral surgery, crown and bridge, dentures/partial and oral hygiene education (the only thing not done yet are implants) – the Family Dental Clinic works with various community programs to provide oral health education and screenings, performing 1,400 screenings outside the clinic in 2010. Project Smile is one program which began as an initiative of the North College Business Association to provide dental screenings to students of Irish Elementary. Dental Clinic staff have been providing screenings at the school for the past several years and giving referrals for care, when needed, based on the screenings. The Dental Clinic is then one of several providers in the community providing follow-up care to children participating in this program. The program has witnessed much improvement in the oral health of children receiving prevention services and education, and care, and is considering expansion into a couple of other schools. The Clinic is also involved in programs (i.e., the Pre-Natal Program and Cavity Free at Three!) and partnerships (i.e., Early Head Start) that encourage oral disease prevention and education in children in their early years.

The Dental Clinic utilizes a sliding fee scale based on the federal poverty level (FPL) guidelines. Based on income, patients pay 15%, 25%, or 35% of the usual customary and reasonable fees, with higher co-pays for crowns, dentures and partials. Limited funding assistance is available through the Health District for children from the Friends of the Health District Pediatric Dental Funding Grant and Project Smile, and for adults from the Tooth Fairy Fund for Grown-ups.

In addition to Health District patients, the Clinic has an agreement with Salud Family Health Centers to provide dental care to Salud patients. From this agreement, the Health District receives funding for one dentist. In 2009, the Clinic provided 3,280 visits to Salud patients.

### **Integrated Care: MH/SA into Primary Care: Update**

Ms. Laura Schwartz, Program Coordinator for Integrated Care, provided an overview of the Integrated Care program. The Integrated Care program provides mental health and substance abuse services within two local safety net medical clinics: Poudre Valley Health System's Family Medicine Center and Salud Family Health Center. MH&SA services are provided by 6 Behavioral Health Specialists (BHS), all of whom are

also Certified Addiction Counselors (or “CAC” certified), a full-time psychiatrist and a program assistant. Services provided by the program include:

- Behavioral Health Consultation – This includes crisis intervention or brief intervention done before, during, or after a patient meets with their primary care provider. The BHS provides feedback to the provider, and at Salud, works side-by-side with them.
- Case Management in Clinics and in the Community – Depending upon the nature and severity of a patient’s illness, a BHS will provide services wherever it will be best received by the patient. Community case management is usually moderately intensive and serves those who are disabled to the point where they are overwhelmed with trying to access services. A BHS will usually meet such a patient in the community with the goal of eventually helping them to come into the clinic for their care.
- Psychiatric Evaluations and Consultations – The full-time psychiatrist splits his time between the two clinics (as well as giving a little time to the Community Dual Disorders Team program). At Salud, the psychiatrist usually meets with patients once (with a possible follow-up later), and may conduct an evaluation which is given to the primary care provider along with recommendations for treatment. Prescriptions and care management are the responsibility of the primary care provider. At the Family Medicine Center, the psychiatrist participates in half-day psych clinics, visiting with patients along with the residents, usually observing only, unless assistance and/or recommendation is needed or asked for.
- Shared Medical Visits (groups) – BHSs lead various group sessions, including expectant mother groups and those who suffer from chronic pain. They are looking into starting a teen group in the future.
- Individual Psychotherapy – For those individuals who cannot get services elsewhere or who prefer getting care through their primary care clinic, individual psychotherapy is offered.

Since the program started in 2005, the number of services annually and the number of unduplicated clients has continued to increase - with unduplicated clients tripling in 2010 compared to 2005. In 2010, 5,241 clinical services were provided and 1,800 unduplicated clients were served.

Some statements heard from clients who have received services from the Integrated Care Team:

- “I like the way you are so kind...”
- “You guys are my second home. If it wasn’t for you I don’t know where I’d be.”
- “I was suffering alone in the darkness without hope. This program brought a comforting light to shine on the path out of my madness.”

BHSs and the psychiatrist also provide half-day psychiatric clinics and resident education. New residents are oriented to behavioral health issues, in general, and to the program. Residents are also taken on a tour of the detox clinic in Greeley and are able to shadow a BHS in a community visit or at the clinic. BHSs and the psychiatrist also provide formal presentations in the community, in the clinics, and at some national conferences.

