



**BOARD OF DIRECTORS
MEETING AND BUDGET HEARING
November 15, 2016**

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

MINUTES

BOARD MEMBERS PRESENT: Michael D. Liggett, Esq., President
Tracy L. Nelson, Ph.D., Vice President
Deirdre Sullivan, Secretary
Faraz Naqvi, M.D., Treasurer
Tess Heffernan, Liaison to UCHealth-North/PVHS Board

STAFF PRESENT: Carol Plock, Executive Director
Bruce Cooper, M.D., Medical Director
Richard Cox, Communications Director
Lorraine Haywood, Finance Director
Laura Mai, Accountant
Dan Sapienza, Policy Coordinator
Chris Sheafor, Support Services Director
Karen Spink, Assistant Director
Nancy Stirling, Assistant to Executive Director
Sarah Tilleman, Dental Services Director
Lin Wilder, Healthy Mind Matters Director

CALL TO ORDER; APPROVAL OF AGENDA

Board President Michael Liggett called the meeting to order at 4:00 p.m. The meeting agenda was amended to add a Board Action item to approve a Resolution concerning signators and access to a safe deposit box.

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

PUBLIC COMMENTS

None.

BUDGET PRESENTATION AND PUBLIC HEARING

Health District Direction and 2017 Budget Presentation

Ms. Carol Plock and Ms. Lorraine Haywood provided an overview of the draft 2017 Budget, including an overview of services, sources of revenue and expected key changes in revenue and expenditures.

Ms. Plock reviewed the services that will be covered by the operational budget and by reserves and grants. Services to be covered by **regular operational funds** include:

- **Dental Care**: Up to now, the Dental Clinic has been separate from Dental Connections. Dental Connections was formed to increase capacity for dental services for those who could not afford the full costs of care and there are currently about 40 local dentists and other dental professionals who provided discounted or no-cost services. While Dental Connections is still needed for those who are not eligible for Medicaid dental coverage, it is not needed at the level that existed when it began. A change being proposed is to incorporate Dental Connections into our other Dental Services, to merge its services with our current Eligibility services, and to rename that staff team something like “eligibility and navigation services.” For the proposed 2017 budget, Dental Connections was thus incorporated into Dental Services, and would no longer exist as a separate program, but the connections to volunteer local dentists and the navigation assistance would continue. In addition to our regular dental services, we are also working to finish up “meaningful use” qualification (which requires certain technology changes), and in 2017 anticipate completing the analysis of community dental capacity, and if needed, the cost of expansion of dental services.
- **Accessing Health Care**: Includes the **Larimer Health Connect** program and **Medicaid Accountable Care Collaboration**. Given the recent presidential election, the future of both approaches may be in question; staff will be tracking potential changes closely, and have begun to consider future scenarios. One of our major grant sources for LHC will end in 2017, so this budget continues reserve expenditures for this project, while at the same time moving a small amount of LHC FTE into the ongoing operations budget.
- **Mental Health/Substance Use Issues**: Another of our major priorities is behavioral health. Programs include: **MH/SA Connections** (including the new Child, Adolescent, Young Adult Connections – CAYAC program); **Integration of MH/SA Care into Primary Care** (Integrated Care); **Community Dual Disorders Treatment (CDDT)** and **Healthy Mind Matters**. In CDDT, we continue to fund a portion of our psychiatrist’s time in addition to funding the building and providing a vehicle for staff use. In 2016, in response to SummitStone’s sudden budget challenge, we had provided temporary bridge funding to assist with a couple of positions; SummitStone has since taken back responsibility for those positions. Healthy Mind Matters provides facilitation and staffing for the Mental Health and Substance Use Alliance. Key priorities of the Alliance are to continue working on the expansion of critical behavioral health services and developing state of the art substance use treatment in our community.
- **Health Promotion & Preventive Services**: Includes **tobacco cessation** services, **cardiovascular screenings** (hypertension, cholesterol, glucose), and the **Healthinfosource.com** web site. The need for these services remains, and there is no one else in the community that does exactly what we do. The screening program will likely be piloting a service with the Family Medicine Center where the nurses will provide intensive care for high-risk individuals who have difficulty getting cardiovascular levels under control.

