



BOARD OF DIRECTORS REGULAR MEETING

**Health District of Northern Larimer County
Virtual Meeting
See connection details at end of agenda**

**Tuesday, May 25, 2021
4:00 p.m.**



BOARD OF DIRECTORS REGULAR MEETING

May 25, 2021

4:00 pm

Virtual

AGENDA

- 4:00 p.m. **Call to Order; Introductions; Approval of Agenda**Michael Liggett
- 4:05 p.m. **PUBLIC COMMENT**
Note: If you choose to comment, please follow the “Guidelines for Public Comment” provided on the back of the agenda.
- 4:10 p.m. **DISCUSSION & ACTIONS**
- **Policy**..... Alyson Williams
 - State Legislative Proposals**
 - HB 21-1276: Prevention of Substance Use Disorders
 - HB21-1299: Office of Gun Violence Prevention
 - SB21-256: Local Regulation of Firearms
 - HB21-1317: Regulating Marijuana Concentrates
 - Other policy issues that may arise
- 4:35 p.m. **PRESENTATIONS**
- **COVID Status Update**James Stewart
 - **Isolation/Recovery & Quarantine (IRQ) for PEH Update**..... Brian Ferrans
 - **Brief Update on Vaccinations** James or Suman
- 4:55 p.m. **OTHER REPORTS & DISCUSSION**
- **Back to Office Planning; In Person Board Meetings**Carol Plock
 - **Board Communication and Access to Documents**
 - Board Email and Open Meetings Law – HB21-1025..... Carol Plock
 - Electronic platform for board materials & policiesKaren Spink, Lin Wilder
- 5:10 p.m. **OTHER UPDATES & REPORTS**
- Executive Director Updates Carol Plock
 - Liaison to PVHS/UCHealth North Report Celeste Kling
- 5:20 p.m. **CONSENT AGENDA**
- Approval of the April 13, 2021 and April 27, 2021 Minutes
 - March 2021 Financials
- 5:25 p.m. **PUBLIC COMMENT (2nd opportunity)** See Note above.
- 5:30 p.m. **ANNOUNCEMENTS**
- June 17 or 22, 4:00 pm – Board of Directors Regular Meeting
 - July 27, 4:00 pm – Board of Directors Regular Meeting
 - August 24, 4:00 pm – Board of Directors Regular Meeting
- 5:35 p.m. **EXECUTIVE SESSION**
For the purpose of addressing personnel matters pursuant to §24-6-402(4)(f) of the C.R.S., topic: Executive Director
- 5:50 p.m. **ADJOURN**

Join Zoom Meeting

Registration is required. Click this link to register:

<https://healthdistrict.zoom.us/meeting/register/tJludOitrD8uEtcIxNIQPCXOASbkirVxFwQE>

After registering, you will receive a confirmation email containing information about joining the meeting.

GUIDELINES FOR PUBLIC COMMENT

The Health District of Northern Larimer County Board welcomes and invites comments from the public. **Public comments or input are taken only during the time on the agenda listed as 'Public Comment.'** If you choose to make comments about any agenda item or about any other topic not on the agenda, please use the following guidelines.

- **Before you begin your comments please:** Identify yourself – spell your name – state your address. Tell us whether you are addressing an agenda item, or another topic.
- **Limit your comments to five (5) minutes.**

■ MISSION ■

The Mission of the Health District of Northern Larimer County is to enhance the health of our community.

■ VISION ■

- ❑ District residents will live long and well.
- ❑ Our community will excel in health assessment, access, promotion and policy development.
 - Our practice of **assessment** will enable individuals and organizations to make informed decisions regarding health practices.
 - All Health District residents will have timely **access** to basic health services.
 - Our community will embrace the **promotion** of responsible, healthy lifestyles, detection of treatable disease, and the **prevention** of injury, disability and early death.
 - Citizens and leaders will be engaged in the creation and implementation of ongoing **systems and health policy development** at local, state, and national levels.
 - Like-minded communities across the country will emulate our successes.

■ STRATEGY ■

The Health District will take a leadership role to:

- ❑ Provide exceptional health services that address unmet needs and opportunities in our community,
- ❑ Systematically assess the health of our community, noting areas of highest priority for improvement,
- ❑ Facilitate community-wide planning and implementation of comprehensive programs,
- ❑ Educate the community and individuals about health issues,
- ❑ Use Health District funds and resources to leverage other funds and resources for prioritized projects, and avoid unnecessary duplication of services,
- ❑ Promote health policy and system improvements at the local, state and national level,
- ❑ Continuously evaluate its programs and services for quality, value, and impact on the health of the community,
- ❑ Share our approaches, strategies, and results, and
- ❑ Oversee and maintain the agreements between Poudre Valley Health System, University of Colorado Health and the Health District on behalf of the community.

■ VALUES ■

- ❑ Dignity and respect for all people
- ❑ Emphasis on innovation, prevention and education
- ❑ Shared responsibility and focused collaborative action to improve health
- ❑ Information-driven and evidence-based decision making
- ❑ Fiscal responsibility/stewardship
- ❑ An informed community makes better decisions concerning health

HB21-1276: PREVENTION OF SUBSTANCE USE DISORDERS

Concerning the prevention of substance use disorders.

Details

Bill Sponsors:	House – <i>Kennedy (D) and Herod (D)</i> Senate – <i>Pettersen (D) and Priola (R)</i>
Committee:	House Health & Insurance House Appropriations
Bill History:	4/15/2021- Introduced in House 5/5/2021- House Health & Insurance Refer Amended to House Appropriations 5/14/2021- House Committee on Appropriations Refer Amended to House Committee of the Whole
Next Action:	5/21/2021- House Second Reading
Fiscal Note:	<u>May 12, 2021</u> ; for FY 2021-22, the bill requires appropriations of \$382,908 to Department of Human Services and \$13,000 to Department of Regulatory Agencies.

Bill Summary

The bill addresses a variety of policy issues related to the general topic of substance use disorder (SUD) prevention. The bill:

- Requires coverage of nonpharmacological alternatives to opioids
- Prohibits carriers from limiting or excluding coverage of atypical opioids or non-opioid medications as alternatives to opioids
- Continues opioid prescribing limitation indefinitely
- Limits the supply of a benzodiazepine that a prescriber may prescribe to a patient who has not been prescribed benzodiazepine in the last 12 months by that prescriber
- Continues indefinitely the requirement that providers query the [Prescription Drug Monitoring Program \(PDMP\)](#) before a second fill of an opioid
- Requires each health care provider to query the [program-PDMP](#) before prescribing or refilling prescription for a benzodiazepine
- Authorizes the Center for Research into Substance Use Disorder Prevention, Treatment, and Recovery Support Strategies ('the Center') to include provider education on best practices for benzodiazepine prescribing and the potential harm of limiting opioid prescriptions to chronic pain patients
- The Office of Behavioral Health (OBH), within the Department of Human Services (DHS), is to convene a collaborative concerning evidence-based prevention practices

Issue Summary

Levels of Prevention

Prevention encompasses a wide range of activities, which are distributed into three distinct categories: primary, secondary, and tertiary. Primary prevention aims to prevent injury or disease before it occurs by preventing exposure, altering behaviors, and increasing resistance to disease or injury.¹ Secondary prevention aims to reduce the impact of disease or injury that has occurred by early intervention, altering behaviors to prevent recurrence/re-injury, implementing programs to improve health, and preventing long-

¹ Institute for Work and Health (April 2015). *Primary, secondary, and tertiary prevention*. Retrieved from <https://www.iwh.on.ca/what-researchers-mean-by/primary-secondary-and-tertiary-prevention>

term problems. Finally, tertiary prevention aims to soften the impact of an ongoing injury or illness by helping people manage long-term issues that tend to be complex. The following graphic illustrates these three levels of prevention and some real world examples.²

Primary Prevention	Secondary Prevention	Tertiary Prevention
<p>Preventing disease before it happens</p> <p>Modifying existing risk factors: Bike helmets Tobacco cessation</p> <p>Preventing development of risk factors: Bike trails located away from vehicles Policies limiting youth from purchasing tobacco</p>	<p>Identifying disease before problems become serious</p> <p>Newborn screening Mammography Regular check ups for people who smoke BMI screening Blood pressure measurement</p>	<p>Preventing complications of disease</p> <p>Post-stroke rehabilitation Blood sugar-lowering medications for diabetes Physical therapy for back injury</p>

Statewide Strategic Plan

The Colorado Department of Human Services (DHS), Office of Behavioral Health (OBH) in conjunction with the Colorado Health Institute (CHI), published *Colorado's Statewide Strategic Plan for Primary Prevention of Substance Abuse: 2019-2024*.³ The plan's first objective is for the state to become a leader in prevention by creating public demand for prevention and funding it. Second, the state should have a prevention system that promotes tested and effective approaches. Third, the prevention workforce will be equipped to deliver high-quality prevention. Finally, an objective of the plan is for statewide prevention funders to align their resources and focus areas.

Alternatives to Opioids

In ~~the~~ 2017 ~~the~~ Colorado Chapter of the American College of Emergency Physicians (COACEP) adopted a strategy known as Alternatives to Opioids (ALTO) to greater utilize non-opioids for pain management.⁴ The ALTO strategy recommends the use of effective non-opioids and to use opioids as secondary treatment in the emergency department. The Colorado Hospital Association (CHA) utilized COACEP's ALTO strategies to initiate the Colorado Opioid Safety Pilot in 2017, which aimed to reduce opioid administration in 10 hospital emergency departments over 6 months.⁵ The Pilot achieved an average of 31.4 percent increase in administration of opioid alternatives, as well as an average of 36 percent reduction in opioid administration across the cohort of 10 emergency departments.⁵ Due to such success, the CHA has established the Colorado ALTO Project to integrate these practices in hospital emergency departments across the state.⁵

Some of these opioid alternatives include lidocaine, nitrous oxide, and nonsteroidal anti-inflammatory drugs (NSAIDs). Each non-opioid alternatives have their own risks, but when used for the pain conditions for which they are indicated, may be as effective as or more effective at reducing pain than opioids with a much lower

² Office of Primary Prevention, Tennessee Department of Health (n.d.) *Office of Primary Prevention*. Retrieved from <https://www.tn.gov/health/health-program-areas/office-of-primary-prevention.html>

³ OBH & CHI (March 2019). *Putting Prevention Science to Work: Colorado's Statewide Strategic Plan for Primary Prevention of Substance Abuse: 2019-2024*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/For%20Clearance%20II%20-%20Strategic%20Plan%20for%20Primary%20Prevention%20of%20Substance%20Abuse.pdf

⁴ Colorado ACEP (2017). *2017 Opioid Prescribing & Treatment Guidelines*. Retrieved from https://cha.com/wp-content/uploads/2018/01/COACEP_Opioid_Guidelines-Final.pdf

⁵ Colorado Hospital Association (2021). *Colorado ALTO Project*. <https://cha.com/opioid-safety/colorado-alto-project/>

risk of serious adverse effects. A recent study found the ibuprofen-acetaminophen combination was as effective as opioid-acetaminophen combinations in treating acute extremity pain in the emergency room.⁶

A federal report from the President's Commission found that federal and other payers' reimbursement policies create barriers to the adoption of non-opioid pain treatments.⁷ In the Colorado Health First program, many NSAIDs are covered by the pharmacy benefit, with many not requiring prior authorizations.⁵ Some of these drugs are not for home-use outside of a health facility so are not included in preferred drug lists for insurance plans.