Integrated Care staff and partners are excited about their work. In the spirit of continual improvement, they would like to see: incorporating more Integrated Care staff in behavioral consultations at FMC, developing better continuity of care for patients who eventually qualify for Medicaid and transfer to a Medicaid provider for care, and the on-going challenge of treating complex medical and mental health issues at both clinics with limited resources.

The Board expressed their appreciation to the Integrated Care Team for the work they are doing to improve the lives of patients at the two clinics. It speaks well of the Health District and is a wonderful example of how we strive to help and interact with all clients with dignity and respect, providing service that is exceptionally high and exceptionally patient-centered. The program has been very successful and is a model worthy of recognition and attention. In response, Ms. Schwartz shared how a physician, who previously worked at Salud, was very disappointed when she learned that the place she went to work for did not have behavioral health care – stating that “it was a huge adjustment!”

### **Understanding Comparative Values of Preventive Care**

Dr. Bruce Cooper, Medical Director, presented on how the Health District evaluates “value” in its programs. In 2000, the Board of Directors adopted the “Evaluation Policy: Value Added” policy (later amended and re-approved in 2003). The policy states that the Health District will regularly evaluate its programs in terms of community need, quality, impact and value. Value is to be estimated by:

1. “measuring the cost of generating program outputs.”
2. “documenting the degree to which current knowledge supports the expectation that those outputs will lead to improved health status.”
3. The Board will decide whether value is sufficient based on normative cost/service standards, comparisons with similar programs, or cost-effectiveness studies.

The Health District has both clinical and community-based programs. Clinical services (i.e., dental and integrated care) provide a vast array of services which allow for comparatively easier value estimation by measuring cost per output. By utilizing Relative Value Units (RVUs), we are able to measure productivity and determine costs. Determining the value of community-based programs, such as prevention (Health Promotion), access expanders (MH&SA, Dental Connections, Prescription Assistance), and meso/macro level interventions (Community Projects, Childhood Outreach, Health Policy Advocacy), is somewhat more difficult. For our community-based programs, we determine value by looking at cost per service, and/or referring to studies estimating cost-effectiveness of similar services when available.

In terms of determining value, it is sometimes possible to look at a cost effectiveness ratio, or alternatively to look at a cost utility ratio that helps determine the number of “QALYs” (quality adjusted life year; 1 QALY = a year in perfect health) saved or added due to specific health benefits. Both are complicated analyses, and good cost effectiveness studies are fairly rare. When looking at costs and benefits, it is important to look at indirect costs like work absenteeism, pain and suffering, etc. In addition, there are also economic benefits to look at such as prevention of illness, avoidance of hospital admissions, etc.

For preventive health care, there are various studies that estimate the cost per QALY (currently there a Tufts study is generally used). Generally, a cost of \$50-100,000 per QALY saved is considered (in the US) to be a reasonable cost; less than \$50,000 is considered to be a very good deal; and anything that is actually cost-savings is considered exceptionally valuable. Unfortunately, information from the Tufts study is limited. Within the study, only 100 out of 1,400 interventions look at public health strategies vs. a very specific direct care intervention. Most of the public health strategies relate to vaccinations; most of the others are related to other medications.

In short, evaluation staff do their best to present evidence to the Board for evaluating the value of Health District programs and services. While there are no perfect methods, a combination of approaches gets us as close as we can possibly get to understanding our programs. It is staff’s objective to provide as accurate information as possible, and as much information as possible, to help the Board make informed (and oftentimes difficult) decisions.

## **Health Promotion: Clinical Preventive Screenings: Update**

Cheri Nichols, Lead Nurse, presented on the Health District's Cardiovascular Screening program. The goal of the program is to reduce cardiovascular disease in our community by providing cardiovascular screenings and education to residents, with a focus on accessibility and coverage throughout the community. In 2010, the program provided: 102 off-site clinics; 1,653 high blood pressure screenings to 1,468 people; 1,454 cholesterol screenings to 1,384 people; and 1,449 fasting plasma glucose screenings for diabetes mellitus. The largest percentage of clients are between the ages of 45 and 74 years of age and more females tend to access services. A sliding fee scale is available for Health District residents.