Other programs to be covered by operational funds that are critical to the rest of the organization include: Communications, Policy, Resource Development, and Assessment/Research/Evaluation.

Time-limited services to be covered by **reserves or grant funding** include:

- **Big Projects:** Larimer Health Connect (over time, the use of reserves will be decreased and costs moved into operations), Advance Care Planning (match for a major grant), CAYAC (match for a grant; some funding for CAYAC in ongoing operations budget), and finishing up the 2016 Triennial Health Needs Assessment.
- **Direct Services:** Dental Care (specialty care, sealants, client assistance) and Community Dual Disorders Treatment (CDDT) (fund a .2 FTE Nurse).
- **Community Planning & Change, Training:** Includes Community MH/SA (behavioral health services expansion, substance use treatment transformation, and Pay for Success for frequent utilizers); Health info sharing, HC Reform & Capacity; Pain management; Aging and Health Care; Population Health Analyst (connected to the local Medicaid Accountable Care Collaborative); Cardiovascular Pilot Planning; and Community and Staff specialized trainings.

Other items to be covered with time-limited/reserve funds are: targeted program outreach (for Dental, Connections/CAYAC, and video outreach), bridging wages, emergency preparedness, coordination for special projects, Healthinfosource.com rebuild, and space. Funds have also been set aside, if needed, for: new Health District projects implementation, Dentist Loan Repayment, Preventive Medicine Resident, CDDT/ACT Facility repairs contingency, other specific grant matches, high-level staff recruitment, and a HPSA (health professional shortage area) survey.

Dr. Naqvi inquired about how much fee income the Health District receives from the Affordable Care Act for services. Given the possibility of ACA repeal, would the Health District's budget be impacted? Staff will research an estimated amount, but even though Medicaid revenues don't cover the full cost of dental care, they bring in about 3 times more revenue than from patients who pay on sliding fee scale, so loss of the dental benefit for adult Medicaid would have a significant impact on the Health District's budget.

Ms. Haywood reviewed for the board the budget timeline and deadlines, sources of revenue (including property and ownership tax, lease revenue, fee income, investment income, and grant and partnership revenues), and inflation and local growth over the past 15 years. Adjustments to the final budget will be made once we receive the final assessed valuations from the County due by December 10. Per state statute, the board is required to finalize the budget by December 15.

Key changes to revenue and expenditures were noted as follows; on the revenue side, there was about a 2.42% increase in property taxes, 3% in lease payment, and small increase in investment revenues anticipated. All of that was balanced by an anticipated decrease in fee income (largely due to now having adequate experience with adult Medicaid dental revenues to more accurately anticipate income), leaving a total of about a 2% increase in revenues.

On the expenditure side, the budget includes just 1.5% increase in the pay for performance pool, salary adjustments for 9 positions that have moved significantly, and minor FTE changes for 8 positions. There is a 3.5% increase in health insurance.

Board Questions/Discussion – It was noted that the expected revenue increases, and thus compensation, does not cover the cost of inflation. As a governmental entity, that is often the case; however, it's important to note that in a good economy, our budget will have “up” years in years immediately following assessor’s valuations, and “down” years, when those assessments stay largely the same. If the economy stays healthy, there would be funds for larger pay increases in 2018.

Another question related to the process for determining priorities and the budget. Annual budgets are largely determined based on board priorities set after the triennial community health assessment and board retreat, with some adjustment for big changes as they happen in the community. In the triennial assessment process, a comprehensive random sample survey and community discussion groups are conducted, other information gathered, and then the Board and staff look at the information and other data about the community, along with the analysis on burden to health and effectiveness of interventions, to create the list of priorities. In 2017 the board will determine any new priorities which will affect the budgets for the following three years.

Between this meeting and the next meeting on December 13, the Board was asked to refer any budget questions or concerns to Ms. Plock as early as possible.

Five-Year Reserves Guide

Though not required by state law, Ms. Plock annually develops a 5-year reserves guide for management purposes in order to assure adequate reserves into the future, which was reviewed with the board. It was noted that it is a management tool, and a moving document, rather than a budget document. The guide has also proven useful in determining reserve amounts available for major expenditures; most recently when the decision was made to purchase the CDDT building. Since the list includes all potential expenditures, recognizing that they will not all come to pass, Ms. Heffernan made a suggestion that the list be prioritized, with those items most likely to be spent near the top of the list.

