



**BOARD OF DIRECTORS
MEETING
October 23, 2012**

**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
Bruce Cooper, M.D., Medical Director
Richard Cox, Communications Director
Rosi Davidson, Smoking Cessation Counselor
Lorraine Haywood, Finance Director
Sue Hewitt, Evaluation Specialist
Laura Mai, Accountant
John Newman, Medical Services Director
Norma Pomerleau, Smoking Cessation Counselor
Chris Sheafor, Support Services Director
Karen Spink, Special Projects Director
Nancy Stirling, Assistant to Executive Director
Daniel Vigil, M.D., Evaluation Specialist
Lin Wilder, Community Impact/Health Promotion Director

CALL TO ORDER; APPROVAL OF AGENDA

President Celeste Kling called the meeting to order at 6:00 p.m. An item concerning a proposed policy change to increase the eligibility level for Prescription Assistance and Mental Health Connections Pro Bono was added under the Discussion and Action section of the agenda.

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

PUBLIC COMMENTS

None.

2012 SUPPLEMENTAL BUDGET

Presentation and Hearing; Board Action

The proposed supplemental budget is due to an increase of \$410,000 in revenues received from the amended lease and consent agreement with the University of Colorado Health and includes expenditures of a portion of the amount for the last couple of months of this year and the remaining amount of \$257,000 going into reserves for future expenditures. Some of the expenditures are to fund a new Health Care Reform/Program Development/Policy department and increase Ms. Karen Spink's position to full-time as Director of the new program beginning in November (which the intent that the position would continue in the 2013 operational budget). Other expenses will be for one-time capital and/or equipment purchases (as outlined in the proposed budget) which are currently needed and would have gone in the 2013 budget but can now be purchased this year instead. No members of the public were present for the hearing, and the board indicated its support for the supplemental budget.

MOTION: To adopt the Supplemental Budget for 2012 as presented.
Motion/Seconded/Carried Unanimously

PRESENTATIONS

Medicaid Accountable Care Collaborative Pilot: Approach, Progress

Ms. Karen Spink, the Health District's Special Projects Director, and Mr. Stephen Thompson, Program Supervisor for the Medicaid Accountable Care Collaborative (MACC) Team, provided an update on the progress of the Collaborative.

The North Larimer County Medicaid Accountable Care Collaborative came about when the State created the Accountable Care Collaborative that incorporated three components: Regional Care Collaborative Organizations (RCCOs), the Statewide Data Analytics Contractor (SDAC), and Primary Care Medical Providers. For this project, the state was divided into 7 regions, with Larimer County and the western slope being Region 1. Rocky Mountain Health Plans (RMHP) is the contractor (RCCO) for this Region. The purpose of RCCOs are to "ensure comprehensive care coordination and a focal point of care for every member by developing a robust network of providers, supporting their providers, providing medical management and care coordination and being accountable to Colorado Medicaid for progress." Locally, a team of people came together and first researched the most effective care coordination strategies. It was learned that highly effective (both improve health and contain costs) care coordination programs must: incorporate evidence-based key elements (such as targeting, multidisciplinary teams, appropriate caseloads, and data sharing), have a strong and varied base of resources/services available for patients, have superb communication and build effective personal relationships. Based on those fundamentals, the local approach to community-based care coordination is to "provide moderate to intensive linked care coordination to a targeted population, provided by a transdisciplinary team, utilizing a consistent approach and set of functions, resources, and communication strategies..."

Funding for the North Larimer County Collaborative comes from a local decision to pool most of the funds that participating providers receive from the State for each client (per member per month or PMPM), plus a portion of the PMPM funding that RMHP receives from the state as contractor for Region 1. Participating providers in northern Larimer County include an FQHC, Salud Family Health Center; a major private practice, Associates in Family Medicine, and a residency program, the PVHS Family Medicine Center. Locally, an Oversight Committee (staffed in part by the Health District with funds from RMHP) has been established to oversee the Medicaid Accountable Care Collaborative Team and has been involved with planning and

implementation of the pilot program. Along with RMHP and the participating providers, the Oversight Committee includes representatives Touchstone Health Partners, Poudre Valley Health System, and the Health District (as facilitator for the group). The Oversight Committee chose to target individuals with moderate to intensive medical and/or mental health needs, with the MACC Team providing moderate to complex outpatient care coordination services and transitions of care for this target group.

