Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS MEETING

March 27, 2018
4:00 pm

Health District of Northern Larimer County
120 Bristlecone Drive
Fort Collins, CO

Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS MEETING
March 27, 2018
4:00 pm
Health District, 1st Floor Conference Room

AGENDA

4:00 p.m. **Board Refreshments**

4:05 p.m. **Call to Order; Introductions; Approval of Agenda** ..... Michael Liggett

4:08 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. **PRESENTATIONS**
- Larimer Health Connect: Results of Last Open Enrollment and Future ..... Karen Spink

4:25 p.m. **DISCUSSION & ACTIONS**
- Policy ..... Alyson Williams
  - **Federal Issues**
    - Omnibus Spending Bill; Trump Opioid Plan
  - **State Issues**
    - Updates (Amendments to HB18-1003 – Opioid Misuse Prevention, HB18-1007 – SUD Coverage and Payment, and HB18-1136 – SUD Residential an Inpatient Treatment
    - HB18-1284 – Disclosure of Prescription Drug Prices
    - HB18-1279 – E-prescribing Controlled Substances
    - SB18-214 – Section 1115 Medicaid Waiver for Work Requirements and Lifetime Limits
- Revisions to Employee Handbook ..... Chris Sheafor
- Larimer County Community Health Improvement Plan Priorities ..... Carol Plock
- Update on URA Board, Special District Membership ..... Chris Sheafor

5:15 p.m. **UPDATES & REPORTS**
- New Board Members (May 22); Cancellation of Election ..... Chris Sheafor
- Executive Director Updates and other Updates ..... Carol Plock, staff
  - Personnel change; healthinfosource.com: Nerdy Minds, focus groups; other
- UCHealth-North/PVHS Board Liaison Report ..... Tess Heffernan

5:30 p.m. **PUBLIC COMMENT (2nd opportunity) See Note above.**

5:35 p.m. **CONSENT AGENDA**
- Approval of the February 27, 2018 Board Meeting Minutes.
- Approval of the January and February 2018 Financials

5:38 p.m. **DECISION**
- Approval of the February 21 (Joint Board Meeting) and March 13, 2018 Board Meeting Minutes.

5:40 p.m. **ANNOUNCEMENTS**
- April 10, 4:00 pm, Board of Directors Special Meeting
- May 1, 4:00 pm, Board of Directors Regular Meeting (moved from April 24; extended)
- May 16, Rethinking Addiction Kickoff (SUD transformation project), special speakers, 7 p.m.

5:45 p.m. **EXECUTIVE SESSION**
For the purpose of discussion pertaining to personnel issues (ED) pursuant to §24-6-402(4)(f) of the C.R.S.

6:20 p.m. **ADJOURN**

■ 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

GUIDELINES FOR PUBLIC COMMENT

The Health District of Northern Larimer County Board welcomes and invites comments from the public. 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.**

Revised 1/26/2016

Health District
LARIMER HEALTH CONNECT

Open Enrollment Report
Plan Year 2018 (OE5)

Larimer Health Connect By The Numbers

11 Number of Health Coverage Guides
Approximately 8 FTE

3 Number of Service Locations
2 in Fort Collins, 1 in Loveland

73 days Length of Open Enrollment
19 fewer days than OE4

1,092 Number of Households Served
23 more households than OE4

1,692 Total Number of Encounters
16 more encounters than OE4

914 Number of People Enrolled during a visit
596 Marketplace, 252 Medicaid, 66 CHP+

"I had been so stressed about my healthcare and I had no idea it would be so easy to get signed up. This is the best customer service I have ever received. I can't tell you what a relief it is to now have healthcare coverage. I'm singing the praises of the Health District to everyone I know! Thank you so much for the work you do in providing this service to the community!"

"There is no way we could have got insurance without this help. We are so grateful for the help and support without which everyday health needs would be in jeopardy."

	Colorado	Larimer County
Total Marketplace Enrollments *As reported in March*	**165,777** ↓ 7% from over 178,000 in 2017	**11,690** ↓ 3% from 12,060 in 2017
Total Medicaid Enrollments *(Feb 2018)*	**1,298,809** ↓ 3% from 1,340,089 in 2017	**64,129** ↓ nearly 4% from 66,676 in 2017

"The Health Coverage Specialists I have worked with have all been well-trained, knowledgeable, and calm. I would imagine that this could be a stressful job, dealing with numbers, the decisions and frustrations of the customers. Thank you for helping us ordinary humans with navigating through this system."

Date: March 23, 2018 **Staff:** Alyson Williams	**POLICY ANALYSIS** **PREPARED FOR THE BOARD OF DIRECTORS**	Health District OF NORTHERN LARIMER COUNTY

HB18-1284: DISCLOSURE OF PRESCRIPTION COSTS AT PHARMACIES

Concerning the cost of prescription drugs purchased at a pharmacy.

Details

Bill Sponsors:	House – *Buckner (D) and Wilson (R)* Senate – *Martinez Humenik (R) and Kefalas (D)*
Committee:	House Health, Insurance, & Environment
Bill History:	3/8/2018- Introduced in House- Assigned to Health, Insurance, & Environment
Next Action:	3/29/2018- Hearing in House Committee on Health, Insurance, & Environment

Bill Summary

This bill prohibits insurance carriers and pharmacy benefit managers (PBMs) from prohibiting a pharmacy or pharmacist from providing a covered individual with information regarding the amount they will have to pay or the clinical efficacy of affordable alternative drugs. The bill also prohibits carriers and PBMs from requiring the pharmacy to charge a copayment that exceeds the total charges that are submitted by the pharmacy. Finally, the bill requires the Commissioner of Insurance to take action against the carrier or PBM when it has been determined that they have not complied with these requirements.

Issue Summary

Prescriptions in Colorado

There are approximately 10.8 medications dispensed per year per person in Colorado, of those 8.7 are generic medications.[1] In 2017, more than 45.9 million prescription drugs were filled at pharmacies in Colorado, resulting in $6.28 billion of retail sales.[2] According to the Colorado Health Institute's (CHI) 2017 Colorado Health Access Survey, 10.7 percent of Coloradans cite the cost of prescription drugs as reason for not filling the medicines they are prescribed.[3] In the 2016 Community Health Survey conducted by the Health District of Northern Larimer County, it was found that 9 percent of residents within the Health District had been unable to have a prescription filled because they could not afford it during the preceding 2 years. This rate is much higher among those who reported being uninsured (28%). Another study by CHI found that in 2015 the median out-of-pocket expenditures on prescription drugs was $149 per year.[4]

Prescription Drug Coverage

A health insurance carrier or pharmacy benefit manager (PBM) creates a formulary for specific health plans to detail a list of covered drugs. A formulary is a list of drugs developed by a committee within the carrier or PBM utilizing evidence-based medicine and the judgment of experts. When creating this list the decision-making committee considers and reviews clinical literature, information from the Food and Drug Administration (FDA), current therapeutic use, economic data, and provider recommendations.[5] The primary

[1] Center for Improving Value in Health Care (n.d.) *Utilization.* Retrieved from http://www.civhc.org/get-data/interactive-data/statewide-metrics/utilization/

[2] Henry J Kaiser Family Foundation (2018). *Health Costs & Budgets Indicators,* Retrieved from https://www.kff.org/state-category/health-costs-budgets/prescription-drugs/

[3] Colorado Health Institute (2017). *Colorado's New Normal: Findings from the 2017 Colorado Health Access Survey.* Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20CHAS%20DESIGN%20FINAL%20for%20Web.pdf

[4] Colorado Health Institute (2016). *Sticker Shock: Prescription Drug Affordability in Colorado.* Retrieved from https://www.coloradohealthinstitute.org/research/sticker-shock-prescription-drug-affordability-colorado

[5] Academy of Managed Care Pharmacy (Nov.2009). *Formulary Management.* Retrieved from http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=9298

purpose of a formulary is to encourage patients to access the most effective and affordable medications available. Frequently, this formulary is combined with a system of tiers to create incentive-based formularies.[6] The tier correlates to the level of coverage that will be provided.

Typically, the most cost-effective or least expensive drugs are assigned to a preferred tier and have the lowest cost-sharing requirements for the patient.[6] How the tiers are structured and whether non-preferred drugs are included in the tiers depends on the plan and the carrier. The first tier tends to be generics and possibly some select brand names, which are the least expensive drugs covered by a plan.[7] Within the second tier are what are known as preferred drugs, or brand name drugs that have been chosen by the committee for the formulary, and tend to be a little more expensive than tier one drugs.[8] The third tier, which may or may not be included in a plan's formulary, are the non-preferred drugs.[8] Finally, the final tier typically includes most specialty drugs and are the most expensive.[8] In 2017, an annual study of employer health benefit plans delineates the average cost sharing for covered individuals that had tiers in their pharmacy benefit formulary.[8] The below chart demonstrates both the average copay and coinsurance for these covered workers.[8]

Prescription Drug Overpayments

When a commercially insured individual's copayments exceed the total cost of the drug to their insurer/PBM it is a prescription drug overpayment, known as a "clawback."[9] Pharmacists tend to report that the insurer

Among Covered Workers With Prescription Drug Coverage, Average Copayments and Coinsurance, 2017

	Average Copay	Average Coinsurance
Plans With Three or More Tiers		
First Tier	$11	17%
Second Tier	$33	25%
Third Tier	$59	38%
Fourth Tier	$110	28%
Plans With Two Tiers		
First Tier	$11	NSD
Second Tier	$30	29%
Plans With the Same Cost-Sharing For All Covered Drugs		
First Tier	$11	19%

NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs.
NSD: Not Sufficient Data

or PBM keeps the overpayment, not the pharmacy itself. A recent study analyzed the general scope of these overpayments, which is difficult to concretely do with the data that is publicly available on prescription drug prices.[10] The study found that brand name drugs had a higher mean overpayment than generics, yet fewer brand name drug claims involved an overpayment than generics.[10] The following chart depicts the overarching results from this study.[10]

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[6] Goldman, D.P., Joyce, G.F., and Zheng, Y. (July 2007). Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health. *JAMA;* 298(1). doi: 10.1001/jama.298.1.61

[7] National Council on Aging (n.d.) *Medicare Part D Copay Tiers.* Retrieved from https://www.mymedicarematters.org/resource-library/infographics/part-d-copay-tiers/

[8] The Kaiser Family Foundation & Health Research and Educational Trust (2017). *Employer Health Benefits: 2017 Annual Survey,* Retrieved from http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017

[9] Van Nuys, K., Joyce, G., Ribero, R., and Goldman, D.P. (March 2018). Overpaying for Prescription Drugs: The Copay Clawback Phenomenon. *USC Leonard D. Schaeffer Center for Health Policy & Economics.* Retrieved from http://healthpolicy.usc.edu/documents/2018.03_Overpaying%20for%20Prescription%20Drugs_White%20Paper_v.1.pdf

Table 1: Frequency and Average Size of Overpayments, 2013

	Number of Claims	Number of Claims with Overpayment	Percentage of Claims Involving Overpayment (95% CI)	Mean Overpayment (SD)
All Drugs	9,539,846	2,188,578	22.94% (22.91, 22.97)	$7.69 (8.59)
Generic	7,295,525	2,055,024	28.17% (28.14, 28.20)	$7.32 (7.43)
Brand	2,244,321	133,554	5.95% (5.92, 5.98)	$13.46 (18.01)

Source: Optum Clinformatics™ Data Mart pharmacy claims, January-June 2013, and CMS NARP reimbursements from the same period. Confidence intervals are binomial.