Nonpharmacological Alternatives

Physical therapy mostly focuses on helping to restore or maintain the ability to move and walk, while occupational therapists focus on improving ability to perform activities of daily living and work. Exercise therapy has been shown to reduce pain and improve function in chronic low back pain and in osteoarthritis of the knee and hip and improve symptoms, function, and wellbeing in fibromyalgia.⁸ A presentation from the Colorado Chapter of the American Physical Therapist Association detailed the studies that have demonstrated that early access to physical therapy decreases opioid use while lowering costs.⁹ Decreasing the out-of-pocket costs associated with accessing physical therapy addresses a potential hurdle to early entrance to the service. The presenter also noted that third-party utilization reviews can delay or prevent physical therapy care for the patient. In the Colorado Medicaid program, a prescription for physical therapy services is required and 48 hours of physical therapy are allowed in a 12-month period.¹⁰ UnitedHealthcare began a pilot program in 2019 for enrollees in five states, which waives copays and deductibles for three physical therapy sessions for those with low back pain.¹¹

Acupuncture/acupressure are widely used for chronic pain despite mixed results in studies and uncertainty about mechanism of action. A meta-analysis of 29 randomized trials that compared acupuncture with "sham" acupuncture¹² showed a significant benefit for acupuncture for any of four conditions—chronic nonspecific musculoskeletal pain (e.g., low back pain, osteoarthritis, chronic headache, and shoulder pain). The researchers estimated that response rates for at least a 50 percent reduction in pain were 50 percent for real acupuncture, 42 percent for sham acupuncture, and 30 percent for no acupuncture.¹³ The risks associated with acupuncture are very low as adverse effects are exceedingly uncommon. Acupuncture has been found to be cost-effective relative to usual care or no treatment in subjects with back pain.¹⁴ Ohio's Medicaid program recently expanded its benefits to include 30 acupuncture and acupuncture plus electrotherapy visits a year for pain management by both acupuncturists and chiropractors.¹⁵

⁶ Chang AK, Bijur PE, Esses D, Barnaby DP, Baer J. Effect of a Single Dose of Oral Opioid and Nonopioid Analgesics on Acute Extremity Pain in the Emergency Department: A Randomized Clinical Trial. *JAMA*. 2017;318(17):1661–1667. doi:10.1001/jama.2017.16190

⁷ The President's Commission on Combating Drug Addiction and the Opioid Crisis. (Nov. 2017). *Final Report*. Retrieved from https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf

⁸ Dowell, D., Haegerich, T., & Davis, R. B. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. *CDC*.

⁹ Flynn, T. (2017). *Improved and Timely Access to Physical Therapy Decreases Opioid Use and Lowers Cost*. Retrieved from http://leg.colorado.gov/sites/default/files/apta_opioid_task_force_presentation_8.22.17.pdf.

¹⁰Centers for Medicare and Medicaid Services. (Feb. 9. 2018). *Colorado State Plan Amendment #17-0038*. Retrieved from <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-17-0038.pdf>

¹¹ PT in Motion (June 24, 2019). *UnitedHealthcare Announces New Pilot Program to Increase Access to Physical Therapist Services as Result of Collaboration with APTA*. Retrieved from <https://www.apta.org/PTinMotion/News/2019/06/24/UHCPilotAndStudy2019/>

¹² Another term for placebo acupuncture, which is performed away from established acupuncture points.

¹³ Vickers, A.J., Cronin, A.M., Maschino, A.C., et al. (2012). Acupuncture for chronic pain: individual patient data meta-analysis. *Arch Intern Med*; 172(19) 1444-53. doi: 10.1001/archinternmed.2012.3654.

¹⁴ Furlan, A. D., Sandoval, J. A., Mailis-Gagnon, A., & Tunks, E. (2006). Opioids for chronic noncancer pain: a meta-analysis of effectiveness and side effects. *CMAJ: Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, 174(11), 1589–1594. <http://doi.org/10.1503/cmaj.051528>

¹⁵ Schroeder, K. (Dec. 25, 2017). Ohioans with Medicaid can get acupuncture for pain next year. *Dayton Daily News*. Retrieved from <https://www.daytondailynews.com/news/local/ohioans-with-medicaid-can-get-acupuncture-for-pain-next-year/x4Nimi4R8jIRksnsyPumKP/>

Opioid Prescribing

Nationally, the opioid prescribing rate has decreased from 81.3 per 100 persons in 2012 to 46.7 per 100 persons in 2019.¹⁶ Although the prescribing amount, Morphine Milligram Equivalents (MME)¹⁷, has decreased nationally in the past few years to 640 MME per capita, it is still substantially above the 180 MME per capita that was measured in 1999.¹⁸

In 2019, the opioid prescribing rate in Colorado was 40 per 100 people, which has decreased from 73.5 prescriptions per 100 people in 2012.¹ State-specific research by the Colorado Department of Public Health and Environment (CDHPE) delineated that the number of opioid prescriptions per person increased with age.¹⁹ One quarter of Coloradans have admitted to using pain medications in ways that were not prescribed by their provider.²⁰ Similarly, 29 percent of Coloradans have use pain medications that were not prescribed to them.⁵ In Larimer County, the prescribing rate has dropped from 84.2 prescriptions per 100 people in 2012 to 52.7 prescriptions per 100 people in 2017.¹⁷

The Centers for Disease Control and Prevention (CDC) promulgated guidelines regarding the prescription of opioids in 2016.^{21,22} The CDC recommended that when prescribing opioids for acute pain it should be sufficient to prescribe a quantity for three or less days, and rarely for more than seven. That should be adequate to address the expected duration of pain severe enough to require opioids while decreasing the risk of long-term use. Furthermore, the guidelines suggest that the use of a PDMP can ensure that the patient is not taking any other opioids or could have a negative interaction between two prescriptions.

The Colorado Department of Health Care Policy and Financing (HCPF) has implemented rules for the Colorado Medicaid program that limited an initial opioid prescription to a 7-day supply and limited refills, with prior authorization required after four refills.²³ Additionally, HCPF limited dosages of opioids to a certain threshold (200 MME per day) for pain management and anything above that MME requires prior authorization.

In 2017, the Colorado Chapter of the American College of Emergency Physicians (COACEP) promulgated practice and policy recommendations regarding opioids.⁵ One of these practice recommendations is the frequent consultation of the PDMP by emergency department (ED) physicians. The recommendations also suggest prescribing the lowest effective dose in the shortest appropriate duration and refusing to refill lost or stolen opioid prescriptions. In the policy section, COACEP recommends that the Colorado PDMP develop an automated query system that can be more readily integrated into electronic health records.

Benzodiazepines

More than 30 percent of overdoses involving opioids also involve benzodiazepines, a type of prescription commonly prescribed for anxiety or to help with insomnia.²⁴ Common benzodiazepines include Valium,

¹⁶ CDC (Dec. 2020). *U.S. Opioid Dispensing Rate Maps*. Retrieved from <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html>

¹⁷ Morphine Milligram Equivalents is a value that is assigned to opioids to represent their relative potency to provide for the ease of comparison.

¹⁸ Guy GP Jr., Zhang K, Bohm MK, et al. (July 2017). Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015. *MMWR Morb Mortal Wkly Rep* 2017;66:697–704. doi: <http://dx.doi.org/10.15585/mmwr.mm6626a4>

¹⁹ Colorado Department of Public Health and Environment (July 2017). *Colorado Prescription Drug Profile*. Retrieved from https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_Colorado%20Rx%20Drug%20Data%20Profile.pdf

²⁰ Colorado Chapter of the American College of Emergency Physicians (2017). *2017 Opioid Prescribing and Treatment Guidelines: Confronting the Opioid Epidemic in Colorado's Emergency Departments*. Retrieved from http://coacep.org/docs/COACEP_Opioid_Guidelines-Final.pdf

²¹ Dowell D., Haegerich T.M., Chou R. (2016) *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016*. *MMWR Recommendation Report*; 65(No. RR-1):1–49. doi: <http://dx.doi.org/10.15585/mmwr.rr6501e1>

²² CDC (2021). *About CDC's Opioid Prescribing Guideline*. Retrieved from <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>

²³ HCPF (July 24, 2019) *Health First Colorado Initiatives Cut Opioid Use More than 50 Percent*. Retrieved from <https://www.colorado.gov/pacific/hcpf/news/health-first-colorado-initiatives-cut-opioid-use-more-50-percent>

²⁴ National Institute on Drug Abuse (NIDA) (March 2018). *Benzodiazepines and Opioids*. Retrieved from <https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids>

Xanax, and Klonopin. The 2016 CDC opioid prescribing guidelines included a recommendation that providers avoid prescribing benzodiazepines and opioids concurrently whenever possible.²¹ A study in North Carolina found that the overdose death rate in patients that had both medications was 10 times higher than those that only received opioids.²⁵ In 2017, 9.7 percent of patient prescription days in Colorado had overlapping opioid and benzodiazepine prescription use.²⁶

Continuing Education

There are many different types of providers that can prescribe opioids; all must complete continuing education (CE) to be certified by their respective accreditation boards and/or to receive licensure from the state. At the state level, different boards govern the licensure of providers that may be registered with the Drug Enforcement Administration (DEA) to prescribe opioids. Each board has different requirements for the providers regarding CE. However, the specific topics to be covered through the continuing education is not currently mandated by law or regulation. Due to the passage of SB19-228, all licensed health care providers²⁷ must also complete at least four credit hours of substance use prevention training per licensing cycle.²⁸ Currently there are a variety of venues where these providers can receive training on effective pain management, appropriate opioid prescribing practices, and substance use disorders. National certification groups have their own requirements for CE to maintain professional certification.