PRESENTATIONS

Integrated Care Program

Dr. Bruce Cooper, Medical Director, provided an overview of the Integrated Care Program for the Board. The Integration of Mental Health and Substance Abuse Care into Primary Care program (Integrated Care Program for short) began about 11 years ago. “Integrated Care” in its ideal rendition is “whole person care” – patient-centered, organized and coordinated by a team of clinicians that builds a coherent unitary plan for the patient. In our 2005 review of the issue, we learned many things, including that mental health and substance use issues are common problems in primary care (50% of clients who seek care for mental health and substance use go to their primary care provider, 50% of clients with mh/su issues refuse referrals to mental health professionals; 70% of visits to PCP stem from psychological factors); PCPs needed and were asking for help with identifying and treating clients with mental health/substance use issues; and there was extremely limited access to psychiatric services in our community. One way to assist primary care physicians was through integrated care – evidence of integrated care was already showing that it produces better outcomes at reduced costs.

Mental illness and substance abuse are common conditions seen in primary care. If one looks at a typical clinic waiting room of 20 patients: 5 of them will have major depression; 3 will have a panic disorder; 4 will have other anxiety disorders; and 3 will have alcohol abuse issues. Some of these have dual disorders. Hence, at least 50% of clients will have mental health/substance use issues. (This information is from a study done by the Merillac Clinic and has been confirmed at the Family Medicine Center and Salud clinics.) Of the 10 most common complaints in adult care (which include: chest pain, back pain, fatigue, shortness of breath, dizziness, insomnia, headache, abdominal pain, swelling, numbness), only 15% were judged to have an “organic” physical illness. 85% were considered to be “non-organic”, psychologically derived. This is what primary care doctors are facing daily in terms of diagnosis.

The Integrated Care program provides a psychiatrist and several behavioral health providers to the two safety net clinics in our community: the Family Medicine Center and Salud Family Health Centers. The providers work directly with clinic patients (screenings, consultations, assessments and interventions, and individual and group therapies) as well as work side-by-side or in consultation with clinic physicians, and provide physician education and trainings. In general, the majority of patients tend to be: female; aged between 35 and 64; have Medicaid health insurance. More than 50% have a serious mental illness; more than 25% have dual diagnoses.

Accomplishments of the Integrated Care program include: building skills sets to meet patient needs (i.e., PCP and FP resident training; co-occurring competence; special skills such as EMDR for treating PTSD); a high-level of integration within the clinics; and team-based transdisciplinary care. BHPs are also working with the clinics to provide group sessions which address specific health issues, such as a “centering pregnancy” project at Salud to support women getting ready for having a baby, which has been proven to improve outcomes and practically abolish the impacts of racial disparity on birth outcomes. Both clinics now offer chronic pain group sessions to assist clients with chronic pain through medication management, therapy, mindfulness training and yoga, as well as medication-assisted addiction treatment specifically for opioid addictions.

When the program started, our challenge was shifting from traditional roles to integration. Now that we are reaping the results of our successes, our challenge is meeting the need for behavioral health services and identifying all those previously unidentifiable mh/su cases. Other challenges include: a health record documentation system that supports full integration, enhancing our effectiveness addressing substance use disorders, and capturing Medicaid reimbursement.

As we look to the future we hope and wait for payment reform to make behavioral health integration a financial best practice. Whether this happens, however, is dependent on what happens at the national level.

Board Comments: Ms. Sullivan mentioned that she has been working with Salud and FMC on integrating food insecurity and developing food pantries. The integrated care model already established at these facilities has set the stage for how other groups can address other health issues. Dr. Naqvi quoted research which indicates an inverse correlation between age and mental health issues. It was noted that younger people typically go to their PCP with their issues, and that almost all frequent or high utilizers have behavioral health challenges. He noted that it is critical to our system to move towards integration to meet these needs. Ms. Heffernan

commented on a book called “Dream Land” that looks at the opioid epidemic – both how it evolved and possible paths forward.