The study also found that the top 20 drugs with the highest rates of overpayments ranged from 49.31 percent of claims with overpayments to 60.49 percent.[10] These drugs treat an assortment of conditions including insomnia, high cholesterol, pain, and coughs.[10]

Carrier/PBM Contracting

Pharmacy benefit managers (PBMs) must negotiate contracts with both pharmacies and insurance plan sponsors. A PBM contract with the pharmacy sets reimbursement rates for dispensing medications, along with other provisions. If a carrier does not utilize a PBM in its pharmacy benefit scheme, then it contracts with pharmacies in the same manner a PBM does. Some contracts reportedly restrict pharmacists from proactively telling a patient that a drug could cost less if they pay the cash price, rather than the cost dictated by their health plan. This restriction is known as a "gag clause." A survey by the National Community Pharmacists Association found that within the past month 38.8 percent of pharmacists reported a gag clause preventing them from providing other options to patients between 10 and 50 times.[10] Much of the information regarding gag clauses comes anecdotally, this includes from media sources like the New York Times.[11]

Other Legislation

There are seven states (Connecticut, Georgia, Maine, Mississippi, North Carolina, North Dakota, and Virginia) that have enacted laws that prohibit "gag clauses" in contracts with pharmacies.[12] Five states (Arkansas, Georgia, Louisiana, Maryland, and North Dakota) have passed legislation targeting overpayments.[10] The Pharmaceutical Care Management Association, which represents PBMs, has filed a lawsuit against the state of North Dakota for its legislation, which targets both of these issues, but goes further than other states and includes language regarding pay-for-performance provisions.[13]

At the federal level, two bills have been recently introduced by a group of bipartisan Senators that target pharmacy gag clauses.[14] The *Patient Right to Know Drug Prices Act* would prohibit PBMs from enacting gag clauses in contracts with pharmacies for marketplace and employer health plans.[15] The other piece of

[10] National Community Pharmacists Association (2016). *Survey of Community Pharmacies*. Retrieved from http://www.ncpa.co/pdf/dir_fee_pharamcy_survey_june_2016.pdf

[11] Pear, R. (Feb 24, 2018). *Why Your Pharmacist Can't Tell You That $20 Prescription Could Cost Only $8.* Retrieved from https://www.nytimes.com/2018/02/24/us/politics/pharmacy-benefit-managers-gag-clauses.html?auth=login-email

[12] National Conference of State Legislatures (March 14, 2018). *Prohbiting PBM "Gag Clauses" that Restrict Pharmacists from Disclosing Price Options Recent State Legislation 2017-2018.* Retrieved from http://www.ncsl.org/Portals/1/Documents/Health/Pharmacist_Gag_clauses-2018_14523.pdf

[13] Pharmaceutical Care Management Association (July 12, 2017). *PCMA Challenges North Dakota Health Mandates that Undermine Patient Safety, Increase Prescription Drug Costs.* Retrieved from https://www.prnewswire.com/news-releases/pcma-challenges-north-dakota-health-mandates-that-undermine-patient-safety-increase-prescription-drug-costs-300487045.html

[14] Office of Senator Susan Collins. (March 15, 2018). *Senator Collins, McCaskill, Stabenow Lead Bipartisan Group of Senators in Introducing Legislation to Prohibit "Gag Clauses" that Cause Consumers to Pay Higher Prices for Prescription Drugs.* Retrieved from https://www.collins.senate.gov/newsroom/senators-collins-mccaskill-stabenow-lead-bipartisan-group-senators-introducing-legislation

legislation, *Know the Lowest Price Act,* provides the same requirement for Medicare Advantage and Medicare Part D health plans.[15] The Pharmaceutical Care Management Association has released a statement on the legislation stating that they "support the patient always paying the lowest cost at the pharmacy counter, whether it's the cash price or the copay."[15] The largest PBM in the country, CVS Health, also applauded the introduction of these bills.[16]

This Legislation

This bill is titled the "Patient Drug Cost Savings Act." The General Assembly declares that consumers have the right to know about the options to reduce the amount of money they pay for prescription drugs at pharmacies. It declares that this bill will save consumers money by allowing pharmacists to provide information regarding the cost of prescription drugs.

The bill prohibits carriers and pharmacy benefit managers that have contracts with pharmacies or pharmacists from prohibiting them from providing a covered person information about the cost-sharing for the drug and that of another, more affordable drug. The other drug that the pharmacist provides information on to the individual must be therapeutically equivalent. A carrier or PBM cannot penalize a pharmacy or pharmacist from disclosing this information or selling the patient a more affordable alternative. A carrier or PBM cannot require a pharmacy to charge and collect a copayment that exceeds the total charges submitted by the network pharmacy. If a carrier has not complied with these requirements the Commissioner of Insurance will institute a corrective action plan for the carrier or use their enforcement powers to obtain compliance. Finally, the bill clarifies if any of these requirements conflict with federal rules or laws, then the federal law or rule supersedes the bill.

Reasons to Support

Overpayments, or "clawbacks," may directly increase a patient's out-of-pocket costs. With over 2 million claims with overpayments in 2013, at an average of $7.69, American consumers overpaid more than 16 million dollars that year. Evidence shows that increased cost-sharing is associated with decreased pharmaceutical use and adherence.[7] The magnitude of the effect of higher prices for patients at the point of sale may be especially great on vulnerable patients and those that are chronically ill. Creating a dual-pronged approach to target the gag clauses and the overpayments will allow patients to not be kept in the dark about when they may be overpaying. The elimination of the gag clauses will also allow pharmacists to ensure that an individual is receiving the most appropriate and affordable medication. The legislation also lessens the interference in the pharmacist-client relationship by the insurer or PBM. Consumers need accurate information at their pharmacy so they can get their drugs at the most affordable price. Furthermore, without the clawbacks, this could slightly decrease the price of drugs for all consumers at the point-of-sale.

Supporters

- Colorado Cross-Disability Coalition

Reasons to Oppose

With many in the PBM industry stating that gag clauses are not a norm for contracting with pharmacies, the problem may be more anecdotal that actual. However, the 38 percent of pharmacists that reported gag clauses may dispute this assertion.

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[15] Pharmaceutical Care Management Association (March 15, 2018). *PCMA Responds to "Patient Right to Know Drug Prices Act" and "Know the Lowest Price Act".* Retrieved from https://www.pcmanet.org/pcma-responds-to-patient-right-to-know-drug-prices-act/

[16] CVS Health (March 15, 2018). *CVS Health Applauds New Legislation to Better Inform Pharmacy Choices.* Retrieved from https://cvshealth.com/newsroom/press-releases/cvs-health-applauds-new-legislation-better-inform-pharmacy-choices

Opponents

- No opposition has been made public at this time

Other Considerations

If an individual opts for paying for the drug at the cash price rather than through their insurance, the money spent will not count towards their maximum costs for that plan year. Therefore, it may take people longer to reach that out-of-pocket maximum if they keep paying the cash price at the pharmacy. This could lead to people actually paying more for their drugs in the long-term, as it takes longer to reach the point when their insurance plan no longer requires cost-sharing.

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. 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.

Date: March 23, 2018 **Staff:** Alyson Williams	**POLICY ANALYSIS** **PREPARED FOR THE BOARD OF DIRECTORS**	Health District OF NORTHERN LARIMER COUNTY

HB18-1279: ELECTRONIC PRESCRIBING CONTROLLED SUBSTANCES

Concerning a requirement that certain practitioners prescribe controlled substances electronically.

Details

Bill Sponsors: House–*Esgar (D),* Buckner (D), Ginal (D), Kennedy (D), Liston (R), McKean (R), Roberts (D)
Senate – *Priola (R) and Moreno (D)*
Committee: House Health, Insurance, & Environment
Bill History: 3/7/2018- Introduced in House- Assigned to Health, Insurance, & Environment
Next Action: 3/29/2018- Hearing in House Committee on Health, Insurance, & Environment

Bill Summary

This bill would require podiatrists, dentists, physicians, physician assistants, advanced practice nurses, and optometrists to prescribe controlled substances only through electronic prescribing, with certain exceptions to this mandate. Providers must comply with the requirement by July 1, 2020 unless they serve in a rural community or have a solo practice (deadline of July 1, 2021). These prescribers are required to report their compliance through the license renewal process. Pharmacists are not required to verify if the prescriber has a valid exemption to this mandate if a prescription is transmitted via a written or oral method.

Issue Summary

E-Prescribing Controlled Substances (EPCS)

On June 1, 2010, the Drug Enforcement Administration's (DEA) rule, "Electronic Prescriptions for Controlled Substances," became effective.[1] This rule allowed, but did not require, providers to write e-prescriptions for controlled substances (EPCS) and permitted pharmacies to receive, dispense, and archive these e-prescriptions. The rule also mandated stringent and audit requirements for EPCS.