Mr. Thompson reviewed the make-up of the MACC Team, the first year of the pilot (June 2011 thru June 2012), and year two of the program. The first year consisted of: the development of policies, procedures and forms, hiring/orienting of staff, data review, development of an electronic record (AllScripts), outreach and education, and budget development. The first client was seen in December 2011. In the data review process during the first year, 134 potential clients were identified or referred, with 61 of these clients becoming active, open cases. As of year two (beginning July 1, 2012), the agreements between the players were renewed, and even though the PMPM to providers was reduced from \$4.00 to \$3.00, there appears to be an adequate budget to maintain the current MACC Team (with continued support from RMHP). Year 2 highlights include: incorporation of Healthy Harbors (a care coordination program for children who are in the foster care system), partnering with other case management efforts, population expansions as Medicaid enrolls more people into the pilot, and improved targeting leading to increased census.

The program has seen both challenges and successes. Some of the challenges noted were: client outreach and engagement, the complexity of the issues being experienced by the client population, data review and targeting, and relationship building with providers. Some of the successes noted were: Oversight Committee support, the assembly of the transdisciplinary team, integration with participating clinics, client experience and feedback, and potential for an effective long-term approach.

Ms. Plock commented that this has been one of the most exciting projects she's ever been involved with. There has been amazing cooperation from the RCCO (RMHP), the three participating providers, the other parties and the Health District. It is a great example of what you can do when you have significant support for what you need, from both the state and the players. We are starting to have access to data that has never been seen before, which allows the project to focus on both individuals and populations and their needs. The team is exceptionally skilled, and it turns out that having RMHP as a partner has been a blessing because they are very forward thinking, and very sensitive to adapting the approach to meet the needs of this local approach. The project is becoming a model for the state.

Tobacco Treatment Program Improvement Project

The Board asked staff (during its retreat) to do a current review of the Health District's tobacco treatment program and how our practices compare to best practices. Staff completed an extensive review of what the research says about current best practices, and the findings were compiled into a report titled "A Review of Evidence in Tobacco-Use Treatment". In addition to the report, board members were provided with an Executive Summary of how our practices compare to those current best practices, and a matrix that gives further detail. (See documents for full details).

At this evening's meeting, Dr. Daniel Vigil and Dr. Bruce Cooper noted that tobacco is still the #1 cause of death/disease, that 12% of adults in the Health District use tobacco, and provided an overview of their findings. In determining what an appropriate "quit rate" would be, Dr. Vigil noted that the answer varies according to what the definition of "quitting" includes, the population, etc., but that a good ballpark is the following: success for those who try to quit without any assistance: about 5%; for those who use a combination of counseling and medications: 20-30%; and our quit rate is about 25-30%. The presentation also covered: evidence review methodology, evidence review findings, and comparison with current and proposed practices. (See presentation slides for details.) Ultimately, the findings were that: counseling is good, medicine is good, and they are best together.

Counseling is a proven benefit when provided in varying formats (individual, group, telephone, internet, etc.), when there is appropriate contact time (4 to 8 sessions; between 90 and 300 minutes), when there is front-loading (more counseling in the first two weeks of an actual quit attempt), and when it includes interpersonal support and practical counseling by a counselor, such as problem solving and stress management. In comparison, the Health District's program includes individual and group counseling, usually provided in a 6-session package, with up to 300 minutes total contact time, and includes practical counseling and social support. CO monitoring will be added as a motivational tool for clients, and staff are examining ways to improve our front-loading capacity.

In regard to medications, the two most effective options are either 1) Chantix, or 2) nicotine replacement (NRT) "combo" therapy (meaning that the person uses two forms of NRT, such as the patch and gum). The Health District's program currently offers free NRT with counseling, and other medications are coordinated with providers. Assistance in obtaining medications (i.e., referral to prescription assistance) is offered when needed, and after reviewing this evidence, the program is changing in order to be able to provide more assistance. The program also offers relapse prevention.

The Health District has set up a referral and training program with Family Medicine Clinic and is working to develop relationships with other community providers. Staff members also are working to increase intervention and referrals from other Health District programs.

The Board complimented staff on their thorough report and review and expressed interest in first seeing whether it could be published and/or presented, then posting the document on the Health District's web site, in order to help other communities or organizations that are interested in improving their tobacco treatment programs.