Program protocols are based on national guidelines with some adaptation to guide recommendations for follow-up (based on test results and risk factors). When indicated, clients are referred to dietitians, their primary care physician, etc. In 2010, 27% of those screened were found to have abnormal cholesterol screening results, 13% to have high blood pressure, and 1% to have abnormally high blood glucose results; all were referred for follow-up care. For those who want to track and monitor their blood pressure levels themselves, the program offers a Home Blood Pressure Cuff loan service. Clients are taught how to use the cuff and can check out the equipment for free for two to three weeks.

The Health District's cardiovascular screening program is unique in the community in that Program nurses not only have nursing expertise but are also skilled in interpersonal (stages of change) techniques and use an interactive approach to engage with clients and help motivate them to take the next step. It's not just a screening, but a screening with a consultation. As an example, "Dave" was a client who obtained screenings from the Cardiovascular Screening program. His results were high in both cholesterol and blood pressure screenings, with a 30% chance of a heart attack risk in the next 10 years. The nurse recommended that he seek care right away to obtain needed medications to lower his LDL and blood pressure. Dave was also referred to a Health District nutritionist and a Smoking Cessation counselor. Fortunately, Dave took initiative and got the care he needed to get his measurements under control. Had Dave gone to a health fair, he likely would not have received the kind of intensive attention he received from this program.

Follow-up services are considered an essential part of the program, to help assure that those with risky screening results have connected with a medical provider and are taking steps to control their condition. Phone calls are made to individuals who have been given recommendations. In 2010, 46% of clients who were referred for follow-up were reached. Of those, 70% followed the recommendation to see a physician, and 45% followed the recommendation to see a dietitian.

The main challenge of the program has been how to reach target (highest risk) populations. A particular success of the program has been work-site screenings. In 2010, the program conducted 29 separate screenings at work sites, increased from 9 a few years ago. The program has been successful in reaching many people who have not been screened before.

One of the key values of maintaining nursing staff for the Health District has been our ability to call them up quickly in case of disasters or other community needs. In the past few years, nurses have quickly responded to the following incidents: 2005 - Stock and organize the Health Van which was loaned for Hurricane Katrina response; 2008 - nurses train and supervise medical triage nurses for COMOM (Colorado Mission of Mercy major dental clinic); 2009 and 2010 - train nurses providing vaccinations for the H1N1 and Meningococcal clinics, and participate in administering vaccinations.

The Board complimented Program staff on their work, noting however that the biggest concern is how to motivate more clients to act on the recommendations they receive, and in particular to see their doctor,

since most conditions respond significantly to medications. Staff are encouraged to think creatively about options, such as mailing a follow-up letter to clients from our Medical Director (in addition to the phone calls), finding ways to make solid connections with primary care providers for those who do not have one, etc.

## **REPORT & DISCUSSION**

### **Results of the Colorado Legislative Session**

The 2011 Legislative Session concluded on May 11. Marty Janssen, Policy Specialist, provided a brief update on bills of interest to the Health District; key ones include:

- Senate Bill 213, to set up monthly premiums for certain CHP+ families, passed and is awaiting the Governor's signature. There has been very strong opposition pushing for the Governor to veto this bill.
- Senate Bill 192 passed and allows for the Prescription Drug Monitoring Program to continue for at least 10 more years. One provision was added requiring disclosure to patients.
- Senate Bill 200, the health insurance exchange bill, also passed. Efforts are underway to appoint board members quickly, with the Governor allowed to appoint 5 of the members.
- Senate Bill 202, concerning the Hospital Transfer Act, failed. Mr. Janssen briefly mentioned other bills that passed or failed. (See "2011 Legislative Session Wrap-Up" document for details.)

Staff are looking ahead as to what issues are likely to come up in the next few months, such as: marijuana legalization, interim budget cuts, HEAL Coalition food initiatives, and CFPI education tax initiative (to raise sales taxes in the next five years to help fund shortages, not necessarily just education). Other issues worth watching include Medicare/Medicaid debates, ACA lawsuits and legislative actions, and the new TABOR lawsuit.