Currently, the process for beginning EPCS consists of four main steps.[2] First, the provider must purchase a DEA-compliant e-prescribing platform that supports EPCS or utilize an existing solution in an electronic health record (EHR). Then they must go through an identity-proofing process to acquire two-factor authentication tokens in order to sign EPCS prescriptions. These tokens are bound to the provider's identity. Finally, the prescriber gains access using the EHR or other platforms for EPCS. The DEA's final rule required prescribers to go through technical steps to approve an e-prescription for a controlled substance. Guidelines have condensed the requirements of the DEA rule into seven main steps[3]:

1. Prescriber indicates to the information system platform that the EPCS are ready to sign.
2. Prescriber executes signing function, which must include a two-factor authentication protocol (i.e. prescriber enters two separate authentication tokens.[4]

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[1] Diversion Control Division, Drug Enforcement Administration, U.S. Department of Justice (2010). *Electronic Prescriptions for Controlled Substances.* Retrieved from https://www.deadiversion.usdoj.gov/ecomm/e_rx/faq/eapplications.htm

[2] DrFirst (n.d.) *EPCS: Getting Started with Electronic Prescribing of Controlled Substances.* Retrieved from http://www.drfirst.com/wp-content/uploads/EPCS_Infographic_from_DrFirst-1.png

[3] Sujansky & Associates, LLC for California HealthCare Foundation (Nov. 24, 2013). *Guidelines for the Electronic Prescribing of Controlled Substances: Identity Proofing, Issuing Authentication Credentials, and Configuring Logical Access Controls.* Retrieved from http://surescripts.com/docs/default-source/getepcs/pdf-guidelinesepcs.pdf

[4] Typically, these tokens are a memorized password plus another token that is uniquely generated by a device (phone, USB, etc.) or by biometrics of the prescriber (fingerprint, retinal pattern).

3. The authentication module of the information system platform checks the prescriber's credentials.
4. The authentication module confirms (or denies) that the authentication tokens correspond to the prescriber's account.
5. The access control module of the information system platform checks that the authenticated prescriber account is permitted to sign controlled substance prescriptions.
6. The access control module confirms (or denies) that the account associated with the prescriber is allowed to sign controlled substance prescriptions.
7. The EPCS is signed.

Controlled Substances in Colorado

Colorado has 1,089 pharmacies, 42,371 prescribers, and over 1.4 million unique patients that either dispensed, prescribed, or consumed a controlled substance (i.e. a drug that has been classified as a Schedule II-V substance).[5] More than 96 percent of Colorado pharmacies are enabled to handle EPCS; however, only 13.3 percent of prescribers are ready.[6] In 2016, only 6.9 percent of controlled substances were prescribed electronically.[6]

The Colorado Controlled Substances Act of 2013 implemented an inventory of Schedule I to V drugs.[7] Statute defines Schedule I substances as those that have a high potential for abuse, no currently accepted medical use in treatment, and lack accepted safety for use under medical supervision.[8] Some of the listed substances under this category include some synthetic opiates, heroin, LSD, and peyote.[8] Schedule II drugs are those that have a high potential for abuse, has currently accepted medical use in treatment or currently accepted medical use with severe restrictions, and the abuse of the substance may lead to severe psychological or physical dependence.[9] Examples of Schedule II substances are morphine, cocaine, some synthetic opiates (i.e. fentanyl and methadone), and amphetamines.[9] The statute defines Schedule III drugs as those substances that have a potential for abuse less than that for schedule I and II drugs, have currently accepted medical use for treatment, and abuse may lead to moderate or low physical dependence or high psychological dependence.[10] Commonly known Schedule III drugs include anabolic steroids, ketamine, and drugs with limited amounts of opiates.[10] Schedule IV substances are accepted for medical use and low potential for abuse as well as limited physical or psychological dependence relative to Schedule III.[11] Notable substances in this schedule are the chemicals that are in the brand name drugs Valium®, Ambien®, and Klonopin®.[11] Finally, Schedule V drugs are substances that have a low potential for abuse, currently accepted for medical use, and abuse may lead to limited physical or psychological dependence.[12] Common drugs in this category include buprenorphine and compound drugs that include a limit dosage of a narcotic (i.e. codeine) but also have another nonnarcotic medicinal ingredient.[12] Colorado's schedule categorization typically mirrors the scheduling that has occurred at the federal level by the DEA.[13]

National Standards for E-Prescribing

The National Council for Prescription Drug Programs (NCPDP) creates and updates standards for the pharmacy and pharmaceutical industry. The NCPDP SCRIPT Standard was first created in 1997 and is

[5] 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
[6] Surescripts (Jan. 2018). *Electronic Prescribing for Controlled Substances.* Retrieved from http://surescripts.com/enhance-prescribing/e-prescribing/e-prescribing-of-controlled-substances/
[7] C.R.S. 18-18-203-207
[8] C.R.S. 18-18-203
[9] C.R.S. 18-18-204
[10] C.R.S. 18-18-205
[11] C.R.S. 18-18-206
[12] C.R.S. 18-18-207
[13] Diversion Control Division, Drug Enforcement Administration, U.S. Department of Justice (2018). *Controlled Substances Schedules* Retrieved from https://www.deadiversion.usdoj.gov/schedules/index.html

updated at least annually.[14] SCRIPT was established to facilitate the electronic transfer of prescription data between prescribers, pharmacies, payers, and other necessary entities. This data can include new prescriptions, refill requests, cancellations, prior authorizations, medical history, and other transactions.

Legislation in Other States

Eight states (Arizona, Connecticut, Maine, Minnesota, New York, North Carolina, Rhode Island, and Virginia) have required e-prescribing for all controlled substances or just opioids, with at least fourteen others considering such a mandate.[15] New York mandates e-prescribing for all substances as of March 2016, with exceptions for practitioners in certain circumstances.[16] New York is the first state to impose fines and other penalties for failing to comply with the e-prescribe mandate.[16] Minnesota was the first state to require e-prescribing of controlled substances but it does not penalizing for noncompliance.[17] Other states have mandated EPCS in a more targeted manner. In 2017, North Carolina passed legislation requiring e-prescribing of Schedule II and III drugs that are opioids/opioid derivatives or are combination drugs that contain opioids, but with exceptions for certain circumstances.[18] Furthermore, North Carolina's law clarifies that pharmacists are not required to check if an e-prescribe exemption is valid if they receive a prescription through different means.[18]

This Legislation

This bill requires podiatrists, dentists, physicians, physician assistants, advance practice nurses, and optometrists to prescribe controlled substances through an electronic prescription (e-prescribe). The prescribers must comply with this requirement by July 1, 2020. The exceptions to the e-prescribing requirement are:

- E-prescribe is not available due to technical or electrical failure.
- The prescription will be dispensed at an out-of-state pharmacy.
- The prescription is being dispensed by the prescriber.
- The prescription has elements that are not supported by the most recent version of the National Council for Prescription Drug Programs SCRIPT Standard.
- The Food and Drug Administration requires the prescription have elements that cannot be met with e-prescribe.
- The prescription is not for a specific patient but allows for the dispensing of a controlled substance under a standing order, approved protocol of drug therapy, collaborative drug management, comprehensive medication management plan, response to a public health emergency, or other circumstances that allow such a prescription.
- The prescription is for a research protocol.
- The prescription is to be administered to a patient in a hospital, nursing care facility, hospice care facility, dialysis treatment clinic, or assisted living residence.
- The prescriber reasonably determines that the patient could not obtain their prescription in a timely manner and that delay would adversely affect the patient's medical condition.

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[14] National Council for Prescription Drug Programs (May 2014). *E-Prescribing Fact Sheet.* Retrieved from https://www.ncpdp.org/NCPDP/media/pdf/EprescribingFactSheet.pdf

[15] Dr First (2018). *E-Prescribing Mandate Map.* Retrieved from http://www.drfirst.com/resources/e-prescribing-mandate-map/

[16] New York State Department of Health. (Dec. 2017). *Electronic Prescribing.* Retrieved from https://www.health.ny.gov/professionals/narcotic/electronic_prescribing/

[17] Minnesota Department of Health (Sept. 2017). *Frequently Asked Questions on E-Prescribing of Controlled Substances.* Retrieved from http://www.health.state.mn.us/e-health/eprescribing/docs/faqforepcs.pdf

[18] North Carolina Board of Pharmacy (July 2017). *Guidance to Pharmacists on Implementation of the Strengthen Opioid Misuse Prevention ("STOP") Act.* Retrieved from http://www.ncbop.org/PDF/GuidanceImplementationSTOPACTJuly2017.pdf

The bill extends that deadline for compliance until July 1, 2021, if the provider practices in a rural area[19] or is in a practice that consists of a sole provider. The Podiatry Board, Dental Board, Medical Board, Board of Nursing, and Board of Optometry are each to adopt rules that define what constitutes a technical or electrical failure and specify the requirements for a podiatrist who claims an exception to the e-prescribe mandate. Each board must include a question on its license renewal questionnaire that asks whether the provider is complying with the e-prescribe mandate. If the provider does not answer the questionnaire accurately or fails to comply with the e-prescribe mandate, the respective board for that prescriber has the grounds for discipline.

The bill clarifies that if a pharmacist receives a prescription for a controlled substance that is not transmitted electronically they are not required to verify the applicability of one of the aforementioned exceptions. Therefore, they can dispense the prescribed controlled substance to the patient if the prescription is otherwise valid and consistent with the requirements of current laws.

Reasons to Support

Increased e-prescribing of prescription drugs can decrease the possibility of prescribing errors or adverse drug events. Due to this potential benefit of e-prescribing, the U.S. Institute of Medicine in 2006 recommended that by 2010 all providers and pharmacies should have e-prescribing capabilities implemented.[20] Beyond ensuring the safety of the patient, the cost-savings of the reduction of adverse drug events can be beneficial for both the consumer and the health care system as a whole. Increased efficiency at the pharmacy and in the provider's office means less effort for the patient if issues arise. Fewer issues and less effort decrease the barriers to prescription drug adherence or having a script filled. E-prescribing of controlled substances (EPCS) can assist in preventing "doctor shopping" by making it easier to see a patient's past prescriptions for controlled substances from other providers. Additionally, EPCS can aid in preventing prescription fraud by eliminating paper prescription pads that can be stolen, altered, or forged.

Supporters

- Anthem Blue Cross Blue Shield
- Colorado Foundation for Universal Health Care
- Colorado Mental Wellness Network

Reasons to Oppose

The cost of implementing and upkeep of a system may present a barrier to practices. While confidentiality protections exist in electronic prescribing systems, there is a small possibility that a breach of these systems could occur and protected patient information could be stolen. Smaller, community, or rural pharmacies may not be ready to accept e-prescriptions and the cost of implementing such a system may be prohibitive. If there is a technological failure or an emergency that inhibits the use of the platform, paper prescription pads will be necessary and with this mandate some offices may not have adequate supplies remaining.

Opponents

- Colorado Medical Society

[19] A rural area is a county with a population less than 3,000 people, a municipality that has a population less than 1,000 that is located more than 10 miles from a municipality that has a population greater than 1,000, or an unincorporated part of a county that is located more than 10 miles from a municipality that has a population greater than 1,000.