As of 2017, more than 100,000 Colorado physicians had participated in training and/or education on topics such as opioid misuse, prescribing practices, substance use treatment and other related issues.²⁹ The Colorado School of Public Health and the Colorado Consortium for Prescription Drug Abuse Prevention have previously partnered to develop and implement three online CE modules on the topic of prescribing practices for physicians, dentists, pharmacists, nurses and veterinarians.³⁰ The Provider Education Work Group of the Consortium has created live CE for prescribers on topics ranging from safe prescribing to MAT in primary care; as of 2017 these events had been delivered seven times to more than 300 providers.³¹ COPIC, a company that provides medical liability insurance to health professionals, allows insured providers to earn points to decrease their premium by attending their in-person and online education seminars, which include programs on opioid prescribing and pain management.³²

Prescription Drug Monitoring Program (PDMP)

The Colorado PDMP was first authorized by law in 2005 and was enhanced by law in 2014 to the program that is currently running.³³ 2017 legislation (SB17-146) expanded pharmacists and prescribers wider access to the PDMP for reasons such as dangerous side-effects, possible abuse and diversion issues (e.g. from animal patients to their owners), drug-to-drug interactions.³⁴ 2018 legislation (SB18-022) limited prescribers

²⁵ Dasgupta N, Funk MJ, Proescholdbell S, Hirsch A, Ribisl KM, Marshall S. Cohort Study of the Impact of High-Dose Opioid Analgesics on Overdose Mortality. *Pain Med Malden Mass*. 2016;17(1):85-98. doi:10.1111/pme.12907.

²⁶ Colorado Consortium for Prescription Drug Abuse Prevention (n.d.) *Consortium Dashboard*. Retrieved from <https://public.tableau.com/profile/omni#1/vizhome/RXConsortiumdashboard/Readmefirst>

²⁷ Licensed health care providers include: physicians, physician assistants, podiatrists, dentists, advance practice nurses with prescriptive authority, optometrists, and veterinarians.

²⁸ C.R.S. §12-30-114

²⁹ Colorado Medical Society. (Sept. 2017). *Colorado leads opioid prevention*. Retrieved from <http://www.cms.org/communications/colorado-leads-opioid-prevention>.

³⁰ Colorado School of Public Health, Center for Health, Work & Environment (n.d.). *Preventing Prescription Drug Abuse*. Retrieved from <http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CHWE/training/Online/Pages/RxAbuse.aspx>.

³¹ Valuck, R. (July 10 2017). *Presentation to the Colorado General Assembly Opioid and Other Substance Use Disorders Interim Study Committee*

³² COPIC (2017). *COPIC Education Catalog*. Retrieved from https://www.callcopic.com/resources/Documents/FINAL_CourseCatalog_04-17.pdf.

³³ Colorado Department of Regulatory Agencies (2014). *Colorado's Prescription Drug Monitoring Program- 2014 and Beyond* [Presentation]. Retrieved from https://www.deaiverison.usdoj.gov/mtgs/pharm_awareness/conf_2014/august_2014/gassen.pdf

³⁴ Colorado Legislative Council (2021). *Prescription Drug Monitoring Program Task Force Report*. http://www.leg.state.co.us/library/reports.nsf/xsp/.ibmmodes/domino/OpenAttachment/library/reports.nsf/81B40E0416B1ABD187257CE6005A3F76/AttachReport/2020_07_01_Consortium_Report_Final.pdf

to prescribing no more than a 7-day supply of opioid medication to a patient who had not received an opioid medication from that provider in the past calendar year, except in cases of transfer of care from another provider who had prescribed an opioid in the past 12 months, and/or in cases of cancer pain, chronic pain, or postsurgical pain.³⁴ Additionally, the law specified that providers need to check the PDMP before providing a second 7-day refill.³⁴ 2019 legislation (SB19-228), while requiring continuing education as mentioned above, also expanded PDMP access to elected coroners and medical examiners in the cases of patients who are subject to an autopsy and died under suspicious, unnatural, or unusual circumstances.³⁴

Through the PDMP, practitioners and pharmacists, even in other states, can query information on Colorado patients.³⁵ Pharmacies must upload prescription data during every business day for medications that are classified as Schedule II-V. Physicians are not required to query the PDMP, unless it is prior to prescribing a refill for an opioid, except in certain circumstances.³⁶ A study found that comprehensive use mandates that require use of the PDMP were associated with a 9.2 percent reduction in the probability of overlapping opioid prescriptions, a 6.6 percent reduction in the probability of having 3 or more opioid prescribers, and an 8 percent reduction in the probability of having overlapping opioid and benzodiazepine prescriptions.³⁷

This Legislation

Coverage for Nonpharmacological Alternatives to Opioids

Health benefit plans issued or renewed after January 1, 2023 must provide a cost-sharing benefit for nonpharmacological treatment for a patient with a pain diagnosis where an opioid might be prescribed. The benefit must include, at a cost-sharing amount not to exceed the amount for a primary care visit, a minimum of 6 physical therapy, 6 occupational therapy, 6 chiropractic, and 6 acupuncture visits. At the time of a person's initial visit for treatment, the professional shall notify the carrier that the person has started treatment.

Within a 120 days after the effective date of this section the Division of Insurance (DOI) must submit to the U.S. Department of Health and Human Services (HHS) its determination whether this requirement is an addition to essential health benefits and subject to defrayal by the state as well as a request that HHS confirm the DOI's determination within 60 days of this submission. The DOI shall implement this section if it receives confirmation from HHS that the coverage does not constitute an additional benefit requiring state defrayal or if 365 days have passed since the DOI submitted its request and HHS has failed to respond. The DOI must conduct an actuarial study to determine the effect, if any, this section has on premiums.

Atypical Opioid Coverage

A carrier that provides prescription drug benefits must provide coverage for at least one atypical opioid that has been approved by the FDA for the treatment of acute or chronic pain at the lowest tier of the carrier's drug formulary and not require step therapy or prior authorization. Also, the carrier is prohibited from requiring step therapy for the prescription and use of any additional atypical opioid medications that have been approved by the FDA for acute or chronic pain. The bill defines "atypical opioid" as a nonopioid analgesic with far lower fatality rates than pure opioid agonists.

Carrier Contracts with Physical Therapists, Occupational Therapists & Acupuncturists

A carrier that has a contract with a physical therapist, occupational therapist, or acupuncturist cannot:

- Prohibit the provider from providing a covered person information on the amount of their financial responsibility for the services

³⁵ Colorado Department of Regulatory Agencies (2018). *About Program*. Retrieved from <https://www.colorado.gov/pacific/dora-pdmp/about-program>

³⁶ C.R.S. § 12-280-404

³⁷ Bao, Y., Wen, K., Johnson, P., Jeng, P.J., Meisel, Z.F., & Schackman, B.R. (Oct. 2018). Assessing the Impact of State Policies for Prescription Drug Monitoring Programs on High-Risk Opioid Prescriptions. *Health Affairs* 37(10). Retrieved from <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0512>

- Penalize the provider for disclosing the covered person's financial responsibility or providing a more affordable alternative or
- Require the provider to charge or collect a copayment that exceeds the total charges submitted

If the Commissioner of Insurance determines that a carrier has not complied with these requirements, the carrier must develop and provide to the DOI for approval a corrective action plan or the DOI can use any of its enforcement powers to ensure carrier compliance.

Opioid/Benzodiazepine Prescribing Limits

The current limitations on opioid prescribing that were enacted with the passage of SB18-022 are continued in perpetuity instead of being repealed on September 1, 2021. This change is for all affected prescribers, including: dentists, physicians, physician assistants, advanced practice nurses with prescriptive authority, optometrists, podiatrists, and veterinarians. By November 1, 2021, the applicable Board for each prescriber must, through rulemaking, limit the supply of a benzodiazepine that a provider may prescribe to a patient who has not obtained a benzodiazepine prescription from that prescriber within the last 12 months. Except, the rules must not limit the supply of a benzodiazepine prescribed to treat a seizure disorder, alcohol withdrawal, or a neurological emergency event, including a posttraumatic brain injury. Prescribers can prescribe benzodiazepines electronically.

Continuing Education

Applicable prescriber licensing boards, in consultation with the Center for Research into Substance Use Disorder Prevention, Treatment, and Recovery Support Strategies (the Center), is to promulgate rules to establish competency-based continuing education requirements for licensed health-care providers to include the potential harm of inappropriately limiting prescriptions to chronic pain patients and best practices for prescribing benzodiazepines. In alignment with these rules, the Center must develop and implement continuing education activities that include best practices for prescribing benzodiazepines as well as the potential harm of inappropriately limiting opioid prescriptions to chronic pain patients. For all the continuing education activities developed by the Center for prescribers, there should be an emphasis on physicians, physician assistants, nurses, and dentists that serve underserved populations.

Prescription Drug Monitoring Program

The bill clarifies that a death investigation, not just an autopsy, of an individual is a valid reason for a medical examiner or coroner to query the PDMP.

The bill requires practitioners or their designee to query the PDMP before prescribing a benzodiazepine unless the medication is prescribed to treat a patient in hospice, a seizure or seizure disorder, alcohol withdrawal, or a neurological emergency event (including a post-traumatic brain injury). Additionally, the practitioner or their designee is required to query the PDMP before prescribing an opioid, current law only requires such a query in the case of a refill of an opioid.

The Pharmacy Board is allowed provide a means of sharing prescription information and electronic health records with the health information organization network to work collaboratively with the state health information exchanges. Use of the information is subject to privacy and security protections in state law and HIPAA.