## **UPDATES & REPORTS**

### **Project Updates:**

- MHSA Partnership – Partnership staff have been working on a current assessment of the crisis response system. Interviews have been conducted with many community leaders, resulting in much information about what has broken down in the system and what opportunities there might be for improvement. Once the information is sorted out, the key parties will be brought together in a facilitated discussion to determine if improvements are possible.

The EIEI project is currently working on a service mapping project to determine what is currently happening in the community in terms of early identification and early intervention. At the same time, the task force is starting the hard work of setting standards for what level of services should be expected from which types of providers – i.e., what should early childhood providers be expected to be doing. Both efforts will result in a comparative “should be” and “what is” that will illuminate gaps, which will allow the task force to begin considering priorities for which gaps to address first.

- Dental Connections is moving full speed ahead. Sheryl Harrell was recently hired as the Program Coordinator. It is looking challenging to be able to start seeing patients in July, but the program will start small and gradually grow as we learn how the program is working and developing. The team is working on a recruitment process for dentists, job descriptions for other program staff, and the design for the program space which will be located in the 202 building.

- Health Care Matters: Work continues as Cynthia Beyer, the newly hired Program Coordinator, becomes educated about the program. Staff are currently working on identifying and inviting “Champions” to be involved in helping us understand the 3 target groups so that appropriate approaches for connecting with them can be developed.
- Medicaid Accountable Care Collaboration – Ms. Karen Spink, a previous program director of the Health District, has returned to the United States and has been contracted to assist with the planning process for the combined community care coordination services. A budget is almost completely finalized and job descriptions have been drafted. Project staff are also working on a compact between four practices, the PVHS Foundation, and RMHP for the project.

### **Attorney Transitions**

Ms. Plock informed the Board that Mr. John Hayes is retiring. Mr. Hayes has served as the Health District’s attorney since 1995. Ms. Plock met recently with Ms. Kendra Carberry, a partner with Mr. Hayes’ firm and whom Mr. Hayes has asked to take over our case. Given all that is going on with health care reform and the big changes anticipated for the health care system locally, and with the history and knowledge that Mr. Hayes and his firm has with the Health District, it seemed to Ms. Plock best to continue with the firm, and the board agreed with that assessment. Mr. Hayes has agreed to be available to be involved in the future as needed and appropriate, while Ms. Carberry, who has been involved with many of our issues in the past, will become our regular legal counsel.

### **Conferences**

The board briefly discussed conference options for the board members; this year, there is budget for each member to attend only one. The main options in this calendar year are the American Public Health Association (APHA) annual conference, and the Colorado Health Symposium. Ms. Plock also mentioned the National Health Policy annual conference as being another conference board members might be interested in, which is usually held in mid- to late January in Washington D.C. Ms. Stirling will contact board members to find out conference preferences.

### **CONSENT AGENDA**

- Approval of April 26, 2011 Board Meeting Minutes
- Approval of the April 2011 Financial Statements

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

### **ANNOUNCEMENTS**

- June 13/14 – Board of Directors Annual Retreat
- June 28, 5:30 pm – Board of Directors Regular Meeting

### **EXECUTIVE SESSION**

A motion was made to go into Executive Session.

**MOTION: To go into Executive Session regarding negotiations pursuant to §24-6-402(4)(e) of the C.R.S.**  
*Motion/Seconded/Carried Unanimously*

The Board retired to Executive Session at 8:55 p.m. Although the tape ran out just as the session concluded, and no further board discussion happened after that point, Chairperson Kling did read the standard statement that the Executive Session was concluded.

The Board came out of Executive Session at 9:50 p.m.

**ADJOURN**

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

The meeting was adjourned at 9:52 p.m.

Respectfully submitted:

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Nancy L. Stirling, Assistant Secretary

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Celeste Holder Kling, President

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Bernard J. Birnbaum, MD, Vice President

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Timothy S. O'Neill, Secretary

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Steven J. Thorson, MD, Treasurer

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Joe D. Hendrickson, PVHS Board Liaison