[20] Roehr, B. (July 2006). Institute of Medicine report strives to reduce medication errors. *BMJ;* 333(7561): 220. doi: 10.1136/bmj.333.7561.220-f

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. 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.

Date: March 23, 2018 **Staff:** Alyson Williams	**POLICY ANALYSIS** **PREPARED FOR THE BOARD OF DIRECTORS**	Health District OF NORTHERN LARIMER COUNTY

SB18-214 REQUEST SELF-SUFFICIENCY WAIVER MEDICAID PROGRAM:

Concerning a waiver from the federal government to implement self-sufficiency provisions in the Colorado medical assistance program

Details

Bill Sponsors:	Senate – *Crowder (R)* House – *Beckman (R)*
Committee:	Senate Committee on Health and Human Services
Bill History:	3/19/2018-Introduced in Senate-Assigned to Health and Human Services
Next Action:	3/29/2018-Hearing in Senate Committee on Health and Human Services

Bill Summary

This bill directs the Colorado Department of Health Care Policy and Financing (HCPF) to develop and submit an application for a Section 1115 Medicaid waiver to implement certain provisions as a part of Colorado's Medicaid program, Health First Colorado. The waiver application must include the requirement for able-bodied adults, with stipulated exceptions, to work, seek work, attend job training, or volunteer for Medicaid eligibility. Able-bodied adults must verify their income on a monthly basis for eligibility. HCPF may prohibit a person from enrolling in Medicaid if the individual does not report a change in income or makes a false statement regarding compliance with the work requirement. A lifetime limit of five years on Medicaid benefits is enacted, with certain exceptions. Under an approved waiver application, HCPF may impose copayments to deter the use of emergency departments and ambulance services for nonemergent services. Finally, HCPF is required to report to the Colorado General Assembly, as well as relevant committees, regarding the preparation, submission, approval, implementation, and outcome of the waiver.

Background

Section 1115 Waivers

Medicaid was originally enacted under Title XIX of the Social Security Amendments of 1965 as a voluntary program for states to partner with the federal government to provide a defined set of medical benefits.[1] The Affordable Care Act (ACA), established a new category of Medicaid eligibility for those states that opted to expand their program.[1] This new group are childless, nonelderly, and nondisabled individuals, commonly known as able-bodied adults without dependents (ABAWDs).[2]

Section 1115 of the Social Security Act allows states to apply for demonstration project waivers that further the goals and intentions of Medicaid while providing more flexibility to states. Since the expansion of Medicaid through the ACA, these waivers have become a key tool for states to incorporate their own ideas as they expand their programs. These demonstration projects are aimed to either build upon existing or novel approaches that promote the objectives of Medicaid. The purpose of providing medical assistance through a waiver has historically been interpreted by the Centers for Medicare and Medicaid Services (CMS) as increased access to care, improved efficiency of the delivery of care, or increased coverage.[2] The

[1] Kaiser Family Foundation (Aug. 2012). *A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage.* Retrieved from https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8349.pdf

[2] Huberfeld, N. (March 2018). Can Work Be Required in the Medicaid Program? *New England Journal of Medicine;* 378(9): 788-91. doi: 10.1056/NEJMp1800549

important aspect of these propositions is that they must be budget neutral.[3] To be budget neutral in these demonstrations the expectation is that expenditures by the federal government will not exceed it would have spent without the demonstration.[3] Section 1115 demonstration waivers are typically granted for an initial five-year period that can be extended for an additional three-to five-year period.[3]

CMS Guidance

On January 11, 2018, CMS released guidance to the states regarding opportunities to promote work and community engagement among Medicaid beneficiaries.[4] In the letter addressed to each state's Medicaid director, CMS committed to "support state demonstrations that require eligible adult beneficiaries to engage in work or community engagement activities […] in order to determine whether those requirements assist beneficiaries in obtaining sustainable employment or other productive community engagement and whether […] leads to improved health outcomes."[4]

The guidance also outlined the populations that should or must be exempt from these requirements. The groups that CMS highlighted that should be exempt from such eligibility requirements are those that are disabled,[5] medically frail, diagnosed with an acute medical condition, or are attending treatment for a chronic substance use disorder. It is suggested that the state align with any existing work requirements that the state has for the Temporary Assistance for Needy Families (TANF) or the Supplemental Nutrition Assistance Program (SNAP).

The guidance specifies that states applying for such as waiver must outline strategies that the state will develop and implement to aid individuals in meeting these requirements and link them to services and supports. However, no federal Medicaid funding can be used for these services, which leaves the state solely responsible for the financial requirements of such services. Finally, the guidance suggests that the application include the plan for reporting, monitoring, and evaluation that will occur to investigate the outcomes of implementing such requirements.

Medicaid

There are approximately 68,045,556 enrollees in the Medicaid program across the country.[6] A Kaiser Family Foundation analysis detailed the breakdown of employment status for Medicaid beneficiaries that are nondisabled and nonelderly adults, the results are detailed in the figure below.[7]

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[3] U.S. Centers for Medicare and Medicaid Services (n.d.). *About Section 1115 Demonstrations.* Retrieved from https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

[4] U.S. Centers for Medicare and Medicaid Services (Jan. 11, 2018). *SMD: 18-002 Opportunities to promote work and community engagement among Medicaid beneficiaries.* Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf

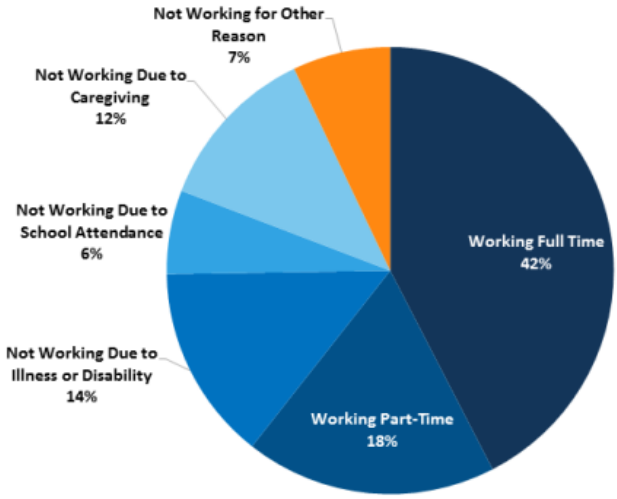
[5] This includes those that are classified for Medicaid purposes as non-disabled but may have an illness or disability as defined by federal statute that may interfere with their ability to meet the work/community engagement requirements.

[6] U.S. Centers for Medicare and Medicaid Services (n.d.). *December 2017 Medicaid and CHIP Enrollment Data Highlights.* Retrieved from https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

[7] Kaiser Family Foundation (Jan. 16, 2018). *Medicaid and Work Requirements: New Guidance, State Waiver Details, and Key Issues.* Retrieved from https://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements-new-guidance-state-waiver-details-and-key-issues/

Figure 1

Work Status and Reason for Not Working Among Non-SSI, Nonelderly Medicaid Adults, 2016



Total = 24.6 million

Notes: "Not Working for Other Reason" includes retired, could not find work, or other reason. Working Full-Time is based on total number of hours worked per week (at least 35 hours). Full-time workers may be simultaneously working more than one-job.
Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Approximately 23.9 percent, or 1.3 million, of Colorado residents are enrolled in the Medicaid program.[8] [9] About 70 percent of nonelderly nondisabled adults in the Colorado Medicaid program are working themselves.[10] Of these enrollees, 448,600 are adults that were newly eligible for the program due to the ACA expansion of the program.[9] Additionally, only 35 percent of enrollees are between the ages of 19 and 64.[9] In Larimer County, 19.3 percent of county residents are enrolled in the Medicaid program.[8] During a month, an average of 65,806 people that live in Larimer County are enrolled in the program.[11] Of these beneficiaries, 24,859 are those that became eligible under the Medicaid expansion of the ACA.[10]

Copayments in the Medicaid Program

States are allowed to implement cost-sharing requirements for Medicaid enrollees.[12] Exemptions are instituted on this allowance for certain population groups and services. Some of these groups include children under 18 (and up to 21 based on the state), pregnant women (based on state), and individuals in hospice. The services exempt for out-of-pocket costs are emergency services, family planning, pregnancy-related services, and preventive services for children. CMS may institute maximum allowable copayments for eligible populations by family income for different types of services.

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[8] Colorado Health Institute (2017). *County Health Profiles.* Retrieved from https://www.coloradohealthinstitute.org/county-health-profiles

[9] Kaiser Family Foundation (n.d.) *State Health Facts.* Retrieved from https://www.kff.org/statedata/

[10] Kaiser Family Foundation (Jan 5 2018). *Understanding the Intersection of Medicaid and Work.* Retrieved from https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-and-work-tables/

[11] Colorado Department of Health Care Policy and Financing (2017). *Larimer County Fact Sheet.* Retrieved from https://www.colorado.gov/pacific/sites/default/files/Larimer%20County%20Fact%20Sheet.pdf

[12] U.S. Centers for Medicare and Medicaid Services (n.d.) *Cost Sharing Out of Pocket Costs.* Retrieved from https://www.medicaid.gov/medicaid/cost-sharing/out-of-pocket-costs/index.html

Colorado's Medicaid program requires co-pays for a variety of services.[13] Currently, if a Medicaid-covered individual access services at an emergency room there is not a co-pay if it has been determined that it was an emergency; however, if it was not an emergency there is a $6 co-pay per emergency room visit. There is no co-pay for using ambulance services but a prior authorization is required if the service is non-emergent such as being transferred to a new hospital.

Lifetime Limits in the Medicaid Program

As of publication, no state has been granted approval by CMS to impose lifetime limits on Medicaid benefits; however, five states (Arizona, Kansas, Maine, Utah and Wisconsin) have applied for such a cap.[14] The Department of Health and Human Services, which oversees CMS, has said it will not comment on the pending waiver applications, so it is unknown if approval will occur.

Approved Section 1115 Waivers with Work Requirements in Other States

Three states (Arkansas, Indiana, and Kentucky) have approved waiver applications that include work requirements as of publication.[15] Of these three, there is litigation pending against Kentucky for the legality of the waiver.[6] All of the approved waivers have occurred since the beginning of the year. At the end of January 2018, a lawsuit was filed challenging the validity of the waiver based on questioning the authority of CMS to issue a work requirement policy.[16] Appendix A includes a chart of the approved waiver applications of these three states and details the requirements, populations, qualifying activities, and penalties for failing to comply with the requirements.