Colorado Substance Use Disorders Prevention Collaborative

OBH is to convene and administer a "Colorado Substance Use Disorders Prevention Collaborative" that includes institutions of higher education, nonprofit agencies, and state agencies in order to gather feedback concerning evidence-based prevention practices. The mission of the collaborative is to:

- Coordinate with and assist state agencies and communities to strengthen the prevention infrastructure and implement a strategic plan for primary prevention of SUDs for state fiscal years 2021-2022 through 2024-2025
- Advance the use of tested and effective prevention programs through education, outreach, advocacy and technical assistance, with an emphasis on addressing the needs of underserved populations and communities
- Direct efforts to raise public awareness of cost savings of prevention
- Provide direct training and technical assistance to communities regarding tested and effective primary prevention programs
- Pursue local and state policy changes that enhance the use of tested and effective primary prevention programs
- Advise state agencies and communities regarding new and innovative primary prevention programs
- Support funding efforts in order to align funding and services and communicate with communities about funding strategies
- Work with key state and community stakeholders to establish a minimum standard for primary prevention programs
- Work with prevention specialists and existing training agencies to provide and support training to strengthen the prevention workforce

OBH and the collaborative are to establish community-based prevention coalitions and delivery systems to reduce substance misuse, implement effective primary prevention programs, and coordinate to provide prevention science training and continuing education to prevention specialists.

To implement the collaborative the General Assembly is to appropriate funds from the Marijuana Tax Cash Fund for state fiscal years 2021-2022 through 2024-2025. By September 1, 2022, every September 1 through 2025, OBH is to report its progress to the General Assembly. This section about the collaborative is repealed on September 30, 2025.

Appropriation

For FY 2021-22, \$382,908 is appropriated to DHS to be used by OBH to implement the bill.

Reasons to Support

Supporters assert that reducing prescribing will also reduce the quantity of drugs available for misuse and abuse. Creating this limit will reduce the chance that the development an opioid use disorder will develop in opioid naïve patients. Additionally, it decreases the possibility that excess opioid pills fall into the hands of someone other than the intended patient. In regards to adding benzodiazepines to the prescription limitations and the requirements surrounding the PDMP, there is a higher likelihood that patients would not mix the use of opioids and benzodiazepines, possibly decreasing the amount of overdoses involving those drugs. This bill protects the availability of these opioids and benzodiazepines products for those who have chronic illness, cancer, seizures, or have other qualifying events, which is a usual trepidation for consumers. The collaborative brings stakeholders together to reflect on evidence-based opioid use disorder prevention activities in order to best inform the future of prevention in the state.

Supporters

- | | |
|---------------------------------------|---|
| • Acupuncture Association of Colorado | • Colorado Occupational Therapist Association |
| • Community Reach Center | • Colorado Providers Association |
| • Colorado Coalition for the Homeless | • Jefferson Center for Mental Health |
| • Colorado Community Health Network | • Mental Health Colorado |
| • Colorado Coroners' Association | |

Reasons to Oppose

Opponents may say that this infringes on the business practices of health plans to ensure that their members are provided with appropriate, affordable, and quality care. Some may say that requiring specific benefit coverage for private plans in state statute interferes with the carrier's ability to complete its mission and goals effectively. Some assert that such benefit mandates could lead to higher premiums for Coloradans.

Some believe that policies that aggressively limit prescription opioid prescribing could drive people to turn to illicit drugs and injectable opioids, such as heroin. Some assert that this policy could force patients to live with inadequately treated pain, which could lead to other physical and behavioral health issues for the patient. A CDC analysis found that chronic pain may be an important contributor to suicide.³⁸ Opponents may also assert this bill is an intrusion into the provider-patient relationship and the practice of medicine.

Legislating PDMP checks could have the unintended consequence of taking up health care resources and time.

Opponents

- America's Health Insurance Plans
- Colorado Association of Health Plans
- Colorado Chamber of Commerce

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of date printed. For more information about this analysis or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.

³⁸ Petrosky E, Harpaz R, Fowler KA, et al. (2018) Chronic Pain Among Suicide Decedents, 2003 to 2014: Findings From the National Violent Death Reporting System. *Ann Intern Med*.169:448–455. doi: <https://doi.org/10.7326/M18-0830> Retrieved from <https://annals.org/aim/fullarticle/2702061/chronic-pain-among-suicide-decedents-2003-2014-findings-from-national>

GUN VIOLENCE PREVENTION MEASURES:
HB21-1299 & SB21-256

Policy Issue Summary

HB21-1299: Office of Gun Violence Prevention

This bill would create the Office of Gun Violence Prevention within the Department of Public Health and Environment (CDPHE). The bill requires the Office to launch and conduct public awareness campaigns to educate the public about existing resources related to gun violence prevention. Additionally, the bill allows the Office to establish and administer a grant program to support community-based organizations who use evidence-based strategies to interrupt cycles of gun violence, trauma, and retaliation. The Office is also required to create and maintain a gun violence research bank.

SB21-256: Local Regulation of Firearms

Current law prohibits a local government from enacting an ordinance, regulation, or other law that prohibits the sale, purchase, or possession of a firearm. The bill permits local governments to prohibit the sale, purchase, transfer, or possession of a firearm, ammunition, or firearm component or accessory that is not less restrictive than state laws. The bill permits a local government, including a special district, to enact an ordinance, resolution, rule, or other regulation that prohibits a permittee from carrying a concealed handgun in a building or specific area within the local government's or governing board's jurisdiction. For a special district, this would be in a building or specific area under the direct control or management of the district.

Background

Due to the compressed timeline that occurs at the end of the legislative session, staff was unable to complete in depth analyses of these bills.

About this Memo

This memo was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This memo is not a complete analysis of this policy issue. This memo is accurate to staff knowledge as of date printed. For more information about this memo or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.

Gun violence also takes a toll on Colorado's youth. More than 848 Coloradans under 25 years old were killed by a gun between 2015 and 2020.⁶ Additionally, experience with gun violence can leave children and young adults with enduring trauma that can develop into mental health concerns such as chronic stress and post-traumatic stress disorder (PTSD).¹

Gun Violence and the Federal Government⁷

In the early 1990s, public sentiment began to view gun violence as a public health concern. In 1992, the U.S. Centers for Disease Control and Prevention (CDC) began to fund research exploring gun injuries and gun violence prevention measures; in 1995, the agency spent \$2.6 million on gun injury research.

However, the National Rifle Association and guns rights activists were strongly opposed to gun violence research, labeling it a threat to America's constitutional rights to purchase and use firearms. U.S. Representative Jay Dickey of Arkansas led Congress to incorporate a provision to the 1996 federal spending bill, which controls the appropriations to the CDC and other agencies. The provision declared "[n]one of the funds made available in this title may be used, in whole or in part, to advocate or promote gun control." That year's spending bill also specified that the \$2.6 million the CDC had previously invested in gun injury research would be reallocated to traumatic brain injury research. CDC funding for research relating to firearms became and has remained effectively nonexistent. The Dickey Amendment has been included in each subsequent federal spending bill and was extended to the National Institutes of Health in 2011.

The amendment was narrowly adjusted in 2018 to permit the CDC authority to research the causes of gun violence. However, the productivity of such authority remains dependent on funding allocations.

Colorado Preemption of Local Control

Current Colorado law prohibits a local government from enacting an ordinance, regulation, or other law that prohibits the sale, purchase, or possession of a firearm.⁸

About this Document

This document was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This document is accurate to staff knowledge as of date printed. For more information about this summary or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.

⁶ CDPHE (2021). *Colorado Health Information Dataset (CoHID)*.

https://cohealthviz.dphe.state.co.us/t/HealthInformaticsPublic/views/COHIDFullDeathQuery_StateDemographyPopEstimates/MortalityStatistics?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no

⁷ National Institutes of Health. (July 2018). *The Dickey Amendment on Federal Funding for Research on Gun Violence: A Legal Dissection*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5993413/>

⁸ §§ 29-11.7-101 — 29-11.7-104

Health District
OF NORTHERN LARIMER COUNTY
BOARD OF DIRECTORS
SPECIAL MEETING
April 13, 2021

Health District Office Building
120 Bristlecone Drive, Fort Collins
Remote Meeting

MINUTES

BOARD MEMBERS PRESENT: Michael D. Liggett, Esq., Board President
Joseph Prows, MD MPH, Board Treasurer
Celeste Kling, J.D., Board Secretary & Liaison to UCH-North/PVH
Molly Gutilla, MS DrPH, Board Vice President
Johanna Ulloa Giron

Staff Present:

Carol Plock, Executive Director
Chris Sheafor, Support Services Director
James Stewart, Medical Director
Karen Spink, Assistant Director
Dana Turner, Dental Director
Richard Cox, Communications Director
Kristen Cochran-Ward, MH/SU Director
Lorraine Haywood, Finance Director

Staff Present:

Brian Ferrans, CIT Director
Alyson Williams, Policy Coordinator
MJ Jorgensen, Project Implementation Coord
Lin Wilder, Special Projects Director
Laura Mai, Assistant Finance Director
Anita Benavidez, Executive Assistant

CALL TO ORDER; WELCOME TO NEW MEMBER, INTRODUCTIONS & APPROVAL OF AGENDA

Director Michael Liggett called the meeting to order at 4:00 p.m.

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

The staff and Board members welcomed Johanna to the Board and each introduced themselves. Johanna shared that she is originally from Bogotá, Colombia but has been in the US for over 30 years. She has a Master's Degree in both Psychology and Social Work and values the importance of community and equity.

PUBLIC COMMENT

None

DISCUSSION & ACTIONS

Policy

Brief overview on Policy Process and Positions

Policy Coordinator Alyson Williams reviewed the process in which the Board takes a position on any given legislation. The Policy team determines prioritization of bills/issue, and which high priority bills require in-depth analysis or briefs. Prioritization is identified at three levels: Priority 1 are generally those bills with the potential to significantly impact the health of the community or Health District operations;

priority 2 bills have potential impact but less significant; and priority 3 bills are of interest. Analyses or briefs are presented to the Board, and the Board may or may not choose to take a position on the bill. If the Board elects to take a position, it may fall into the following categories: Strongly Support, Support, Oppose, Strongly Oppose, Neutral. For positions other than neutral, policy staff communicates the Board position to relevant policymakers and legislators; for ‘strong’ positions, staff may send to more legislators or take more action, such as testifying.

So far, legislators have been in session for 60 days, with 546 bills introduced, 82 bills killed or lost, 35 signed, and the Board has taken a position on 14 issues thus far. The general assembly may go through June 15, but the hope is to be done by Memorial Day.

