



**BOARD OF DIRECTORS  
MEETING  
July 23, 2009**

**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/Data Specialist  
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  
Laura Mai, Accountant  
Emily Mayfield, Accountant  
John Newman, Clinical Services Director  
Janelle Patrias, Program Specialist, MHSA Partnership  
Judy Robison-Bullard, Support Services  
Chris Sheafor, Support Services Director  
Nancy Stirling, Assistant to Executive Director  
Lin Wilder, CI & HP Director

**OTHERS PRESENT:** Steve Collins, Sample & Bailey

**CALL TO ORDER; INTRODUCTIONS; APPROVAL OF AGENDA**

President Joe Hendrickson called the meeting to order at 5:55 pm. A motion to approve the agenda was offered and seconded.

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

**PUBLIC COMMENT**

None.

## **DISCUSSION & ACTION**

### **2008 Audit Report**

On June 30 Board members received a copy of the 2008 Audit Report and Report to the Board of Directors provided by Sample & Bailey, the Health District's auditors. Mr. Steve Collins, a representative from Sample & Bailey, attends this meeting to briefly review the auditing process and outcomes and to answer any questions the Board might have concerning the reports.

Overall, Mr. Collins reported that the audit went very well, noting a good system of controls, a very good job of segregating job duties between individuals, competent management, good approval and review process, good expense and budget control, and good oversight by management and the Board. It was noted that 90% of the Health District's revenue comes from property tax revenue and the rest comes mostly from client fees. In 2008, property taxes were up 8.5% and services income was up 14%. The major challenge for the year was the dramatic decline in interest due to the economy, and the loss of over \$100,000 due to the Lehman Brothers' failure in September 2008, which was one of the investments in the Colorado Diversified Trust Government Pool. It is possible that some of those funds might be recouped; COLOTRUST, which received the assets of CDT, is working to try to capture at least a fraction of the loss.

A board question to the auditor was whether there were any problems noted within the programmatic areas, or any sort of obvious imbalance between operations and reserves. The answer to both questions was "no" – and that the Health District has a strong liquid position.

A question was raised about the properties currently leased to PVHS (and any properties purchased by PVHS during the HOLA period) and whether the legal documents indicate that when the Hospital Operating Lease Agreement expires, such properties return to the Health District. While not all properties are specified in the HOLA, there is an amendment to the lease that basically states that anything PVHS owns at the time the HOLA expires becomes Health District property, if the lease is not extended. While the Health District does not have any control over PVHS purchases during the HOLA period, we do continue to have oversight responsibilities over the covenants and other features in the HOLA.

The Finance staff were recognized and thanked for their dedication and significant efforts, which result in such a well-run financial system for the organization. Staff present and recognized included: Emily Mayfield, Laura Mai, Rebecca Gonzalez-Rogers, Desiree Lange, and Director Lorraine Haywood. It was noted that Laura was responsible for finding and distributing Delta Dental funds that have helped patients receive \$53,000 worth of vouchers.

## **PRESENTATION**

### **Employee Compensation Background & Overview**

At a previous board meeting, during a preliminary conversation about possibly creating an intermediate leave program for employees, several questions were raised concerning the benefits employees currently receive. This evening, in response to those questions, Ms. Plock provided an overview of employee benefits and compensation and the Pay-for-Performance system.

The Health District's Board in 1997 and 1998 spent a great deal of time developing a pay and benefits system that met their key values and purposes. They wanted to be able to recruit and retain the best quality employees, to be able to identify and reward high performers, and wanted

a fair, consistent system in which employees know what is expected of them and who understand the pay for performance system.

The Health District provides several benefits to its employees – some which are required by law and others which are required by policy, contract, or agreement. By law, the Health District provides Social Security, Medicare, Worker’s Compensation Insurance, and Unemployment insurance. By policy, contract, or agreement, the Health District provides a retirement match (5% employer match to 3% required employee pay in to a 401(a) fund); malpractice insurance for doctors and dentists; licensure (when required for jobs). For positions that are more difficult to recruit and fill, such as dentists and psychiatrists, the Health District has offered very limited incentives in the form of either CMEs (for psychiatrist) or loan repayment (for dentists, according to a board-approved policy) in order to be competitive.