This Legislation

This bill mandates the Colorado Department of Health Care Policy and Financing (HCPF) to prepare and submit a waiver to the Centers for Medicare and Medicaid Services (CMS) by March 30, 2019. The waiver shall be a demonstration waiver under Section 1115 of the Social Security Act or any other waiver that is deemed applicable. The general purpose of the waiver is to institute work requirements for able-bodied adults and require other self-sufficiency measures to receive medical assistance under the Medicaid program. If the waiver is approved for this purpose, the state appropriates necessary funds, and the federal government participates financially, then HCPF is to implement the components of the waiver.

The bill requires the waiver developed and submitted by HCPF to include certain provisions. First, to be eligible for the Medicaid program, an able-bodied adult must be employed, be actively seeking employment, or volunteering for a nonprofit for at least 20 hours each week. This condition for eligibility is not applicable if the person is over the age of 18 but attending high school full-time, pregnant, the sole caregiver for a family member that is under 5 years old, or is receiving temporary or permanent long-term disability benefits from a public or private source. Second, the waiver must place a requirement on non-exempt able-bodied adults to verify their income on a monthly basis for eligibility redetermination. The third provision that must be included in the waiver is allowing HCPF to prohibit a person from enrolling or continuing in Medicaid if they fail to report a change in their family income or make a false statement regarding their compliance with the work requirements. The waiver application must include a lifetime limit on enrollment in Medicaid unless the recipient is pregnant, the sole caregiver of a family member who is under 5 years old,

[13] Health First Colorado (2018). *Benefits and Services.* Retrieved from https://www.healthfirstcolorado.com/benefits-services/
[14] Weixel, N. (Feb. 13, 2018). *Trump officials face decision on lifetime limits for Medicaid.* Retrieved from http://thehill.com/policy/healthcare/373544-trump-officials-face-decision-on-lifetime-limits-for-medicaid
[15] National Academy for State Health Policy (March 5, 2018). *State Proposals for Medicaid Work and Community Engagement Requirements.* Retrieved from https://nashp.org/state-proposals-for-medicaid-work-and-community-engagement-requirements/
[16] Kaiser Family Foundation (Jan. 29, 2018). *A Guide to the Lawsuit Challenging CMS's Approval of the Kentucky HEALTH Medicaid Waiver.* Retrieved from https://www.kff.org/medicaid/issue-brief/a-guide-to-the-lawsuit-challenging-cmss-approval-of-the-kentucky-health-medicaid-waiver/

receiving temporary or permanent long-term disability benefits from a public or private source, over the age of 18 but attending high school full-time, or employed full-time but continues to meet the income eligibility limits. Finally, the submitted waiver application must include a provision that authorizes HCPF to impose meaningful copayments to deter the nonemergency use of emergency departments and use of ambulance services for nonemergency transportation or when not medically necessary.

Starting in 2018 annually thereafter, indefinitely, HCPF must report to the Senate Committee on Health and Human Services and House Committee on Public Health Care and Human Services (or their successor committees) the status of the waiver. This status report includes the preparation, submission, approval, renewal, state plan amendments, implementation, and outcomes of the waiver.

Reasons to Support

Supporters may point to Colorado's low supply of workers for an increasing number of jobs as a reason to require work for Medicaid beneficiaries that are able-bodied. Work requirements in Medicaid are part of the solution to increase labor force participation. It would benefit employers that do not have to source employees from foreign countries, the expanding economy of Colorado, and the new workers that gain increased financial stability. Others believe work requirements are worth pursuing because they serve as a social contract that the majority of Americans support.[17] A recent Rasmussen Reports survey found that 64 percent of Americans think that childless, able-bodied adults in their state should be required to work as a condition for receiving Medicaid.[18] Supporters claim that a lifetime limit is part of a comprehensive approach to encourage enrollees to work.

Supporters

- Any support has not been made publicly available at this time.

Reasons to Oppose

Data suggests that the true number of adults that receive Medicaid benefits that are able to work but choose not to is small. The administrative burden that the work and income requirements will place on relevant departments at both the state and local level will be great. By adding the layer of confirming income or unemployed adults meet the exemption criteria will require investment in compliance personnel and procedures that will raise the cost of the program itself. Increasing the cost of administration could mean less money in budget for additional services like dental programs.

Many of the provisions of the bill could push people out of coverage. The additional administrative burden, mainly increased paperwork to prove they are meeting the requirements or qualify for an exemption, on the individual could push people out of coverage. This can include those that are working or engaging in approved activities. The CMS guidance requires states to exempt people that are labelled "medically frail." This bill only excludes those getting disability payments, which is a very high burden to achieve, as not all that are considered medically frail by CMS are formally labelled as disabled. Many people can work some, but not enough to meet this bill's requirements, due to illness or conditions that do not rise to "full" disability. These conditions may allow individuals to work for periods, but when a flare up occurs they cannot attend work in order to care for their health. Others may have illnesses that allow them to work for short periods, but cannot meet the 20 hour per week mandate.

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[17] Rachidi, A. (March 20, 2018). *The truth about Medicaid work requirements.* Retrieved from http://www.aei.org/publication/the-truth-about-medicaid-work-requirements/

[18] Rasmussen Reports (2018). *64% Say 'Yes' to Work Requirements for Medicaid Recipients.* Retrieved from http://www.rasmussenreports.com/public_content/lifestyle/general_lifestyle/january_2018/64_say_yes_to_work_requirements_for_medicaid_recipients

It will leave out many people with mental health conditions and substance use disorders. To prove that they may qualify for an exemption these individuals will need to obtain letters from providers, medical records, and whatever additional documentation the state may deem necessary. Administrative red tape and paperwork has been demonstrated to reduce enrollment in Medicaid.[19] Furthermore, many people with substance use disorders may relapse several times and go in and out of the workforce. The work requirement and lifetime limit could force an individual to forgo health coverage, which would not be helpful in addressing the underlying issue of a substance use disorder through appropriate treatment. Without health insurance people are more likely to delay treatment for both their physical and mental health conditions leading to poor health outcomes, which may cost the system more in the long-run.

The bill also does not specify those able-bodied adults that are caregivers, but not for a child under the age of five. Many individuals do not have a choice but to not engage in work but act as the caregiver for a family member that may have a chronic illness, disability, or a disorder associated with age (i.e. Alzheimer's). Requiring work of this group of individuals could be detrimental to their health and that of the family member they are caring for. If an individual complies with the work requirement they may have to pay for care for their family member, which would have the opposite of this bill's desired effect of pulling the individual and their family out of poverty. Also, the person they are caring for may qualify for Medicaid or already be enrolled in the program. In cases where the family member being cared for had to enter long-term care in a skilled nursing facility Medicaid may end up paying for that care. In Colorado this care costs $91,958 on average.[20] The cost for the Medicaid coverage in this facility would likely be far greater than providing health insurance to the healthier family member.

The bill does not specify age as an exemption from the work requirement. This could harm those between the ages of 50-64, an age group that particularly benefitted from the ACA expansion.[21] Older Medicaid enrollees are more likely to be out of work and are more likely than their younger counterparts to have a serious chronic health condition that may limit the jobs that will accommodate their limitations.

This bill does not specify college or other higher-learning as either an exemption to the work requirement or as community engagement. A study of millennials ages 25-32 have found that those with a two-year degree are less likely to be unemployed or live in poverty and attain higher annual incomes than those that solely have a high school diploma.[22] These findings are even more pronounced for those that have a bachelor's degree or higher. This age-group tends to be the population that this bill is targeting, nonelderly and nondisabled. Allowing these individuals to attend school and receive Medicaid coverage appears to be a more beneficial path out of poverty or unemployment that a requirement to work or volunteer.

This bill does not acknowledge the challenges for those enrolled in Medicaid that have been involved with the criminal justice system. The majority of those that have been released from jail or prison feel that their

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[19] Sanger-Katz, M. (Jan. 18, 2018). *Hate Paperwork? Medicaid Recipients will be Drowning in it.* Retrieved from https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html?rref=collection%2Fbyline%2Fmargot-sanger-katz&action=click&contentCollection=undefined&region=stream&module=stream_unit&version=latest&contentPlacement=1&pgtype=collection

[20] Genworth Financial (2018). *Compare Long Term Care Costs Across the United States.* Retrieved from https://www.genworth.com/about-us/industry-expertise/cost-of-care.html

[21] Center on Budget and Policy Priorities (Feb. 20, 2018). *How Medicaid Work Requirements will Harm Older Americans.* Retrieved from https://www.cbpp.org/sites/default/files/atoms/files/2-20-18health.pdf

[22] Pew Research Center (Feb 11, 2014). *The Rising Cost of Not Going to College.* Retrieved from http://www.pewsocialtrends.org/2014/02/11/the-rising-cost-of-not-going-to-college/

criminal record has negatively affected their job search.[23] If an individual has to continually be reporting their job search activities to Medicaid and conduct a job search, it could demotivate the individual, decrease the likelihood of finding a job with sufficient wages and increase the likelihood of recidivism.

Time-limiting Medicaid coverage has the risk of increasing the rate of uninsured individuals in the state. Furthermore, it could push sick and uninsured individuals into emergency rooms, where they can end up costing the state. As people drop out but remain uninsured, then the health care costs are borne by the insured, which drives up costs for the whole system. This proposal would also place a large administrative burden on the state, as it has to create a tracking system for each beneficiary to know when they have "timed-out" of the program. This would cost the department not only man-hours but additional taxpayer dollars. A study of Medicaid expansion enrollees in Ohio found that among those individuals who were unemployed when they gained covered, 75 percent said that having health insurance made the task of securing a job easier.[24]

Opponents

- Any opposition has not been made publicly available at this time.