State Legislative Proposals

State Budget:

SB21-205: 2021-22 Long Appropriations Bill (the Budget) will be heard in the House tomorrow. The total state budget is \$34.1B, an 11% increase from the prior year, \$13.1B of which is the General Fund. It places \$1.7B into reserves – the largest amount for a couple of decades, and earmarks \$800M for recovery from COVID & its economic distress. \$21M in new funding is slated for public health funding, both state and local.

Thus far 28 amendments have been offered with nine passing in the Senate. Budget issues of special interest to the Health District including continuation of the Senior Dental Program, and restoration of the Adult Dental Medical benefits cap to \$1,500/year. Programs included in the Colorado stimulus funds: (1) Small Business grants and sales tax relief; (2) Infrastructure “shovel-ready” projects including clean energy, main street revitalization and state park access; (3) Workforce including educator licensure, SNAP employment & training, training for re-entry from incarceration, etc.; (4) Rural dollars for wildlife, water plan, and rural economic development, drought response, local agriculture, etc.; and (5) Family support including school tutoring, mental health screenings in school, funding for the mental health hotline, etc.

SB21-199: Remove Barriers to Certain Public Opportunities

This bill removes the requirement to verify lawful presence for state or local public benefits. It repeals the prohibition for state agencies or political subdivision from entering into or renewing a public contract with a contractor who knowingly employs or contracts persons who are undocumented. It also repeals current law requiring state agencies and local governments to use secure and verifiable documents when providing services or issuing official documents. Action on the bill was laid-over to include amendments. It will likely have no impact on Federal regulations for immigration law.

MOTION: To strongly support SB21-199: Remove Barriers to Certain Public Opportunities
Moved/Seconded/Carried Unanimously

HB21-1150: Create the Colorado Office of New Americans.

This bill creates the Colorado Office of New Americans (ONA). The ONA serves as the point of contact for immigrant-serving state agencies, private sector organizations, and the public about immigrant issues in Colorado. As its main priority, the ONA is required to implement a statewide strategy to facilitate economic stability and promote successful economic, social, linguistic, and cultural integration by

investing in the success of immigrants in Colorado. Financing is primarily driven through gifts and grants but the bill has been set aside for appropriation. Board members expressed their desire for financing to be included in the Long Bill. There was significant discussion about use of the words “linguistic and cultural integration” and the need to ensure that “integration” does not become assimilation, resulting in the loss of an individual’s heritage.

MOTION: To support HB21-1150: Create the Colorado Office of New Americans, while encouraging clarification around “linguistic and cultural integration,” in order that it not become a mechanism that would cause the loss of an individual’s heritage.

Moved/Seconded/Carried Unanimously

HB21-1232: Standardized Health Benefit Plan Colorado Option.

The Colorado Health Insurance Option was a two-phased approach aimed at addressing the affordability of health insurance in Colorado. Phase One included the creation of a standardized insurance plan by the Division of Insurance (DOI) for carriers to offer in areas where they currently offer plans in both the individual and small group markets. It encouraged insurance carriers to work with other groups of the health care industry (i.e. hospitals, prescription drug manufacturers, providers) to reduce their insurance premiums by 6% each year over three years. Originally, if the cost reduction targets are not met, Phase Two would be triggered, and the State of Colorado would offer the standardized plan on individual and small group markets through the newly established Colorado Option Authority, a quasi-governmental entity.

In a major ‘strike-below’ amendment, the language that looks has the DOI create a Standardized Plan, and requires that carriers offer it, reducing premium rates by 6% over the next three years. Insurance carriers would have to work with hospitals and providers to cut costs. If carriers can’t get adequate networks, there is a provision that allows the Commissioner to compel participation. While the board was conceptually in favor of a standardized plan and reduction in costs, they were concerned about what and who it might impact, and potential unintended consequences.

MOTION: To take a Neutral/Monitoring position on HB21-1232: Standardized Health Benefit Plan Colorado Option

Moved/Seconded/Carried Unanimously

Update on SB21-085: Actuarial Review Health Insurance Mandate Legislation.

Concerning actuarial reviews of proposed legislation that may impose a new health benefit mandate on health benefit plans. In a prior review of the bill, the board recommended several amendments. Some have been made, including exclusion of public programs, doing actuarial reviews if a benefit is being cut/reduced (not just added), and a greater focus on health equity. Another amendment that the board supported was not amended: a mandate that results in a premium impact of less than 1% would be deemed negligible and not performed. There was significant discussion; the board appreciates the intent of the bill but is concerned that the budget would not result in comprehensive analyses, and it would be very difficult to provide timely and meaningful data.

MOTION: To take a position of mild opposition on SB21-085: Actuarial Review Health Insurance Mandate Legislation.

Moved/Seconded/Carried Unanimously

HB21-1198: Health Care Billing Requirements for Indigent Patients.

The bill requires hospitals to screen uninsured patients for health coverage options and potential financial assistance for which they may be eligible. Each hospital must use a uniform application developed by the Department of Health Care Policy and Financing (HCPF) when screening a patient. It also limits the amount that low-income patients pay for certain health services by tying what they owe to an established rate while also limiting the size of payments charged on a monthly basis. In addition, it prohibits hospitals from sending a patient to collections unless they have screened the patient for coverage and assistance, offered a fair payment plan, and provided information regarding patient rights. Amendments that are anticipated to be added include what rate to be used when Medicare doesn't have a rate to use, and the removal of providing a payment plan that doesn't exceed 5% of income for patients who are non-qualifying. Other potential amendments include its application to only hospitals and free standing emergency department; incorporating provider protections in the case of patients deliberately misreporting their income, and removing the provision regarding cancellation of debt after 36 months.

MOTION: To support HB21-1198: Health Care Billing Requirements for Indigent Patients, with the amendments listed above.

Moved/Seconded/Carried Unanimously

DISCUSSION**Brief Status Update, COVID and the Health District*****COVID and the Health District***

Executive Director Carol Plock provided an update on COVID-19 in Larimer County. The 7-day case rate has more than doubled over the past three weeks, with a positivity rate of 7.5% and hospitalizations on the rise. If it continues we could move back to Orange on the COVID dial. Larimer County has seen an increase in cases of the UK variant with 130 cases. Both the UK and California variants are spreading. We are seeing rising cases and higher positivity among children less than 10 and those 11-17 years of age. Larimer County remains a region of concern in the state and in an elevated state of case growth.

On the vaccine front, Larimer County has administered more than 233,000 doses, with 90,000 being fully vaccinated. Thirty percent of residents have gotten at least one dose. Larimer County's goal is to have 65% of those ages 16+ vaccinated with at least one dose by May 6. FEMA set up a mass vaccination site at The Ranch. They will be open Monday through Saturday, 10:00 am – 6:00 pm. A complication is the FDA/CDC/CDPHE recommendation to pause the J&J vaccines, as they review six cases of reported blood clots (out of 7M doses).

There are a number of equity clinics planned for this week. Our team had a successful pop-up clinic in Red Feather Lakes, vaccinating 161 very grateful residents. They also did a two-day pop-up clinic at the Cultural Enrichment Center, vaccinating just a bit under 200. The Health District team is poised to work with congregate shelters, beginning tomorrow, with two clinics at the Murphy Center, one at the Blue Spruce shelter, and one at Catholic Charities. Then on Sunday, they will run a clinic at Holy Family church, where there has been great response from the congregation. A mass vaccination site is scheduled at the Holiday Twin drive-in on April 25.

Regarding the Isolation, Recovery, and Quarantine (IRQ) site, three weeks passed without a guest but we now have two guests, one from county corrections and the other from the Blue Spruce shelter.

PUBLIC COMMENT (2nd opportunity)

None

ANNOUNCEMENTS

- April 27, 4:00 pm – Board of Directors Regular Meeting
- May 11, 4:00 pm – Board of Directors Special Meeting (Policy)
- May 25, 4:00 pm – Board of Directors Regular Meeting

ADJOURN

MOTION: To Adjourn the Meeting
Moved/Seconded/Carried Unanimously

The meeting was adjourned at 5:37 p.m.

Respectfully submitted:

Anita Benavidez, Assistant to the Board of Directors

Michael D. Liggett, Esq., Board President

Molly Gutilla, MS DrPH, Board Vice President

Celeste Kling, J.D., Board Secretary and Liaison to UCH-North and PVHS Board

Joseph Prows, MD MPH, Board Treasurer

Johanna Ulloa Giron

Health District
OF NORTHERN LARIMER COUNTY
BOARD OF DIRECTORS
REGULAR MEETING
April 27, 2021

Health District Office Building
120 Bristlecone Drive, Fort Collins
Remote Meeting

MINUTES

BOARD MEMBERS PRESENT: Michael D. Liggett, Esq., Board President
Joseph Prows, MD MPH, Board Treasurer
Celeste Kling, J.D., Board Secretary & Liaison to UCH-North/PVH
Molly Gutilla, MS DrPH, Board Vice President
Johanna Ulloa Giron

Staff Present:

Carol Plock, Executive Director
Chris Sheafor, Support Services Director
James Stewart, Medical Director
Karen Spink, Assistant Director
Richard Cox, Communications Director
Kristen Cochran-Ward, MH/SU Director
Lorraine Haywood, Finance Director
Brian Ferrans, CIT Director

Staff Present:

Jessica Shannon, Res. Development Coord.
Sue Hewitt, Evaluation Coordinator
Suman Mathur, Evaluator/Data Analyst
Alyson Williams, Policy Coordinator
Laura Mai, Assistant Finance Director
Anita Benavidez, Executive Assistant
Kevin Unger, President/CEO UCHealth-North

Public Present:

Stephane Cosby
Debra Herrick

CALL TO ORDER; INTRODUCTIONS & APPROVAL OF AGENDA

Director Michael Liggett called the meeting to order at 4:00 p.m.

MOTION: To approve the agenda as Presented
Moved/Seconded/Carried Unanimously

PUBLIC COMMENT

None

PRESENTATIONS

UCHealth North Report: Kevin Unger, President/CEO, provided a brief status update on COVID and PVH –the hospital currently has just under 40 COVID patients 13 in ICU. At 50 cases in ICU, they initiate incident command. Over the weekend, they experienced notable ICU capacity issues – in part because this is also a busy trauma season. Although the biggest challenge early in the pandemic was securing PPE, the current major challenge is staffing, particularly in qualified critical care staff. The nursing shortage may last for some time, in part because it is difficult to compete for nurses when there are so many opportunities to become a travelling professional and earn higher wages. There are efforts to expand new grad programs, but that is a long term solution and the need is immediate.