In regard to employee compensation, by policy there are certain designated responsibilities for staff and for the Board. Staff responsibilities include: conducting a market analysis at least every 3 years, collecting costs of living information, showing impact on budget of proposed increases, creating and implementing performance and pay management system, using Board parameters. Board responsibilities include: approval of general parameters for overall pay change allowed in annual budget, approval of overall personnel budget, and approval of system for adjusting compensations.

The Pay for Performance system that was approved by the Board in 1998 and which has been in effect since then includes four steps: a bi-annual market evaluation, a budget analysis, employee performance management, and pay increase allocation. In the bi-annual market evaluation, job descriptions are checked for accuracy and a consultant expert matches jobs to market, researches organizations of similar size and sets market pay levels. Market adjustments may be made, and the grade range chart is adjusted (bi-annually). Pay ranges are then set within 3 performance zones: entry level or developmental, market level, or superior performer.

The budget analysis includes determining anticipated revenue and expenditures for coming year and determining an average pay increase budget (if any) based on that information.

Employee performance management begins with the employee and their supervisor working together to determine a performance plan and expectations for the employee. Over the year of the plan, the supervisor observes and documents the employees’ performance and provides feedback and coaching. At the end of the year, the supervisor meets with the employee and appraises the employee’s performance. Directors then review the appraisals for consistency and accuracy and the Cabinet determines pay increases.

Experience with this system has proven that it works very well. We are able to recruit and retain quality candidates, while poor performers (or bad matches) are identified, and often choose not to stay. Employees trust the system and it has become part of the organization’s culture.

In light of the current economic situation and how various companies are dealing with shortfalls, a question was raised about how market studies will treat employee furloughs. The answer to this, and what impact the current economy will have on markets, remains to be seen.

## **DISCUSSION & ACTION**

### **Employee Intermediate Medical Leave Proposal**

In reviewing the Health District's paid time off benefits and comparing them with other local benchmark organizations, we learned that while we were in the middle of the ballpark for flex/vacation/sick leave, we were lacking in providing our employees some kind of assistance with the gap of time between when an employee first becomes ill and when long-term disability begins. To address this gap and help alleviate some of the financial challenges employees face who must take medical leave for two weeks or longer, an "intermediate medical leave" proposal was drafted. Significant effort went into trying to balance out who to provide the service to, how to make it fair and make it affordable. (See draft document for full details.)

The proposed Intermediate Medical Leave (IML) would be a benefit that assists an employee who is experiencing a serious medical illness by providing a portion of their salary (66%) for the time period between when they must be out for a period of two weeks and when long-term disability insurance begins at 90 days. Employees who have completed one year's service with the Health District who are experiencing a verifiable medical problem that will require them to be out of work for more than two weeks would be eligible for IML. The leave would only apply to the employee's illness and not that of a family member. Employees would be required to use their flex time for the first two weeks of medical leave up until the time when the intermediate medical leave would kick in. If the employee runs out of flex time during the two weeks, they would be unpaid until the IML begins, at which point they would then receive 66% of their normal pay for the duration of the short-term leave, up until the long-term disability would begin. IML would be available only one time within a 12-month period.

Initially, the Health District would fund the policy out of reserves for the time period between July 1 and December 31, 2009. Beginning in 2010, the Health District would allocate \$10,000 annually in its regular operational budget, and would change its paid time off policy to reduce by one day per year the accumulation of paid time off (flex time) for each person who has worked at the Health District for one year or more.

Other options to provide intermediate medical leave considered but determined to be either too costly (for the employer or the employee) or not feasible included: purchasing short-term disability insurance; having the employee purchase short-term disability insurance voluntarily; continuing as is by allowing employees to donate a portion of their own flex time to another person who needs it; and creating a voluntary "paid time off bank" which people can deposit some of their time on an ongoing basis in order to use it in the future.

The Board was invited to take time to consider the draft proposal and ask questions at the upcoming Board Retreat. Staff are still working on the final details and will bring it back to the Board for a decision in a future board meeting.

### **Identity Security: new federal law, FTC**

A new rule from the Federal Trade Commission, known as the "Red Flags Rule" goes into effect on August 1, 2009. It was initially thought that the rule would not apply to the Health District, but after a recent interpretation of the Act in May 2009, which defines "creditors" to include health care organizations who regularly defer payments for services and/or who arrange for the extension of credit or payment plans, we are, therefore, required to comply with the rule.