About this Analysis

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[23] Visher, C., Debus, S., & Yahner, J. (Oct. 2008). Employment after Prison: A Longitudinal Study of Releasees in Three States. *Urban Institute Justice Policy Center.* Retrieved from https://www.urban.org/sites/default/files/publication/32106/411778-Employment-after-Prison-A-Longitudinal-Study-of-Releasees-in-Three-States.PDF

[24] Ohio Department of Medicaid (2016). *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly.* Retrieved from http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf

APPENDIX A:

State	Waiver Status	Medicaid Expansion Status	Work Requirement Hours	Qualifying Activities	Population Group	Exempted Groups	Penalties for Non-Compliance
AR	Approved Mar. 5, 2018	Implemented ACA Medicaid expansion through waiver	80 hours/month	-Employment or self-employment, or those whose income is consistent with being employed/self-employed at least 80 hours/month -Enrollment in educational program (high school, higher education, or GED classes) -On-the-job or vocational training -Job search or job search training (up to 40 hours/month) -Community service -Participation in classes on health insurance, using health care, or healthy living (up to 20 hours/year) -Participating in programs through state Department of Workforce Services -Compliance with either SNAP or Transitional Employment Assistance (TEA) employment programs	Non-medically frail individuals ages 19-49 in ACA Medicaid expansion group *(in the waiver, the state also requested limiting the ACA Medicaid expansion eligibility group to those earning 100 percent of the federal poverty level (FPL) or less; this aspect of the waiver was not approved)*	-Individuals 50 and older -Full-time students (attending high school, an institution of higher education, vocational training, or job training) -Those exempt from SNAP work requirements -Those receiving Transitional Employment Assistance (TEA) cash assistance or who are exempt from TEA work requirements -Individuals incapacitated in the short term or medically certified as physically or mentally unfit for employment, or has an acute medical condition validated by a medical professional that would prevent compliance with requirements -Caregivers of an incapacitated individual -Those who live with a minor dependent child age 17 or younger -Those receiving unemployment benefits -Those participating in alcohol or drug addiction treatment program -Pregnant women, through the end of post-partum care	Individuals must demonstrate compliance on a monthly basis. Loss of eligibility if enrollee fails to meet work requirements for any three months during the coverage year (either consecutive or non-consecutive months), with coverage termination occurring at the end of the third month of noncompliance. Unless a good cause exemption is met, individual would be locked out of coverage until start of next coverage year and would need to file a new application at that time. Good cause exemptions include: -Disability of individual or if individual has an immediate family member in the home with a disability and is unable to meet requirements for due to this; -Hospitalization/serious illness of the individual or an immediate family member in the home; -Birth or death of a family member in the home; -Severe inclement weather or natural disaster causing inability to meet requirement; or -Individual has family emergency or other life changing event (e.g., divorce or domestic violence). If state determines that an individual's failure to comply or report compliance was the result of a catastrophic event or circumstances beyond an individual's control, the individual will receive retroactive coverage to the date coverage ended without the need for a new application.

National Academy for State Health Policy (March 5, 2018). *State Proposals for Medicaid Work and Community Engagement Requirements.* Retrieved from https://nashp.org/state-proposals-for-medicaid-work-and-community-engagement-requirements/

State	Waiver Status	Medicaid Expansion Status	Work Requirement Hours	Qualifying Activities	Population Group	Exempted Groups	Penalties for Non-Compliance
IN	Approved Feb. 2, 2018	Implemented ACA Medicaid expansion through waiver	Requirements will increase over the course of the individual's first year of participation, beginning at five hours/week at the seventh month of enrollment and increasing to 20 hours/week at 18 months and beyond Enrollees must meet the community engagement requirements for eight months per calendar year	-Subsidized or unsubsidized employment -Participating in state's Gateway to Work program -Managed care entities employment initiatives -Job skills training -Job search activities -Education related to employment; general education (e.g. GED or community college) -Accredited ESL education or homeschooling -Vocational education/training -Community work experience -Community service/public service -Volunteer work -Caregiving services for a non-dependent relative or other individual with a chronic, disabling health condition -Compliance with SNAP work requirements Certain tribal members will be considered as meeting the Gateway to Work requirement due to tribe's Pathways employment program. Gateway to Work will also encourage enrollees with a substance use disorder to seek treatment by considering participation in treatment program as criteria for exemption.	Able-bodied individuals enrolled in Healthy Indiana Plan (HIP), up to age 60	-Full- and part-time students -Pregnant women -Primary caregivers of a dependent (either minor child or disabled adult) -Medically frail individuals -Certification of temporary illness or incapacity -In active substance use disorder treatment -Individuals over age 59 -Former foster children under age 26 -Chronically homeless individuals -TANF recipients -Recent incarceration -Some other exemptions possible based on individual review	Requirements will be phased in during the second year, with an enrollee grace period of six months. Each December, state will evaluate if enrollees have met work requirement hours for the prior 12-month calendar year. If requirements are not met, eligibility will be suspended beginning on the first day of the new calendar year. Individuals with suspended benefits can reactivate eligibility by meeting one of the following criteria: 1) becoming eligible under another eligibility group; 2) qualifying for an exemption; 3) completing one calendar month of the work requirement hours and submitting documentation information to the state. Unless an individual reactivates eligibility, eligibility will remain suspended until redetermination date; if at that time the individual does not qualify for an exemption, enrollment will be terminated and individual will need to reapply to regain coverage.

State	Waiver Status	Medicaid Expansion Status	Work Requirement Hours	Qualifying Activities	Population Group	Exempted Groups	Penalties for Non-Compliance
KY	Approved Jan. 12, 2018. *(Three organizations, including the National Health Law Program, the Kentucky Equal Justice Center, and the Southern Poverty Law Center, filed a lawsuit challenging the waiver on Jan. 24, 2018.)*	Implemented ACA Medicaid expansion through waiver *(originally implemented traditional expansion; state sought waiver in 2016)*	80 hours/month; requirements will be phased in by region	-Subsidized or unsubsidized employment -Self-employment -Job skills training -Job search activities -Enrollment in educational program related to employment (e.g., management training) -General education (e.g., high school, GED, college or graduate education, ESL classes) -Vocational education and training -Community work experience -Community service/public service -Caregiving services for a non-dependent relative or other individual with a chronic, disabling health condition -Participation in substance use disorder treatment	Able-bodied adults ages 19 to 64 Kentucky HEALTH beneficiaries who have not been subject to the requirements in the past five years will be provided a three-month grace period prior to being subject to the requirements	-Children under age of 19 -Pregnant women -Primary caregivers of a dependent (either minor child or disabled adult; limited to only one exemption per household) -Medically frail individuals -Full-time students	After a one-month opportunity to become compliant, individuals who fail to meet requirements for a month will have their benefits suspended unless a good-cause exemption is issued. Good cause exemptions include: -Disability of the individual or if individual has an immediate family member in the home with a disability and is unable to meet requirements for due to this; -Hospitalization/serious illness of the individual or an immediate family member in the home; -Birth or death of a family member in the home; -Severe inclement weather or natural disaster causing inability to meet requirement; or -Individual has family emergency or other life changing event (e.g., divorce or domestic violence). Individuals can reactivate eligibility on the first day of the month after the individual complies with the requirements during a 30-day period or completes a state-approved health literacy or financial literacy course (the option to take a course is only available once in a 12-month benefit period). Individuals who, during a suspension period, become pregnant, are determined to be medically frail, become a primary caregiver of a dependent (either minor child or disabled adult — limited to only one exemption per household), are diagnosed with an acute medical condition that would prevent them from compliance with requirements (validated by a medical professional), or become a full-time student, or become eligible for Medicaid under an eligibility group not subject to the work and community engagement requirements can reactivate benefits, with an effective date aligned with their new eligibility category or status. Individuals with suspended benefits at the time of their redetermination date who do not qualify for an exemption will have their enrollment terminated and will have to submit a new application to regain coverage

Health District
OF NORTHERN LARIMER COUNTY

Memo

To: Board of Directors, Health District of Northern Larimer County

From: Alyson Williams, Policy Coordinator

Date: March 23, 2018

Re: Staff Recommendation for 3/27 Board Meeting Bill Positions

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HB18-1279: Electronic Prescribing Controlled Substances

Staff recommends that the Board of Directors support HB18-1279.

HB18-1284: Disclosure of Prescription Costs at Pharmacies

Staff recommends that the Board of Directors support HB18-1284

SB18-214: Request Self-Sufficiency Waiver Medicaid Program

Staff recommends that the Board of Directors strongly oppose SB18-214

Memorandum

To: Health District Board

From: Chris Sheafor

Date: 3/23/2018

Re: Revisions to the Employee Handbook

Every two years the Health District reviews its Employee Handbook and makes changes to bring it up to date and include new programs, regulations and edits to make it clearer. Some of the changes were made to incorporate existing stand-alone policies into the Handbook to make them more accessible to staff. A few were added because of our research through the Employer's Council (EC) and the Society for Human Resource Management (SHRM) which indicated that they be included in a comprehensive Employee Handbook. Still others were included because of changes to laws or Health District benefits programs. Finally, some were revised based on input from our legal counsel.

The attached copy has been highlighted to show which sections or paragraphs have substantial changes. I can provide more information about why these were done if you desire.

Your approval of these changes is requested, as the Employee Handbook is one of the few internal policies that requires Board of Directors approval.

Employee Handbook

March 2018

Health District
OF NORTHERN LARIMER COUNTY

Presented for Approval by the Board of Directors of the Health District on March 27, 2018

Health District
OF NORTHERN LARIMER COUNTY

120 Bristlecone Drive, Fort Collins, CO 80524
970•224•5209 fax 970•221•7165
info@healthdistrict.org www.healthdistrict.org

Welcome New Employee!

On behalf of your coworkers and the Board of Directors, we welcome you to the Health District of Northern Larimer County and wish you every success here.

We believe that each employee contributes directly to the Health District's mission of enhancing our community's health status and to our success, and we hope you will take pride in being a member of our team. This handbook was developed to describe some of the expectations of our employees and to outline the policies, programs, and benefits available to eligible employees. Employees should familiarize themselves with the contents of the employee handbook as soon as possible; it will answer many questions about employment with the Health District.

We hope your experiences here will be challenging, enjoyable and rewarding. Again, welcome!

IMPORTANT

This handbook is designed to acquaint you with the Health District and provide you with information about working conditions, employee benefits, and some of the guidelines affecting your employment. You should read, understand, and comply with all provisions of the handbook. It describes many of your responsibilities as an employee and outlines the programs developed by the Health District to benefit employees. One of our objectives is to provide a work environment that is conducive to both personal and professional growth.

Employees have the right to end their work relationship with the organization, with or without advance notice or cause. The organization has the same right. Employment with the Health District is “at will” as to both the employer and employee, and nothing contained in this handbook modifies or changes that status. **THE LANGUAGE USED IN THIS HANDBOOK AND ANY VERBAL STATEMENTS BY MANAGEMENT ARE NOT INTENDED TO CONSTITUTE A CONTRACT OF EMPLOYMENT, EITHER EXPRESS OR IMPLIED, NOR IS THERE A GUARANTEE OF EMPLOYMENT FOR ANY SPECIFIC DURATION. NO REPRESENTATIVE OF THE HEALTH DISTRICT OF NORTHERN LARIMER COUNTY, OTHER THAN THE EXECUTIVE DIRECTOR (OR THEIR DESIGNEE) OF THE ORGANIZATION, HAS AUTHORITY TO ENTER INTO AN AGREEMENT OF EMPLOYMENT FOR ANY SPECIFIED PERIOD AND ANY SUCH AGREEMENT MUST BE IN WRITING, SIGNED BY THE EXECUTIVE DIRECTOR AND THE EMPLOYEE.**

No employee handbook can anticipate every circumstance or question. As the Health District continues to change, we reserve the right to revise, supplement, or rescind any guidelines or portion of the handbook as is deemed appropriate, at the sole and absolute discretion of the Board of Directors of the Health District.