Major emphasis is currently on getting people vaccinated. They have delivered 615,000 doses of Pfizer and Moderna vaccine (no J & J has been received). After weeks of strong community interest, it is a

little disheartening to see, across the state, a lot of open clinic appointments with vaccine supply now becoming greater than demand. Northern Colorado is still filling clinics but that is expected to shift in the next couple of weeks. While providers in Larimer County are working to hit the goal of 65% vaccinated by the end of May, it may be hard to do without taking the vaccine out to more places instead of holding the mass clinics in limited locations. They are continually monitoring ICU capacity; the hope is that we do not experience another COVID surge, since that plus 'trauma season' (unintentional injuries that come with warmer weather) would create significant challenge.

UCHealth reports total FY2020 Community Benefit in the amounts of \$1.1B systemwide (up from \$933M in the prior year), and \$329M in northern Colorado (up from \$240M). These amounts include \$427M in systemwide uncompensated care (up from \$367M in the prior year), and \$109M in northern Colorado (up from \$68M). UCHealth North Community Health areas of focus include: (1) access to care including the Aspen club senior support services, a sexual assault nurse examiner, community paramedics, FMC cancer prevention initiative, and more; (2) behavioral health and suicide, including the ZERO suicide program, integrating behavioral health with primary care, etc.; and (3) substance use disorders, including ongoing work with alternatives to opioid pain management, prevention of alcohol & risk-related trauma in youth, medication-assisted addiction treatment services, and more.

Poudre Valley Hospital Master Plan: PVH is in need of upgrading. In 2019, the Board of Directors approved \$1.1M for design funding. The Master Plan will provide expansion of surgical/cardiac/GI and pulmonary departments interventional radiology, bring some interventional cardiac procedures back from MCR, renovate several areas including Pediatrics, Birthing Center, and Women's/Family Center, and create an improved lobby area and finishes that create a consistent feel across the campus. Projected budget is \$76M and the work, to be completed in two phases. Activity on the project should begin this year, with completion scheduled for 2023, just shy of PVH's 100-year anniversary.

UCHealth has had a strong focus on getting our community vaccinated in order to be able to return to normalcy. At this point, the strategy is changing from mass vaccine clinics by appointment to walk-in clinics to going out into the community; they are interested in going anywhere people are interested in getting vaccinated. While it is likely that vaccinations will eventually move to primary care offices, the current challenge is in storage, the size of the vials, and the 'no waste' requirements.

Plans for Mountain Crest: It has been determined that the current 28 beds is not adequate and that the need is for 40-44 behavioral health (BH) beds. Consideration is being given to the best way to expand - whether to expand and upgrade the current building, to build a new facility at the Harmony Campus (or another location), or to move the services back into PVH, since a lot of patients at MC have medical needs, and a lot of patients at PVH have BH needs. Services for adults will be separated from services for pediatrics/youth.

Hospice: They have been exploring the possibility of inpatient hospice for years, and are working on a potential trial concept. Pathways Hospice is also creating an inpatient hospice; the thinking is that UCHealth's would have a shorter length of stay and higher level of care, while Pathway's would be a longer length of stay.

Diversity, equity, inclusion and social determinants of health: UCHealth (system) has hired a Chief of Diversity officer, and has been focusing on their workforce - holding listening sessions with their staff to identify what has been done successfully, and what more can be done moving forward. They are conscious that they need to hear from a variety of different cultural perspectives (race/ethnicity, LGBTQ, etc.)

DISCUSSION & ACTIONS

Policy

Policy Coordinator Alyson Williams reported that the CO legislators have been in session for 74 days, with 581 bills introduced; 90 killed/lost; and 68 signed. The Board has taken a position on 19 issues.

State Legislative Proposals

State Budget:

The proposed 2021-2022 FY General Fund Budget is \$13.1B with House and Senate amendments for increases of: 2% for emergency medical transportation; \$1M for SBIRT training grant program (total budget to \$1.5M); \$2M for mental health screenings in school based health centers; \$5M for housing assistance; and \$1M for the Tony Grampsasouth Services Program.

Key Bill Updates on bills of interest:

Two bills have passed: HB21-1075: Remove the Term Illegal Alien, and SB21-211: Adult Dental Benefit. Bill SB21-085 Actuarial Analysis Health Benefit Legislation has been killed – Appropriations voted down the amendment.

HB21-1198 Health Care Billing for Indigent Patients update:

The board previously voted to support this bill if four amendments were made, and added a fifth suggestion. Three out of the five concerns were amended: narrowing the type of facility that the bill applies to; adding what rate should be used when a service doesn't have a Medicare rate; and removal of the requirement of a payment plan that does not exceed 5% of monthly income for patients who don't qualify under the bill. The concepts of incorporating provider protections in the case of patients who deliberately misrepresent their income or investigation of assets before debt cancellation were not changed. Whether or not there will be an excessive administrative burden for hospitals is not determined; UCHHealth doesn't think it will be a burden, but smaller hospitals are more concerned; HCPH has agreed to shoulder some of the initial work to assist hospitals.

**MOTION: To support HB21-1198: Health Care Billing for Indigent Patients, as amended.
*Moved/Seconded/Carried Unanimously***

HB21-1232 Colorado Standardized Plan update:

A 'grand bargain' appears to have been struck, which would offer a standardized health insurance plan for the individual and small group market, with an expectation of premium reduction rates of 6% per year for three years. The reimbursement rates for hospitals have a floor of 165% of Medicare rates; for providers, the floor is 135% of Medicare rate for their specific geographic region. There is no adjustment for acuity and quality. Hospitals and providers will be required to accept rates if it is deemed necessary in order to have network adequacy. Some groups, including the Colorado Medical Society and specialty groups, are opposed; others are still looking for amendments, and many advocacy groups are in support. Analysis to come.

SB21-181: Health Equity Strategic Plan Address Health Disparities

This bill renames the Health Disparities Grant Program to the Health Disparities and Community Grant Program and expands its functions. It also expands the makeup of the Health Equity Commission and directs the development of an Equity Strategic Plan to coordinate state agencies' work in addressing social determinants of health disparities. Starting January 1, 2022, the office must issue a biennial report on health disparities in Colorado by race and ethnicity that includes an assessment of social determinants of health and recommend strategies to address inequities, to be used in strategic planning.

**MOTION: To support SB21-181: Health Equity Strategic Plan Address Health Disparities
*Moved/Seconded/Carried Unanimously***

SB21-194: Maternal Health Providers

Key points in this bill include: (1) A requirement for state regulated health plans and Medicaid to reimburse health professionals that provide services related to labor and delivery in a way that promotes high-quality, cost-effective care, prevents risk in subsequent pregnancy, and does not discriminate based on the type of provider or facility. (2) Labor and delivery health care professionals must implement best practices for interprofessional collaboration and the transfer of a pregnant woman from home or a birthing center to a health facility. (3) CDPHE and the Colorado Maternal Mortality Review Committee must make recommendations to improve numerous topics related to maternal health. (4) HCPF must seek an amendment to the state Medicaid plan and the Children's Health Plan Plus (CHP+) to provide 12 months of postpartum medical benefits to persons who qualified for benefits while pregnant. This is part of a package of bills trying to address birth equity. Ms. Williams noted that Native Americans are the population at highest risk in Colorado.

MOTION: To support bullet points 2 & 3, and strongly support bullet point 4 of SB21-194: Maternal Health Providers.
Moved/Seconded/Carried Unanimously

SB21-242: Housing Development Grants Hotels Tenancy Support Program

The bill allows the Division of Housing within the Department of Local Affairs (DOLA) to use the housing development grant fund for rental assistance, tenancy support service programs, and awarding grants and loans to local governments and nonprofit organizations for the purchase of underutilized hotels, underutilized motels, and other underutilized properties. The bill expands those who are eligible to benefit from these programs to include unhoused individuals and transfers \$15 million from the General Fund to the Housing Development Grant Fund specifically for those purposes. It requires DOLA to report on the programs provided to unhoused individuals as well as the grants and loans awarded.

MOTION: To support SB21-242: Housing Development Grants Hotels Tenancy Support Program
Moved/Seconded/Carried Unanimously

SB21-243: Colorado Department of Public Health and Environment Appropriation Public Health Infrastructure

For each of the 2021-22, 2022-23, and 2023-24 state fiscal years, the bill requires the General Assembly to appropriate \$21,090,149 to the Department of Public Health and Environment as follows: \$10,000,000 for distributions to local public health agencies and \$11,090,149 for CDPHE's disease control and public health response. Funding will be provided to agencies capable of assessing and responding to the need including local or state public health agencies.

MOTION: To support SB21-243: Colorado Department of Public Health and Environment Appropriation – Public Health Infrastructure
Moved/Seconded/Carried Unanimously

American Jobs Plan and the American Families Plan:

There is no legislation yet, but items being discussed in the Jobs Plan include affordable housing, expanded access to long term care services under Medicaid, protections from future pandemics, etc. An American Families plan is being discussed. Funding for the \$1.8T plan would come from taxes applied to high-end earners, and key programs being discussed would include: national child care and PreK; paid family leave, and tuition-free community college. Rep. Neguse has led a request to include an expansion of Medicare by lowering the eligibility age, expanding Medicare benefits to include vision & dental, and include an out-of-pocket cap; and empowering Medicare to negotiate drug prices for all Americans.

Ms. Williams announced that she will be leaving the Health District because her husband was accepted into a PA program in Utah. She will be working for the United Way.

DISCUSSION & ACTIONS

Employee Appreciation and Well-Being (COVID) Concept

Ms. Plock noted the memo included in today's Board packet. Health District staff have gone all out to help the community in unusual ways during the pandemic. In recognizing their incredibly hard work in the constantly changing environment, and the new ways the Health District has been able to provide assistance to the community, leadership would like to thank staff for all their efforts, and provide assistance that would help staff have a little extra time to recover a little in the last half of the year. In an effort to show our deep appreciation, they recommend that we offer extra PTO time. All employees would receive two extra days of PTO; those whose jobs have required extraordinary commitment could receive up to an additional five days. It is important to note that this would require a reduction of certain scheduling and productivity expectations, and extension of some timelines, and other adjustments, in order to allow people to take some extended time off. The board was strongly supportive.