PRESENTATIONS

2013 Budget – Brief Introduction

Ms. Plock provided a brief introduction of the 2013 proposed budget and its genesis. Property tax projections are projected to remain somewhat flat (until possibly 2016), and increases in insurance (health, life, disability, liability, etc.) and fixed costs (utilities, janitorial, etc.) are expected for 2013; however, the increased lease revenue provides new opportunities. In developing the proposed budget, the main priorities for the ongoing, operational budget were reviewed (variety of minor staffing changes to restore staffing adequacy where cuts went too deep and adjustments for current needs, staff pay increases, expanded dental capacity, the new Health Care Reform/Program Development/Policy department, and full incorporation of

Healthinfosource). The key new priorities for reserve funding expenditures were also reviewed (expanded dental capacity through a part-time oral surgeon, dental client assistance, dental sealants, CDDT Case Aid position, Aging and Health Care Initiative, obesity initiative, trainings and conferences particularly regarding the upcoming health care changes, rebuild of Healthinfosource website, paperless file conversion, computer programming catchup, and community education). (See "Health District Budget 2013: Genesis" document for full details).

Board Discussion: The Board briefly discussed the Health District's provision of direct services and community convening initiatives and whether more emphasis should be given to one or the other. The general consensus is that both kinds of services and efforts are important and valued in achieving the Health District's mission, and balance is needed between the two when prioritizing funding needs and considering impact to the public's health. For the formal budget presentation, staff will incorporate the proportions spent in each area, and will also review the process and iterations of the decisions the Board have made previously (generated from the triennial review) that influenced the development of this budget. An opportunity to further discuss this issue can be provided in the next board retreat.

Employee Compensation

Mr. Chris Sheafor provided a brief report concerning employee compensation in 2012. The amount budgeted for pay increases in 2012 was 1.5%, which amount was allocated to staff (not including the Executive Director). After necessary adjustments were made, it equated to an average increase of 1.43% for employees in 2012. (See "Report on Employee Compensation 2012" for further details.) The annual adjustment process brought the average of all Health District positions to 94.75% of the market ("market" being defined as the 50th percentile for that position) for the range they were in. Wage increases for Northern Colorado are projected by Mountain States Employers Council to be 2.6% in 2013. All employees of the Health District, including Directors, receive the same benefits package. A summary of benefits is provided in the "Report" document and includes benefits which are required by law, benefits that the Health District has committed to provide (retirement, health/dental/life insurance, etc.), and a few very limited benefits specific to particular positions (i.e., loan repayment for dentists). It is the Health District's policy to review the benefits package every 5 to 8 years.

MOTION: To Set a Public Hearing on the proposed 2013 budget for November 13, 2012 at 5:30 pm.

Motion/Seconded/Carried Unanimously

Ms. Kling asked if the Board would like to discuss, in a future meeting, whether or not to create a policy allowing proxy voting, to address cases where a board member may not be in attendance to a meeting but would like to still offer a vote by proxy on issues requiring a board position; the board answered in the affirmative, and it will be put on a future agenda.

Policy Changes for PA, Pro Bono in MH Connections

Mr. John Newman, Clinical Services Director, pointed out to the Board that in the last quarterly report, Prescription Assistance efforts to obtain prescriptions through Manufacturer Prescription Assistance Programs (MPAPs) only reached 75% of target, a notable decrease. There appears to be two reasons for this: 1) manufacturers are decreasing or terminating programs (affecting 4,000 MPAPs, or 16% of our annual workload); and 2) Since the "Adults without Dependent Children" Medicaid expansion was initiated, the PA program has lost about 100 people (acknowledging

that it is great news that they now have insurance coverage). In light of this, staff began to look at ways to fill the excess capacity with other people in need of prescription assistance. The obvious first step is to consider expanding the eligibility level for the PA program, which currently provides care on a sliding fee scale up to 200% of the Federal Poverty Level (FPL). Given that it is now generally acknowledged that people living at levels as high as 300 or 400% of FPL can need assistance in affording their health care, an increase to 250% seems reasonable. After doing some research and projections, it was determined that a) there is a significant but not overwhelming number of people whose incomes are between 200 & 250% who are in need of prescription assistance; b) some MPAP programs (but not all) provide assistance to those whose incomes are 250% or below; and c) we anticipate that the available currently unspent funds available for vouchers should match the anticipated utilization by this new group closely. Therefore, staff is recommending that the Board consider increasing the eligibility level for Prescription Assistance to 250% FPL.

In another area, there is also a decrease in Mental Health Connection's Pro Bono services to 72% of target. It is believed that the reason is similar to PA in that individuals moving into Medicaid no longer need pro bono services. The eligibility level for this program is also 200% FPL. If we consider increasing the level to 250%, the change should be affordable since the program is "pro bono" and therefore provided for little or no money. Therefore, staff is recommending that the Board consider increasing the eligibility level for Pro Bono services to 250% FPL as well. The board noted that these programs are good examples of programs that impact those who are living at the lower levels of the middle class, and reminded the staff of the importance of connecting with the growing CHMG to be sure they are aware of our resources that are available for some of their patients.