This issue supersedes all previous issues.

EMPLOYEE HANDBOOK
TABLE OF CONTENTS

Approved by Board of Directors
Health District of Northern Larimer County
March 27, 2018

100.00 INTRODUCTION

This document contains the personnel guidelines approved by the Board of Directors of the Health District of Northern Larimer County. All revisions to these guidelines must be approved by the Board, and will take effect on the date that they are approved, and, unless otherwise stated, will supersede and replace the applicable guideline.

The Executive Director of the Health District or his or her designee has responsibility for administering these personnel guidelines. The Executive Director is authorized to act upon situations not covered by, or exceptions to, these written guidelines. In cases of emergency or natural disasters the Executive Director may develop or invoke policies written specifically for those situations.

All employees are expected to be familiar with these guidelines and should consult with their supervisor on questions of interpretation before decisions are made or actions taken. All new employees will receive a copy of these guidelines and sign a statement that they have received the guidelines. This statement will be kept in each employee's personnel file. The current Employee Handbook is also available on the sidebar of *In The Loop.*

100.01 OVERVIEW OF THE HEALTH DISTRICT

Who We Are

The Health District is a public agency that provides residents of northern Larimer County with dental, mental health, preventive health, and advance care planning services, in addition to connecting people to more affordable health insurance and prescription options. We also join with other local organizations to assess and plan to better meet prioritized health care needs of our community.

Mission, Vision, Strategy and Values

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.

Approved by Board of Directors
Health District of Northern Larimer County
March 27, 2018

- 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

200.00 EMPLOYMENT PRACTICES

200.01 EQUAL EMPLOYMENT OPPORTUNITY (EEO)

In order to provide equal employment and advancement opportunities to all individuals, employment decisions at the Health District will be based on merit, qualifications, and abilities. The Health District does not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, national origin, age, disability, sexual orientation, genetic information, or any other applicable status protected by federal, state or local law**.**

200.02 HARASSMENT

The Health District strives to maintain a work environment free from unlawful harassment. In doing so, the Health District prohibits unlawful harassment because of race, color, religion, sex, national origin, age, disability, sexual orientation, genetic information, or any other applicable status protected by federal, state or local law.

Unlawful harassment includes verbal or physical conduct that has the purpose or effect of substantially interfering with an individual's work performance, or creating an intimidating, hostile or offensive work environment. Actions based on race, color, religion, sex, including gender identity and pregnancy, national origin, age, disability, sexual orientation, genetic information, or any other applicable status protected by federal, state or local law will not be tolerated. Prohibited behavior may include, without limitation, the following:

- Written form such as cartoons, email, posters, drawings or photographs.
- Verbal conduct such as epithets, derogatory comments, slurs or jokes.
- Physical conduct such as assault, or blocking an individual's movements.

This policy applies to all employees including managers, supervisors, co-workers, and non-employees such as interns, volunteers, customers, clients, vendors, and consultants.

Sexual Harassment

Because sexual harassment raises issues that are to some extent unique in comparison to other harassment, the Health District believes it warrants separate emphasis. The Health District strongly opposes sexual harassment and inappropriate sexual conduct. Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, and engagement in any other unwelcome or offensive verbal or physical conduct of a sexual nature, including, without limitation:

- Submission to such conduct is made explicitly or implicitly a term or condition of employment;
- Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment; or.
- Such conduct having the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment.

All employees are expected to conduct themselves in a professional and businesslike manner at all times. Conduct which may violate this policy includes, without limitation, sexually implicit or explicit communications whether in:

- Written form such as cartoons, posters, calendars, notes, letters, email.
- Verbal form such as comments, jokes, foul or obscene language of a sexual nature, gossiping, or questions about another's sex life, or repeated unwanted requests for dates.
- Physical gestures and other nonverbal behavior, such as unwelcome touching, grabbing, fondling, kissing, massaging, and brushing up against another's body.

200.03 EEO COMPLAINT PROCEDURE

If an employee experiences or observes a violation of the EEO policy or the harassment as outlined in Section 200.02, including sexual harassment, please use the following complaint procedure. The Health District expects employees to make a timely complaint to enable the Health District to investigate and correct any behavior that may be in violation of this policy.

The incident should be reported to the employee's supervisor or, if the supervisor is involved in the harassment, to the next level supervisor. Supervisors must report all incidents to their director, if the director is not involved. The Designated EEO/ADA Officer and the Executive Director must also be informed by the supervisor of all sexual harassment complaints. The incident will be promptly investigated and corrective action will be taken where appropriate. Employee's complaints will be kept as confidential as practicable, to the extent confidentiality is consistent with a thorough investigation and any corrective action necessary.

The Health District prohibits retaliation against any employee for filing a complaint under this policy or for assisting in a complaint investigation. If an employee believes there has been a violation of the Health District EEO or retaliation standard, the employee should follow the complaint procedure contained in the harassment policy.

If the Health District determines that an employee's behavior is in violation of this policy, disciplinary action will be taken, up to and including termination of employment.

200.04 EMPLOYMENT CATEGORIES

It is the intent of the Health District to clarify the definitions of employment classifications so employees understand their employment status and benefit eligibility. These classifications do not guarantee employment for any specified period of time. Accordingly, the right to terminate the employment relationship at any time is retained by both the employee and the Health District.

I. Each employee is designated as either NONEXEMPT (Overtime Eligible) or EXEMPT from federal and state wage and hour laws. See Section 300.04 for further information. NONEXEMPT employees are entitled to compensation under the specific provisions of federal and state laws. EXEMPT employees are excluded from specific provisions of federal and state wage and hour laws. An employee's EXEMPT or NONEXEMPT classification may be changed only upon approval of the Director responsible for Human Resources or their designee.

II. In addition to the above categories, each employee will belong to one other employment category:

REGULAR FULL-TIME employees are those who are not in a temporary status and who are regularly scheduled to work 30 or more hours per week. They are eligible for the Health District's benefit package, subject to the terms, conditions, and limitations of each benefit program and subject to the Board of Directors' authority to modify or eliminate any such program.

REGULAR PART-TIME employees are those who are not assigned to a temporary status and who are regularly scheduled to work less than 30 hours per week, but at least 20 hours per week. They are eligible for the Health District's benefit package, subject to the terms, conditions, and limitations of each benefit program and subject to the Board of Directors' authority to modify or eliminate any such program.

TIME-LIMITED FULL-TIME employees are those who are not in a temporary status and who are regularly scheduled to work 30 or more hours per week. In addition, they must be hired under a project or funding source with a defined ending date or a soft money source (for example, a special project or outside funding source) or are an interim replacement expected to last more than five months. They are eligible for the Health District’s benefit package subject to the terms, conditions, and limitations

of each benefit program and subject to the Board of Directors' authority to modify or eliminate any such program.

TIME-LIMITED PART-TIME employees are those who are not in a temporary status and who are regularly scheduled to work less than 30 hours per week, but at least 20 hours a week. In addition, they must be hired under a special project or funding source with a defined ending date, or are an interim replacement expected to last more than five months. They are eligible for the Health District's benefit package subject to the terms, conditions, and limitations of each benefit program and subject to the Board of Directors' authority to modify or eliminate any such program.

PART-TIME employees are those who are not assigned to a temporary status and who are regularly scheduled to work less than 20 hours per week. While they do receive all legally mandated benefits (such as Social Security, workers' compensation), they are ineligible for any of the Health District's other benefit programs.

TEMPORARY employees are those who are hired as interim replacements, to temporarily supplement the work force, or to assist in the completion of a specific project and do not fit the requirements for a time-limited employee. Employment assignments in this category are of a limited duration either by time or event, which will be defined at the time of hire. If a temporary employee remains to the end of this period and is still needed, the temporary appointment will be reevaluated for consideration of a move to the appropriate status. Employment beyond any initially stated period does not in any way imply a change in employment status. Temporary employees retain that status unless and until notified of a change by their supervisor. While temporary employees receive all legally mandated benefits (such as Social Security, workers' compensation), they are ineligible for any of the Health District's other benefit programs. Individuals hired through temporary agencies are not employees of the Health District.

CASUAL/PRN employees are those who have established an employment relationship with the Health District but who are assigned to work on an intermittent and/or unpredictable basis. While they receive all legally mandated benefits (such as workers' compensation insurance and Social Security), they are ineligible for any of the Health District's other benefit programs.

200.05 PERSONNEL DATA CHANGES

It is the responsibility of each employee to promptly notify the Health District of any changes in personnel data. Personal mailing addresses, telephone numbers, number and names of dependents, individuals to be contacted in the event of emergency, educational accomplishments, and other such status reports should be accurate and current at all times. If personnel data has changed, notify the Human Resources Department.

200.06 ACCESS TO PERSONNEL FILES

The Health District maintains a personnel file on each employee. The personnel file includes such information as the employee's job application, resume, records of licensure, documentation of performance appraisals and salary increases, and other employment records.

Personnel files are the property of the Health District, and access to the information they contain is restricted according to the provisions of Colorado and federal law**.** Generally, only the employee, supervisors and management personnel of the Health District who have a legitimate reason to review information in a file are allowed to do so, unless otherwise provided by Colorado law.

Employees who wish to review their own file should contact the Human Resources Department. With reasonable advance notice, an employee may review his/her own personnel file in the Human Resources Department's offices subject to procedures developed by the Health District that ensure that no alteration or modification to, or deletions from, an employee's file shall occur. Alteration, modification, or removal of documents from an employee's personnel file may be subject to disciplinary action up to and including termination.

200.07 SAFETY

To assist in providing a safe and healthful work environment for employees, customers, and visitors, the Health District has established the following workplace safety guidelines.

Each employee is expected to obey safety rules and to exercise caution in all work activities. Employees must immediately report any unsafe condition to the appropriate supervisor. Employees who violate safety standards, cause hazardous or dangerous situations, or fail to report or, where appropriate, remedy such situations are out of compliance with Health District Internal Policies. These situations may be subject to corrective action and/or termination.