MOTION: To approve the additional time off and the reduction in productivity for the second half of 2021.

Moved/Seconded/Carried Unanimously

A board comment was to use this experience to develop plans for future situations.

OTHER UPDATES & REPORTS

COVID – Dr. James Stewart

Dr. Stewart provided an update on COVID around the globe, noting that there are some tragic hotspots (India in particular), while there have been real success stories in other locations – the UK and Israel. The US sits in the middle of the pack. Most places in the US are doing well with case rates, although Colorado and a few other states are not as good. Nationally, cases are down about 33% from a week ago. Hospitalizations are down about 9% and the 7-day case average is at 650/day. The 4th wave nationally seems to be starting to trend down. In Larimer County, cases have been flat the last week or two. Those 18-44 are now the hardest hit group, and our community still has challenges in providing a proportionate share of vaccines to the Latinx and nonwhite, non Latinx population. Roughly 56% of LC residents over the age of 16 have received at least the first dose. Confirmed COVID deaths in Larimer County have dropped significantly. The CDC reports 7,157 breakthrough COVID infections (.008%) with 2,078 cases asymptomatic. A “real-world” large medical center trial reports high efficacy for the both the Pfizer and Moderna vaccines, and Moderna reports that COVID-19 protection remains strong at six months.

Vaccine Report – Suman Mather

Ms. Mather provided an update on the Health District's vaccination clinic efforts. To date, the Health District has delivered 1, 522 doses with five clinics, totaling 319 first dose vaccinations in February; four clinics and 2 mobile clinics with 396 served in March; and two clinics along with multiple mobile clinics reaching 807 including a clinic at the Holiday Twin Drive-In (focusing on Hispanic/Latinx community members) that served over 100. Most of the mobile clinics in April were part of the equity effort (Vaccine for All). 44% of those vaccinations by the Health District went to BIPOC and/or Hispanic/Latinx populations. Staff hopes to have more J&J vaccine available and are looking at Mason Place, SummitStone, and rural areas for future first doses.

Executive Director Updates – Carol Plock

Ms. Plock provided an update on status of the Isolation/Recovery and Quarantine facility for those experiencing homelessness on Myrtle. There are currently six guests, and staff is working on an exit plan by the end of May. Homeward Alliance has found a hotel option that will accept COVID positive guests. They received a specific grant to pay for rooms and food. There may be a continuing need for transportation. In other news, Ms. Plock received a package that contained an official commemorative Easter Egg from the White House, passed along by Salud in recognition for all our work responding to the COVID-19 pandemic.

PUBLIC COMMENT (2nd opportunity)

None

CONSENT AGENDA

- Approval of Minutes for the March 9 and March 16 Special Meetings; and the March 23, 2021 Regular Board Meeting
- Revised October and November 2020 Financials; January and February 2021 Financials

MOTION: To approve the consent agenda

Moved/Seconded/Carried Unanimously

Planning for the annual retreat, work session, and 6-month post annual review will happen in May.

ANNOUNCEMENTS

- May 11, 4:00 pm – Board of Directors Special Meeting (Policy)
- May 25, 4:00 pm – Board of Directors Regular Meeting
- June 22, 4:00 –m – Board of Directors Regular Meeting

ADJOURN

MOTION: To Adjourn the Meeting

Moved/Seconded/Carried Unanimously

The meeting was adjourned at 6:03 p.m.

Respectfully submitted:

Anita Benavidez, Assistant to the Board of Directors

Michael D. Liggett, Esq., Board President

Molly Gutilla, MS DrPH, Board Vice President

Celeste Kling, J.D., Board Secretary and Liaison to UCH-North and PVHS Board

Joseph Prows, MD MPH, Board Treasurer

Johanna Ulloa Giron

HEALTH DISTRICT
of Northern Larimer County
March 2021
Summary Financial Narrative

Revenues

The Health District is 1.5 % behind year-to-date tax revenue projections. Interest income is 84.1% behind year-to-date projections. Lease revenue is at year-to-date projections. Yield rates on investment earnings decreased slightly from 0.45% to 0.38% (based on the weighted average of all investments). Fee for service revenue from clients is 28.6% behind year-to-date projections and revenue from third party reimbursements is 11.2% behind year-to-date projections. Total operating revenues for the Health District (excluding grants and special projects) are 2.0% behind year-to-date projections.

Expenditures

Operating expenditures (excluding grants and special projects) are 19.5% behind year-to-date projections. Program variances are as follows: Administration 11.2%; Board 70.2%; Connections: Mental Health/Substance Issues Services 26.2%; Dental Services 17.9%; MH/SUD/Primary Care 18.1%; Health Promotion 17.1%; Community Impact 21.9%; Program Assessment and Evaluation 13.4%; Health Care Access 15.1%; and Resource Development 13.3%.

Capital Outlay

Capital expenditures are 0.2% behind year-to-date projections.

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY
BALANCE SHEET
As of 3/31/2021

ASSETS

Current Assets:	
Cash & Investments	\$4,922,925
Accounts Receivable	49,227
Property Taxes Receivable	6,534,574
Specific Ownership Tax Receivable	66,020
Prepaid Expenses	54,786
Total Current Assets	<u>11,627,532</u>
Property and Equipment	
Land	4,592,595
Building and Leasehold Improvements	7,171,247
Equipment	1,191,400
Accumulated Depreciation	<u>(2,974,682)</u>
Total Property and Equipment	<u>9,980,560</u>
Total Assets	<u><u>21,608,093</u></u>

LIABILITIES AND EQUITY

Current Liabilities:	
Accounts Payable	942,246
Deposits	7,786
Deferred Revenue	432,518
Total Current Liabilities	<u>1,382,550</u>
Long-term Liabilities:	
Compensated Absences Payable	50,250
Total Long-term Liabilities	<u>50,250</u>
Deferred Inflows of Resources	
Deferred Property Tax Revenue	4,765,539
Total Deferred Inflows of Revenues	<u>4,765,539</u>
Total Liabilities & Deferred Inflows of Resources	<u>6,198,339</u>
EQUITY	
Retained Earnings	13,900,525
Net Income	1,509,228
TOTAL EQUITY	<u>15,409,754</u>
TOTAL LIABILITIES AND EQUITY	<u><u>21,608,093</u></u>

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY
STATEMENT OF REVENUES AND EXPENSES
As of 3/31/2021

	<u>Current Month</u>	<u>Year to Date</u>
Revenue		
Property Taxes	1,769,034	3,509,429
Specific Ownership Taxes	66,020	162,047
Lease Revenue	96,697	290,090
Interest Income	977	4,137
Fee For Service Income	12,492	29,811
Third Party Income	64,406	195,722
Grant Income	54,548	121,175
Special Projects	30	3,286
Miscellaneous Income	8,145	12,745
Total Revenue	<u>2,072,349</u>	<u>4,328,441</u>
Expenses:		
Operating Expenses		
Administration	90,014	233,149
Board Expenses	620	3,371
Connections: Mental Health/Substance Issues Svcs	124,393	392,043
Dental Services	261,009	792,131
Integrated Care (MHSA/PC)	79,676	249,643
Health Promotion	56,276	177,726
Community Impact	43,782	139,240
Program Assessment & Evaluation	19,106	57,406
Health Care Access	77,265	255,793
Resource Development	13,518	41,866
Mulberry Offices	8,970	16,799
Special Projects	82,896	293,522
Grant Projects	35,462	108,930
Total Operating Expenses	<u>892,986</u>	<u>2,761,620</u>
Depreciation and Amortization		
Depreciation Expense	20,453	57,593
Total Depreciation and Amortization	<u>20,453</u>	<u>57,593</u>
Total Expenses	<u>913,439</u>	<u>2,819,213</u>
Net Income	<u><u>1,158,909</u></u>	<u><u>1,509,228</u></u>

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY
Statement of Revenues and Expenditures - Budget and Actual
As of 3/31/2021

	Current Month			Year to Date			Annual	Remaining
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Funds
Revenue:								
Property Taxes	\$1,031,850	\$1,769,034	\$737,184	\$3,574,400	\$3,509,429	(\$64,971)	\$8,274,968	\$4,765,539
Specific Ownership Taxes	45,311	66,020	20,709	153,329	162,047	8,718	650,000	487,953
Lease Revenue	96,697	96,697	0	290,090	290,090	0	1,183,569	893,478
Interest Income	12,000	977	(11,023)	26,000	4,137	(21,863)	130,000	125,863
Sales Revenue	50	0	(50)	150	0	(150)	600	600
Fee for Services Income	13,923	12,492	(1,432)	41,770	29,811	(11,959)	167,081	137,270
Third Party Reimbursements	73,472	64,406	(9,066)	220,417	195,722	(24,695)	881,666	685,944
Grant Revenue	58,640	54,548	(4,092)	199,712	121,175	(78,537)	1,404,188	1,283,013
Partnership Revenue	2,058	30	(2,028)	6,174	3,286	(2,887)	24,695	21,409
Donations Sponsorships/Fundraising	0	30	30	0	30	30	0	(30)
Miscellaneous Income	1,635	8,145	6,509	4,906	12,745	7,839	19,625	6,880
Total Revenue	\$1,335,637	\$2,072,379	\$736,742	\$4,516,948	\$4,328,471	(\$188,477)	\$12,736,392	\$8,407,920
Expenditures:								
Operating Expenditures								
Administration	\$87,292	\$90,014	(\$2,722)	\$262,616	\$233,149	\$29,466	\$922,767	\$689,618
Board Expenses	4,468	620	3,848	11,303	3,371	7,932	75,523	72,152
Connections: Mental Health/Substance Issues Svcs	176,521	124,393	52,128	531,347	392,043	139,305	2,121,411	1,729,368
Dental Services	321,162	261,009	60,153	964,300	792,131	172,169	3,864,795	3,072,664
Integrated Care (MH/SUD/PC)	101,223	79,676	21,547	304,866	249,643	55,223	1,219,791	970,148
Health Promotion	71,463	56,276	15,187	214,283	177,726	36,557	865,158	687,432
Community Impact	59,078	43,782	15,296	178,359	139,240	39,119	713,580	574,340
Program Assessment & Evaluation	21,979	19,106	2,873	66,293	57,406	8,887	265,194	207,788
Health Care Access	100,004	77,265	22,739	301,312	255,793	45,520	1,208,842	953,049
Resource Development	16,105	13,518	2,588	48,316	41,866	6,450	193,262	151,396
Mulberry Office	15,961	8,970	6,990	47,882	16,799	31,083	191,529	174,730
Contingency (Operations)	0	0	0	0	0	0	60,000	60,000
Special Projects	146,627	82,896	63,731	438,882	293,522	145,360	2,673,230	2,379,708
Grant Projects	55,695	35,462	20,233	190,878	108,930	81,948	1,404,188	1,295,258
Total Operating Expenditures	\$1,177,577	\$892,986	\$284,591	\$3,560,637	\$2,761,620	\$799,017	\$15,779,270	\$13,017,650
Net Income	\$158,060	\$1,179,392	\$1,021,332	\$956,311	\$1,566,852	\$610,541	(\$3,042,878)	(\$4,609,730)