Informal Discussion of Key Points from APHA

Staff and board members were invited to share some information about what they learned at the recent American Public Health Association conference held in Denver.

Dr. Naqvi focused mostly on sessions that pertained to elderly care and end of life care. Much of what he came away with was the continuing confirmation that the level of the numbers of elderly the country is going to be facing is out of concert with the available resources we have right now, and the country is ill prepared to identify and serve those with health care needs. Of particular concern are those with (or who will have) Alzheimer’s and their tremendous care needs, as well as other dementia and mental health issues. These cases are going to fall on society to provide care as families are unable to provide the level of care that is needed.

Ms. Nelson attended a late-breaking session from the CDC, where they discussed unprecedented change in ability to impact health issues. They have created a document looking at health conditions that potentially could have guaranteed progress within 5 years; she will share the website. Three buckets of prevention were noted: clinical preventive services in physician’s offices, connections to services in the community, and interventions that reach the whole community. Being aware of the potential and likely outcomes may be valuable when talking to legislators about priorities.

Ms. Sullivan spent time learning more about social determinants of health (affordable housing, education, etc.) and how communities can de-silo services. One example was utilizing community paramedics to provide some health services to decrease disparity. She noted growing gaps in disparities in the Hispanic/Latino community. Also attended were sessions on aging in place, and health promotion.

Ms. Heffernan attended the Hospital Trustees Conference for the PVHS board, discussing the future of health care. One session focused on the elderly, noting that hospitalization actually sets them back, and that home-based health care, telemedicine, and telepsychiatry all look promising. Care Coordination is a big part of this movement. In general, hospitals are focusing on dispersed services rather than hospitalization being the center of care.

Mr. Liggett spent a day and a half at the conference. He felt like the word “health” was too limiting, that the conference is more about human well-being. He was impressed by the sessions he attended (for example, gun control and homelessness), by the quality and depth of research at the sessions, and by the attention to how the information could be used. He found the conference to be inspiring and appreciated everyone involved.

UPDATES & REPORTS

Program and Health-related Updates

- **Post-election National: Issues relating to the health of the community** – Given the results of the national elections, staff have already begun to consider potential impact on our priorities, and a draft document entitled “What are the key elements of the Affordable Care Act and What are the issues to be aware of when ‘repeal and replace Obamacare’ is considered” was shared with the board .

The biggest issue of concern for our organization would be the repeal of Medicaid expansion – which would impact the number of lives covered by health insurance and their health, prescriptions, mental health, etc.

The Board expressed their appreciation for the document and for the considerations being made which will help in keeping in front of the concerns and issues. They inquired if there was a way the Health District could do some community education – what does this mean to human lives in our community? It might be an appropriate topic for the next Compass issue. The Board expressed their understanding that we need to wait and see what unfolds and that the organization will continue to respond in a way that is promotes the most health for our community.

- **Post-election State & Local: Summary of voter decisions**

Mr. Dan Sapienza, Policy Coordinator, provided a quick review of election outcomes of ballot issues and legislators: the ColoradoCares universal health care proposal was defeated, as was an increase tax on cigarettes. Physician aid in dying passed. The local measure to expand critical behavioral health services did not pass. The City of Boulder did pass a sugar-sweetened beverage tax.

Locally, many of our representatives were re-elected. A new representative, Hugh McKean, will replace Brian DeGrosso. Senator Kevin Lundberg was re-elected and was appointed to serve on the Joint Budget Committee.

- **Larimer Health Connect: Open Enrollment 4** – Ms. Spink provided a brief update on the current open enrollment session. Staff are very busy with appointments and are completely booked out through November 28 for Medicaid and December 6 for the Marketplace. Though people can sign up any time during the year for Medicaid, we do see an increase during the enrollment period. In the first 10 days, staff have served 225 customers. Most people are coming in with many questions and concerns related to the future of services given the election. The message that is being conveyed to them is that the ACA is still the law at this point, and people are encouraged to continue to seek coverage. The day after the election saw the most enrollments ever in marketplaces. As of last Friday, we were up 54% in enrollment compared to a year ago.
- **FLSA: Changes in Overtime Regulations** – Ms. Spink informed the board that there is new Division of Labor overtime regulations that are expected to go into effect on December 1. There is a possibility that it might get postponed by the legislature as they determine to clarify the regulation. The new regulations revise the criteria defining the type of employee who is eligible for overtime (non-exempt employee) and the type of employee who is not eligible for overtime (exempt employee). The new minimum salary threshold for overtime eligibility is now \$913 per week or \$47,476 per year (up from \$455 per week). We currently have 107 part-time and full-time employees. Of those, 43 are overtime eligible. With the new law we have 10 staff members who would be affected. All but one of the 10 moved to that classification because they are less than full-time. Directors are in the process of communicating these changes to supervisors and affected staff.