MOTION: To approve moving the eligibility levels of the Prescription Assistance and Pro Bono programs to 250% of FPL, effective no later than December 1, 2012.
Motion/Seconded/Carried Unanimously

Policy 99-01: Contract Signature Policy: Amendments

In a previous review of this policy, the Board gave instructions to have only 3 categories and to include definitions. The first category is being increased from \$25,000 to \$50,000 and allows the Executive Director to sign the contract if the amount is already included in the budget and the budget has already been approved by the Board. The second category, for amounts between \$50,000 and \$99,999, would require the Board to have an opportunity to hear about it and discuss it. If more than \$100,000 (the third category), the Board would actually need to see and approve the actual contract. The Board approved the categories and descriptions, however requested that the "staff designee" language be consistent for each category.

MOTION: To approve Board Policy 99-01 as amended.
Motion/Seconded/Carried Unanimously

Draft 2013 Board Meeting Schedule

Included in the meeting packet was a draft schedule for 2013 Board of Directors meetings. Two changes were requested: 1) change the March 26 meeting date to March 28; and 2) change the April 23 meeting date to April 30. The final meeting schedule will be presented to the Board at the January 2013 board meeting for official approval.

UPDATES & REPORTS

3rd Quarter Program Summary and Executive Director Report

In the report, it was noted that dental work load was very high this quarter. Part of the increase was attributed to HeadStart Early Childhood and Project Smile screenings. In the quarter, 547 screenings were accomplished; in October, an additional 258 screenings were provided for a total of 805 screenings. Children from nineteen schools participated in the Early Childhood screening program, and in Project Smile, 4 schools and one day care. For the 385 Project Smile screenings, 3% of the children needed dental care right away; 27% had some type of caries or needed to be seen by a dentist; and 70% didn't need any follow-up.

The Board was reminded that the Dental Connections Celebration event is being held tomorrow evening at the Fort Collins Country Club.

The Health Care Matters presentation has been seen by close to 400 people. Staff are now working to put the data together and will give the Board a presentation on what we have been finding in the near future.

PVHS Liaison Report

Given the recent changes, the PVHS Board has decided to go to 6 board meetings and an in-town retreat per year. Board members will also set aside time every month for a phone conference if needed. Two members whose terms have expired will be leaving the Board: Dr. Gary Ludwin and Stu VanMeveren. At the next board meeting, the Board will be considering individuals to fill those vacancies. PVH is also planning to changing the organization of the medical staff, to be organized by service lines rather than departments. This will lead to decisions being made by the hospital in a different way, and perhaps to some changes in credentialing.

CONSENT AGENDA

- Approval of the August 2012 Financial Statements
- Approval of the August 7 and September 6, 2012 Board Meeting Minutes

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

ANNOUNCEMENTS

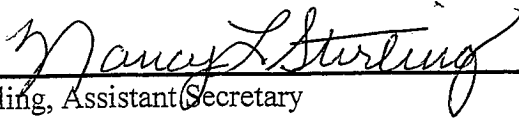
- October 24, 6:00 pm – Dental Connections Celebration at Fort Collins Country Club
- October 27-31 – APHA Annual Conference, San Francisco CA
- November 13, 5:30 pm – Regular Board Meeting (and 2013 Budget Hearing)
- Thursday, December 13, 5:30 pm – Regular Board Meeting

ADJOURN

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

The meeting was adjourned at 9:24 p.m.

Respectfully submitted:



Nancy L. Stirling, Assistant Secretary



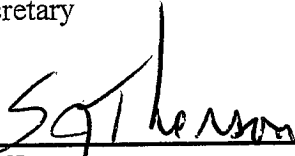
Celeste Holder Kling, President



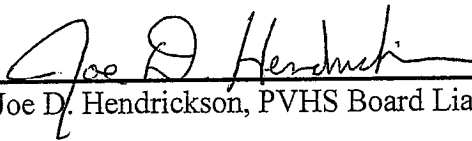
Bernard J. Birnbaum, MD, Vice President

(Absent for approval vote)

Timothy S. O'Neill, Secretary



Steven J. Thorson, MD, Treasurer



Joe D. Hendrickson, PVHS Board Liaison