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF NON OPERATIONAL EXPENDITURES - BUDGET TO ACTUAL

For 3/1/2020 to 3/31/2020

	<u>Current Month</u> <u>Budget</u>	<u>Current Month</u> <u>Actual</u>	<u>Current Month</u> <u>Variance</u>	<u>Year to Date</u> <u>Budget</u>	<u>Year to Date</u> <u>Actual</u>	<u>Year to Date</u> <u>Variance</u>	<u>Annual Budget</u>	<u>Annual Funds</u> <u>Remaining</u>
Non-Operating Expenditures								
Building	-	-	-	2,757,000	2,750,131	6,869	2,818,500	68,369
Capital Equipment	5,000	-	5,000	5,000	-	5,000	14,300	14,300
General Office Equipment	-	-	-	-	-	-	60,000	60,000
Medical & Dental Equipment	-	11,950	(11,950)	40,000	46,596	(6,596)	121,775	75,179
Computer Equipment	-	-	-	-	-	-	-	-
Computer Software	-	-	-	-	-	-	-	-
Equipment for Building	-	-	-	5,700	5,670	30	57,700	52,030
Total Non-Operating Expenditures	<u>\$ 5,000</u>	<u>\$ 11,950</u>	<u>\$ (6,950)</u>	<u>\$ 2,807,700</u>	<u>\$ 2,802,398</u>	<u>\$ 5,302</u>	<u>\$ 3,072,275</u>	<u>\$ 269,877</u>

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY
Statement of Program Revenues and Expenditures - Budget and Actual
As of 3/31/2021

	Current Month			Year to Date			Annual	Remaining
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Funds
<u>Administration</u>								
Revenue:								
Miscellaneous Income	\$875	\$7,452	\$6,577	\$2,625	\$7,452	\$4,827	\$10,500	\$3,048
Total Revenue	875	7,452	6,577	2,625	7,452	4,827	10,500	3,048
Expenditures:								
Salaries and Benefits	47,970	43,099	4,871	143,910	132,836	11,074	575,638	442,802
Supplies and Purchased Services	39,322	46,915	(7,593)	118,706	100,314	18,393	347,129	246,815
Total Expenditures	87,292	90,014	(2,722)	262,616	233,149	29,466	922,767	689,618
<u>Board of Directors</u>								
Expenditures:								
Salaries and Benefits	0	0	0	0	1,191	(1,191)	8,612	7,421
Supplies and Purchased Services	2,468	620	1,848	7,303	2,180	5,123	37,911	35,731
Election Expenses	2,000	0	2,000	4,000	0	4,000	29,000	29,000
Total Expenditures	4,468	620	3,848	11,303	3,371	7,932	75,523	72,152
<u>Connections: Mental Health/substance Issue</u>								
Revenue:								
Fees, Reimbursements & Other Income	2,083	4,139	2,056	6,250	7,182	932	25,000	17,818
Total Revenue	2,083	4,139	2,056	6,250	7,182	932	25,000	17,818
Expenditures:								
Salaries and Benefits	149,724	107,538	42,186	449,172	324,174	124,998	1,796,687	1,472,513
Supplies and Purchased Services	26,797	16,855	9,942	82,176	67,869	14,307	324,724	256,855
Total Expenditures	176,521	124,393	52,128	531,347	392,043	139,305	2,121,411	1,729,368
<u>Dental Services</u>								
Revenue:								
Fees, Reimbursements & Other Income	54,982	60,696	5,714	164,945	178,005	13,060	659,779	481,774
Total Revenue	54,982	60,696	5,714	164,945	178,005	13,060	659,779	481,774
Expenditures:								
Salaries and Benefits	260,167	219,127	41,041	780,502	670,218	110,284	3,122,009	2,451,791
Supplies and Purchased Services	60,995	41,882	19,112	183,798	121,913	61,885	742,786	620,873
Total Expenditures	321,162	261,009	60,153	964,300	792,131	172,169	3,864,795	3,072,664

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY
Statement of Program Revenues and Expenditures - Budget and Actual
As of 3/31/2021

	Current Month			Year to Date			Annual	Remaining
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Funds
<u>Integrated Care (MHSA/PC)</u>								
Revenue:								
Fees, Reimbursements & Other Income	17,106	0	(17,106)	51,319	0	(51,319)	205,275	205,275
Total Revenue	17,106	0	(17,106)	51,319	0	(51,319)	205,275	205,275
Expenditures:								
Salaries and Benefits	90,153	74,207	15,946	270,458	230,989	39,469	1,081,834	850,845
Supplies and Purchased Services	11,070	5,469	5,601	34,408	18,654	15,753	137,957	119,303
Total Expenditures	101,223	79,676	21,547	304,866	249,643	55,223	1,219,791	970,148
<u>Community Impact</u>								
Revenue:								
Fees, Reimbursements & Other Income	0	0	0	0	0	0	0	0
Total Revenue	0	0	0	0	0	0	0	0
Expenditures:								
Salaries and Benefits	51,732	40,334	11,398	155,197	129,980	25,217	620,789	490,809
Supplies and Purchased Services	7,346	3,447	3,898	23,162	9,261	13,901	92,791	83,530
Total Expenditures	59,078	43,782	15,296	178,359	139,240	39,119	713,580	574,340
<u>Program Assessment & Evaluation</u>								
Revenue:								
Fees, Reimbursements & Other Income	0	0	0	0	0	0	0	0
Total Revenue	0	0	0	0	0	0	0	0
Expenditures:								
Salaries and Benefits	18,778	16,866	1,912	56,333	52,361	3,973	225,333	172,972
Supplies and Purchased Services	3,201	2,240	961	9,960	5,046	4,914	39,861	34,815
Total Expenditures	21,979	19,106	2,873	66,293	57,406	8,887	265,194	207,788
<u>Health Promotion</u>								
Revenue:								
Fees, Reimbursements & Other Income	700	100	(600)	2,101	100	(2,001)	8,402	8,302
Total Revenue	700	100	(600)	2,101	100	(2,001)	8,402	8,302
Expenditures:								
Salaries and Benefits	57,328	49,424	7,904	171,984	154,542	17,442	687,936	533,394
Supplies and Purchased Services	14,135	6,852	7,283	42,299	23,184	19,115	177,222	154,038
Total Expenditures	71,463	56,276	15,187	214,283	177,726	36,557	865,158	687,432

Unaudited - For Management Use Only

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY
Statement of Program Revenues and Expenditures - Budget and Actual
As of 3/31/2021

	Current Month			Year to Date			Annual	Remaining
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Funds
Health Care Access								
Revenue:								
Fees, Reimbursements & Other Income	0	0	0	0	0	0	0	0
Total Revenue	0	0	0	0	0	0	0	0
Expenditures:								
Salaries and Benefits	81,971	69,581	12,389	245,912	220,111	25,801	983,647	763,536
Supplies and Purchased Services	18,033	7,684	10,350	55,401	35,682	19,719	225,195	189,513
Total Expenditures	100,004	77,265	22,739	301,312	255,793	45,520	1,208,842	953,049
Resource Development								
Revenue:								
Fees, Reimbursements & Other Income	0	0	0	0	0	0	0	0
Total Revenue	0	0	0	0	0	0	0	0
Expenditures:								
Salaries and Benefits	13,946	12,648	1,298	41,838	39,332	2,506	167,352	128,020
Supplies and Purchased Services	2,159	869	1,290	6,478	2,534	3,944	25,910	23,376
Total Expenditures	16,105	13,518	2,588	48,316	41,866	6,450	193,262	151,396
Mulberry Offices								
Revenue:								
Fees, Reimbursements & Other Income	13,335	12,656	(679)	40,004	42,586	2,582	160,016	117,430
Total Revenue	13,335	12,656	(679)	40,004	42,586	2,582	160,016	117,430
Expenditures:								
Salaries and Benefits	0	0	0	0	0	0	0	0
Supplies and Purchased Services	15,961	8,970	6,990	47,882	16,799	31,083	191,529	174,730
Total Revenue	15,961	8,970	6,990	47,882	16,799	31,083	191,529	174,730

Health District of Northern Larimer County

Investment Schedule March 2021

Investment	Institution	Current Value	%	Current Yield	Maturity
Local Government Investment Pool	COLOTRUST	\$ 1,383	0.031%	0.01%	N/A
Local Government Investment Pool	COLOTRUST	\$ 3,129,046	69.015%	0.07%	N/A
Flex Savings Account	First National Bank	\$ 138,440	3.053%	0.05%	N/A
Certificate of Deposit	Advantage Bank	\$ 140,656	3.102%	1.60%	12/27/2021
Certificate of Deposit	Advantage Bank	\$ 113,764	2.509%	2.15%	9/2/2021
Certificate of Deposit	Points West	\$ 115,322	2.544%	0.70%	12/12/2021
Certificate of Deposit	Points West	\$ 156,147	3.444%	1.00%	4/2/2022
Certificate of Deposit	Adams State Bank	\$ 239,075	5.273%	1.59%	10/7/2021
Certificate of Deposit	Cache Bank & Trust	\$ 250,000	5.514%	1.01%	1/9/2021
Certificate of Deposit	Farmers Bank	\$ 250,000	5.514%	0.65%	6/27/2022
Total/Weighted Average		<u>\$ 4,533,833</u>	<u>100.000%</u>	<u>0.38%</u>	

Notes:

The local government investment pool invests in U.S. Treasury securities, U.S. Government agency securities, certificate of deposits, commercial paper, money market funds and repurchase agreements backed by these same securities.