3rd Quarter Program Summaries and Executive Director Report

Included in the meeting packet is the 2016 3rd Quarter Report. In other news, the community health assessment discussion group meetings have started.

UCHealth-North (PVHS) Liaison Report

Ms. Heffernan mentioned that she will be participating on the MCR Board, though not as a voting member. The board asked Ms. Plock to continue to investigate this issue and to discuss it with Mr. Unger, CEO and President of PVH and MCR. In other news, Ms. Heffernan noted that it was clear from the recent conference for hospitals that having PVH being part of a larger health system puts our community ahead and was a wise move. PVH has a standard of care that is far better and should be proud to be part of UCHealth.

Board Participation in Funding

The time and dedication that Health District Board members give are very much appreciated. In considering our funding structure and unique mission, there isn't quite the traditional emphasis on financial board contributions as other nonprofit organizations. However, board giving does play a significant role in obtaining foundation funding. More and more grant funding entities are increasingly weighing board giving when considering funding a proposal and some even require that 100% of the board members support the organization financially. They are not interested in how much a board member contributes, just that they do. Board contributions before the end of this year will increase our eligibility for funding opportunities in 2017. Board members were asked to consider giving a gift that furthers our mission before December 31. Board members were given the option to send a check or contribute via PayPal online. The Board expressed their support of this invitation and willingness to contribute. Ms. Shannon will send an email to the board members with instructions for contributing.

Board Decision

The Health District is in need of another safe deposit box. The Health District has four other boxes which are filled, thus requiring an additional box for storing important documents and records. The Board was asked to approve a resolution that specifies who is eligible to access the safe deposit box.

MOTION: To approve Resolution 2016-18 to approve signators and access to Safe Deposit Box XX42.
Motion/Seconded/Carried Unanimously

CONSENT AGENDA

- Approval of August 23, September 27, and October 19, 2016 Board Meeting Minutes
- Approval of the August and September 2016 Financial Statements

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

ANNOUNCEMENTS

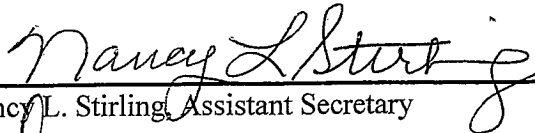
- November 15-17 – Triennial Community Health Assessment Focus Group Meetings
- Tuesday, December 13, 4:00 pm – Board of Directors Regular Meeting

ADJOURN

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

The meeting was adjourned at 6:00 p.m.

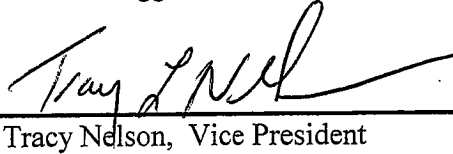
Respectfully submitted:




Nancy L. Stirling, Assistant Secretary



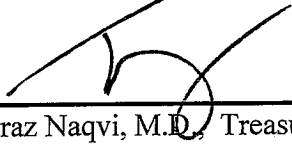
Michael Liggett, President



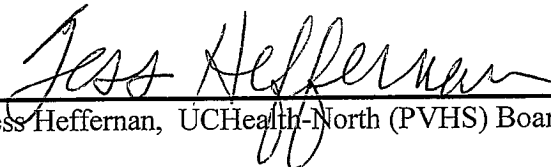
Tracy Nelson, Vice President



Deirdre Sullivan, Secretary



Faraz Naqvi, M.D., Treasurer



Tess Heffernan, UHealth-North (PVHS) Board Liaison