The Health District, in its eligibility process, has always had some processes in place to detect possible criminal activity and this rule formalizes what we've been doing all along. The intent of the rule is for organizations to develop and implement a written identity theft prevention program to detect, prevent and mitigate identify theft in connection with certain patient accounts. A draft Identity Theft Detection Policy and Procedure was presented to the Board for their review. Before it can be initiated by the required compliance date of August 1, the Board's approval is required.

**MOTION: To approve the Identity Theft Detection Policy and Procedure as presented.**  
*Motion/Seconded/Carried Unanimously*

### **Parental Involvement Leave: New Colorado Law**

There is a new Colorado law that we are required to have in place right away. The law requires that employers allow unpaid leave for employees to address issues around specific school activities for their child/children. Activities allowed by the new law include: parent-teacher conferences and meetings about special education services, response to intervention, dropout prevention, attendance, truancy, or disciplinary issues. The flex time system the Health District uses already allows employees to use their flex time for such activities. The change this new law makes for us is that if an employee does not have flex time available, the Health District must allow the employee to take unpaid leave for these types of activities. A copy of the Parental Involvement Leave statement that would be included in the Employee Handbook was presented for the Board's review and approval.

**MOTION: To approve the Parental Involvement Leave policy revision to the Health District's Employee Handbook as presented.**  
*Motion/Seconded/Carried Unanimously*

### **Board: Potential Assistance in Fundraising for Adult Dental Fund**

In January 2009, the Health District launched the Tooth Fairy Fund for Grown-Ups to provide additional financial assistance for those who are unable to pay even the low sliding-scale fees at the Health District's Family Dental Clinic. A local anonymous donor has offered a \$20,000 matching challenge grant if we meet this donation in 2009. We recently learned that the deadline to obtain donations has been moved up from the end of the year to October 31, 2009. Thus far we have raised close to half of the amount needed.

Staff asked the Board if they would be willing to assist efforts to increase donations and if they would be willing to invite key leaders, friends, and/or associates to attend a special "Get to Know You" event and tour of the Dental Clinic, and to send letters to others requesting donations. Board members were enthusiastic about the idea, agreed to participate, and offered suggestions, including an idea to deliver request letters on behalf of Dr. Thorson and Dr. Birnbaum to all PVH-affiliated doctors.

## **UPDATES & REPORTS**

### **Community Dual Disorders Treatment Program Outcomes and Digital Story**

Janelle Patrias, a Program Specialist involved with the Mental Health and Substance Abuse Partnership, provided an update on the first year of the Community Dual Disorders Team (CDDT) program. The program has been described as a "small program making a BIG difference." The CDDT program is a collaboration of efforts between the Fort Collins Housing Authority, the City of Fort Collins, the Health District, and the Larimer Center for Mental Health

and works with individuals with the most severe mental health and substance use disorders and who are homeless. Based on the Integrated Dual Diagnosis Treatment model, an evidence-based practice, the CDDT program strives to understand what is currently available in the community and works to restructure and improve the system to derive better outcomes for those individuals who are sometimes considered beyond help. Program elements include housing, counseling, case management, group treatment, and medication. Since the program focuses on the homeless population, finding housing opportunities for them was essential. The program was jump-started when it was awarded 12 housing vouchers from the City of Fort Collins' Community Development Block Grant Commission (CDBG).

By establishing a methodology to collect and compare data, we were able to determine specific findings just from the first year of the program:

- **100% retention in program.** This is remarkable when you consider the population the program is working with and that these individuals have been involved with many other treatment programs unsuccessfully.
  - **61% reduction in service utilization,** including hospitalizations, incarceration, and emergency room use. Comparing emergency room and ambulance use prior to and after the 12-months of the program, there was a 70% reduction in ambulance transfers and 50% reduction in emergency room visits.
  - **60% reduction in detoxification** utilization and also reduction in inpatient psychiatric admissions.
  - **75% reduction in jail and prison nights.** There were 382 jail nights prior the program, and 153 after 12 months of the program. The 153 days were all within the first few months of the program, showing that as the clients continued with the program they experienced fewer, if any, incarcerations.
  - **Cost Savings:** In determining cost savings, while not able to look at actual medical billing statements, were able to determine cost averages. The following cost savings were figured:
    - **\$260,000** – savings after 12 months of the program. Prior to the program, total costs of services provided to clients totaled over \$425,000. After 12 months, costs of services totaled \$165, 486.
    - **\$21,690** – average savings per person in the program.
- Costs and Net Costs:**
- **\$22,120** – average per person cost of treatment and housing
  - **\$435** – net cost per participant to provide housing and treatment services

There are other changes that can't be measured, yet are impactful. Service providers regularly hear stories about how the program has changed lives. While the program has not (and was not expected to) result in complete elimination of substance abuse, each participant has had periods of sobriety that were the longest period of sobriety they have had since their addiction began. They feel proud, it gives them hope and a sense that they have support now and can succeed. One person, homeless for more than 10 years and who was a severe alcoholic, came in proudly talking about 4 weeks of abstinence. He has a new perspective on what his life can be like. A video was shown to the Board of another client willing to share his story in a "digital storytelling" piece developed by Health District staff.

Board members were very impressed with the presentation and the reductions to ambulance and emergency room utilizations due to the program. They expressed interest in finding a way to

share this information with medical providers via publishing in a medical journal such as the Annals of Emergency Medicine, present it at APHA, and/or sharing with the local community what we're doing via the CrossCurrents program on the City's cable channel. It was also suggested that there might be an opportunity to partner with PVH's Home Case Management Program, which uses Advanced Practice Nurses to provide case management, to provide a medical care element to the program.

One question was raised about whether a participant ever "graduates" from the program. While individuals do not necessarily "graduate" – it is a time-unlimited program – the goal is to help them progress to their greatest possible level of independence – perhaps not being dependent on housing vouchers or requiring as much support. Given that the program provides services to those with the most severe chronic mental illnesses and significant addiction disorders, it is designed to continue to be available to these individuals in case they should relapse or need support. It was also noted that the program is dependent upon the housing vouchers and can only help as many people as they have vouchers for. There is an opportunity coming up soon to reapply to CDBG and another likely source, and the aim is to increase the vouchers in order to expand the program. So far the program has used its funding very well and has enough to enroll one or two more participants. Ms. Patrias noted that the program is still young, still evolving and processes are adapted as determined and needed.

### **Generic Equivalents and Alternatives in the Prescription Assistance Program**

Dr. Bruce Cooper, the Health District's Medical Director, provided a brief overview on generic equivalents and alternatives in the Prescription Assistance (PA) Program. One purpose of the study was to determine whether there might be potential savings within the PA program if vouchers for generic alternatives were substituted for single-source brand-named drugs. Another reason for the study was to determine, based on a suggestion from Dr. Thorson, if it would be possible and worth it to having PA take on a role of educating local physicians on generic medications and options.

Today, we know that substituting generic drugs is safe and simple and usually very cost-saving. Studies have shown that practices to switch brand-name drugs with generic equivalents or alternatives are underused. This can be attributed to aggressive marketing directed at physicians and patients and the fact that many physicians are not always aware of which drugs have generics or what the cost differentials are. For the past 6 years it has been a policy of the PA program to switch brand-name drugs to generics when equivalents are available and when a physician has not indicated "dispense as written" on the prescription. Pharmacists, by state law, are also allowed to switch to generic equivalents when not otherwise specified; however, not all pharmacists do so all the time.

In 2008, the Health District budgeted \$285,000 and spent \$270,373 to supply PA clients with vouchers to purchase medications. 4,025 vouchers were issued – 49% were for brand-name drugs and 45% were for generics (6% were unclassified). Of those brand-name prescriptions, one-quarter (1/4) of them actually had generic equivalents, but were not filled as generics. If every one of those brand-name prescriptions had been switched to their generic equivalents, there would have been a potential \$6,846 in savings. For the 8% of the brand-named drugs prescribed which were for single-source brands not covered by MPAPs (manufacturers prescription assistance programs) but in a therapeutic class with generic alternatives, if the

generic alternatives had been used, there could have been a potential savings of over \$7,000. If all prescriptions had been converted, the maximum possible savings is probably around \$14,000.

The study concluded that there may be opportunities to reduce voucher costs for clients and the program. One strategy would be to have PA staff look for generic opportunities and work with pharmacists to fill with generic equivalents whenever available, unless rejected by the prescribing physician, thereby reducing costs to the Health District and clients. Another would be to explore the costs, burdens, and benefits of providing clients with information to share with their physicians on generic alternatives for the most commonly used medications, thereby educating physicians on generic options and cost differentials between brand-name and generic equivalent drugs. Having patients approach their physicians with such information has been shown to be effective in educating physicians about generic options and reducing costs to patients.

The Board complimented staff on the great research and valuable information, noting that perhaps a targeted approach to the most costly practices might work, and indicating openness to the role of helping physicians understand the implications. It was mentioned that the University of Wyoming Pharmacy program is always looking for places to place students and perhaps, if such a role is determined to be needed, there might be an opportunity for them to provide pharmacy consultation to the PA program.

### **Health Care Reform**

Carrie Cortiglio, Policy Analyst, provided an overview of what appears to be shaping up in the national House and Senate around the issue of healthcare reform.

Currently, two of the three House Committees working on the “America’s Affordable Health Choices Act of 2009” bill have passed their versions and they are still waiting on the House Energy and Commerce Committee to pass its version. The Senate bill titled “Affordable Health Choices Act” has passed out of committee, but the Senate Finance committee has yet to release and mark-up their bill.

There are emerging similar components to each of the bills, such as individual mandate; premium subsidies to help low-income people purchase insurance; expansion of public health insurance programs; insurance market reforms; and pooling mechanisms to allow individuals and small employers to purchase insurance.

Key issues being raised in response to the bills are: public option vs. private plans only; financing mechanisms (taxing health benefits, surtax on wealthy, savings to Medicare/Medicaid); potential for achieving cost containment, and affordability. Pros of a public plan include costs savings, more power to negotiate prices, and it could be given wide latitude to experiment with different payment plans and schemes. On the opposite side there is concern about reimbursement rates.

Board members commented about the importance of acting this year, even if the reform is not as complete as would be desired; and about the challenge that if all people in the country were covered right away, there would not be enough primary care physicians to care for everyone.

The Board brainstormed some initial key values that they will consider conveying to legislators regarding healthcare reform, although they did not come to final decisions and agreed to discuss the issue further at a future meeting. There was support for portability, and concern about reimbursement levels for providers. Possible values included: 1) Strong support for achieving health care reform this year, even if it is not perfect; 2) Health care reform must try to cover everyone; 3) It must address affordability for those of all incomes; 4) Quality of care is a key consideration, and defining and using comparative effectiveness is important; 5) It must attempt cost containment, perhaps through administrative savings; 6) It is important to include a public plan option; 7) Prevention should be an element, though it may not be cost-saving.

### **Emergency Preparedness**

Given the late hour, this report was postponed. However, there were questions about what the process will be for distributing H1N1 vaccine in our community. Since planning is still taking place, it was too early to know, and updates will be provided to the Board as things evolve.

### **PVHS Liaison Report**

Ms. Thielen informed the Board that the management and leadership of the Poudre Valley Health System is keeping watch on healthcare reform efforts and doing some preliminary thinking about how they might be affected. Also, because of their reputation as a high-quality hospital, they are attractive to others as a potential business partner. The Board expressed their need to be involved early on in any serious discussions that may impact any of the elements included in the lease agreement.

### **MHSA Partnership, Dental Health Partnership**

In the interest of time, this section was skipped.

### **Quarterly Report and Executive Director Update**

The Board expressed their appreciation for the report. They thought it was wonderful that dental clients were being connected to our smoking program and were pleased with our partnership with Mountain Crest Behavioral Healthcare to exchange psychiatrist time.

### **CONSENT AGENDA**

- Approval of May 26, 2009 Board Meeting Minutes
- Approval of December 2008 Final, April and May Financial Statements

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

### **ANNOUNCEMENTS**

- July 27, 8:30-4:30 – Board of Directors Mini-Retreat, to be held at Tamasag
- July 28 – Regular Board Meeting CANCELLED
- August 6, 4:00 – 9:00 pm – Staff Summer Picnic, at Spring Canyon Park (Board are invited to judge the cupcakes/cookies contest)

### **ADJOURN**

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

The meeting was adjourned at 9:07 p.m.

Respectfully submitted:

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Nancy L. Stirling, Assistant Secretary

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Joe D. Hendrickson, President

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Celeste Holder Kling, Vice President

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Bernard J. Birnbaum, Secretary

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Steven J. Thorson, Treasurer

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Lee Thielen, PVHS Board Liaison