In the case of accidents that result in injury, regardless of how insignificant the injury may appear, employees should immediately notify their supervisor and complete the appropriate incident report. Such reports are necessary to comply with laws and initiate insurance and workers' compensation benefits procedures.

200.08 EMERGENCY CLOSINGS

Sometimes natural disasters or other emergencies may disrupt Health District operations. In extreme cases, they may require the closing of all or part of a work facility.

Only the Executive Director, or his or her designee, may make the decision to close all or part of the Health District.

Notice of unscheduled closures will be posted to the Health District website (healthdistrict.org) and social media (Facebook and Twitter) as soon as possible. Closures also will be announced to local news media, including the Coloradoan, KUNC, and Denver television stations (4, 7, 9 and 31). Employees should not rely exclusively on news media to confirm a closure, however, since news reports might be delayed.

Employees also will be notified of closures by automated phone calls (whenever possible) and/or Health District email. Employees are responsible for ensuring that an up-to-date phone number is on file for the automated call list.

Employees who work in non-Health District facilities should follow the closure policies for those organizations.

If employees think that closure of a Health District facility might be possible, and they have not been notified by phone, they should check the following sources:

1. Health District website
2. Health District social media
3. Health District email
4. Local news media

If employees are still uncertain of the status, they should contact their supervisor (no earlier than 6:30a.m.) on his or her listed cell phone.

As soon as a closure is announced, supervisors are responsible for ensuring that attempts are made to notify clients. Employees who have scheduled meetings are responsible for attempting to notify meeting participants to cancel and reschedule.

Once employees are aware of a closure, they should let their supervisor know (or designee, if the supervisor is out of town) by calling or texting them on their cell phone or emailing them at their Health District email address. Employees are responsible for having cell phone numbers for their supervisors and their designees. If they do not hear from their employees, supervisors should attempt to contact them by text or phone.

Snow Closures
The most likely reason for a closure is severe weather, particularly snowstorms. Whenever possible, decisions regarding snow closures will be made by 6 a.m. and announced by 6:30 a.m. If heavy snow conditions make it appear that a closure might be imminent, but a decision has not been announced by 6:30 a.m., employees should contact their supervisor to find out if a decision is still pending. Because weather conditions can change rapidly, snow or other weather-related closures may be announced at any time, and a decision to remain open may be reversed later.

Some employees have long commutes or early start times that require them to leave the house near or before the time when a snow closure might ordinarily be announced. These employees may delay their departure slightly until they have confirmed that the Health District will be open. However, if they delay their departure and the Health District remains open, they must inform their supervisor (or designee) that they will be late.

Minor tardiness during severe weather events may be excused, especially since adverse road conditions might increase commuting time. However, a lengthy period away from work must be made up in the same work week or charged to paid time off (or compensatory time, if available). If employees are completely absent due to weather conditions, and the Health District remains open, they must use paid time off (PTO)(or compensatory time, if available) for any work time missed.

When the Health District is officially closed because of severe weather or another emergency, resulting employee absences will be considered paid time.

200.09 EMPLOYMENT OF RELATIVES OR THOSE IN CLOSE RELATIONSHIPS

For purposes of this section, the following terms shall have the following meanings:

The term “relative” includes anyone other than a current spouse who is related by blood, marriage or adoption, or anyone whose relationship with an employee is similar to someone related by blood, marriage or adoption (e.g. children, step

children, adoptive children, grandchildren, dependents, parents, step-parents, in-laws, grandparents, siblings, uncles, aunts, nieces and nephews).

The term “spouse” means someone who has a legal, marital relationship or who is involved in a relationship characterized by permanence, duration and stability normally associated with marriage.

The Health District wishes to give any qualified applicant the opportunity for employment, whether related to present employees or not. However, certain situations can create an actual or potential conflict of interest and must be avoided. The Health District reserves the right to make staffing changes or not hire an individual if such a conflict cannot be avoided.

Relatives, including without limitation spouses and those with whom the employee is intimate, must immediately disclose that they are relatives of another employee in the following circumstances:

- Where a relative supervises another relative or has a supervisory/reporting work relationship;
- Where a relative has access to confidential information, including payroll and personnel records of another relative; or
- Where the relative is in a position to audit, verify or receive money handled by another relative.
- Where the relative is on the same sub-team within the same department.

If a relative or other close relationship is discovered after employment or if two employees become relatives during their employment, subject to applicable law, the Health District may require one of the two such employees to be transferred. If no such transfer is available, the Health District may require one of the employees to terminate their employment within 90 days of the onset of the relative or other close relationship.

300.00 PAY PRACTICES

300.01 TIMEKEEPING

Accurately recording time worked is the responsibility of every nonexempt employee. Federal and state laws require the Health District to keep an accurate record of time worked in order to calculate employee pay and benefits. **Time worked is all the time actually spent on the job performing assigned duties.** For purposes of calculating overtime, the workweek begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. on the following Saturday.

Nonexempt employees must accurately record the time they begin and end their work, as well as the beginning and ending time of each meal period. They should also record the beginning and ending time of any split shift or departure from work for personal reasons. Nonexempt employees may not work off the clock. OVERTIME WORK BY NONEXEMPT EMPLOYEES MUST BE APPROVED BEFORE IT IS PERFORMED.

The Health District utilizes an electronic timekeeping system. Nonexempt employees are expected to use the time clocks located at the work site. Employees who have approval from their supervisor to begin or end their day off site will use the internet time clock via the intranet. It is the responsibility of non-exempt employees to use care when clocking in and out in order to avoid making errors in time reporting. Accurate time clock system usage is viewed as a performance expectation and is evaluated as part of the performance review process.

If an employee fails to correct a missed punch in the electronic time-keeping system or submit a Missed Punch/Time Correction form before the end of the payroll period, any wages due for uncorrected missed hours will be paid the following pay period.

Altering, falsifying, tampering with time records, or recording time on another employee's time record will not be tolerated.

For further information see Internal Policy 3-18: Timekeeping Procedures.

300.02 PAYDAYS

There are two pay periods in a month. The pay period from the 1st through the 15th day of the month will be paid on the 20th day of the month. The pay period from the 16th through the last workday of the month will be paid on the 5th day of the following month. Each paycheck will include earnings for all work performed through the end of the previous payroll period. If payday falls either on a weekend or a designated holiday, employees will be paid on the first workday following the weekend or designated holiday.

The Health District requires that employees' pay be deposited electronically into their accounts with financial institutions, unless certain conditions exist. An employee may be authorized to receive payment by check if he or she meets one of the following conditions for exemption:

- Is unable to establish a qualifying account at a financial institution
- Certifies that payment by direct deposit would be impractical and/or more costly than payment by check

In the event that the Health District has to be closed in response to an emergency situation, the distribution of paper paychecks may be suspended. However, distribution of paychecks by direct deposit will continue uninterrupted.

Those employees not receiving direct deposit may pick up their paychecks in person from the Finance Department by 3:00 p.m. on payday; if their check has not been picked up by that time, it will be mailed to the employees' address of record.

300.03 PAY DEDUCTIONS

Federal, state and local income tax laws require that the Health District make certain deductions from every employee's compensation. The Health District must also withhold Social Security and Medicare taxes (FICA) on each employee's earnings. Social Security taxes have a wage base limit that is subject to the tax and is updated annually by the Internal Revenue Service. The Health District matches the amount of Social Security and Medicare taxes paid by each employee.

The Health District offers programs and benefits beyond those required by law. Eligible employees may voluntarily authorize deductions from their paychecks to cover the costs of participation in these programs.

Exempt employees must be paid on a salary basis. This means exempt employees will regularly receive a predetermined amount of compensation each pay period on a weekly basis. The Health District is committed to complying with salary basis requirements which allows properly authorized deductions.

If an employee believes that an improper deduction has been made to their earnings, the employee should immediately report this information to the Finance Department. Reports of improper deductions will be promptly investigated. If it is determined that an improper deduction has occurred, the employee will be promptly reimbursed.

300.04 OVERTIME

Exempt employees are not eligible for overtime or compensatory time. Nonexempt employees may be asked or required to work overtime assignments when operating requirements or other needs cannot be met within a normal forty (40) hour work week.

NONEXEMPT EMPLOYEES MUST RECEIVE PRIOR AUTHORIZATION FROM THEIR SUPERVISOR BEFORE WORKING OVERTIME. Overtime work without receiving prior authorization from the supervisor will not be tolerated. Nonexempt employees may not work “off the clock.”

For nonexempt employees it is Health District policy to utilize compensatory time off in lieu of overtime in accordance with FLSA guidelines. The Health District does not normally pay cash overtime payments. On rare occasions, overtime pay may be considered if the supervisor has submitted a request and received approval from their director and the Executive Director. Compensatory time off will be granted at a rate of one and one-half hours for each hour worked over 40 in a work week.

PAID TIME OFF AND HOLIDAYS WILL NOT BE COUNTED AS HOURS WORKED FOR PURPOSES OF CALCULATING OVERTIME.

300.05 REST PERIODS AND MEAL BREAKS

Nonexempt employees are allowed one ten minute rest period for every four hours of work. To the extent possible, breaks should be taken in the middle of work periods.

Nonexempt employees are also entitled to at least one-half hour of unpaid meal period for each workday that is in excess of five consecutive hours of work. Meal periods may be longer depending on the needs of the organization. Typically, it is expected that nonexempt employees will take meal breaks on a daily basis. Occasionally, employees may need to work through their meal break. This is allowed so long as it has been approved by their supervisor. Nonexempt employees may not regularly work through their meal break on a long-term basis without requesting and receiving prior approval from their director, which approval will be given only in special circumstances.

300.06 WORK SCHEDULES

Work schedules for employees vary throughout our organization. Supervisors will assign employees their individual work schedules. Staffing needs and operational demands may necessitate variations in starting and ending times, as well as variations in the total hours that may be scheduled each day and week. Supervisors must approve changes to an individual’s normal work schedule.

Flexible scheduling is available in some cases to allow employees to vary their starting and ending times each day within established limits. Employees should consult their supervisors to determine if their position is eligible.

The Health District believes that working in teams is the preferred way to accomplish tasks, recognizing that at times working from remote locations can be an employee's more efficient way of completing certain assignments. Normally only part of any particular position's duties lends itself to telework. The Telework Policy provides a criteria and procedure for employees working from home or other remote locations. Telework is intended only for regular, recurring work done from a remote location on an ongoing basis.

For further information see Internal Policy 3-12: Telework Policy.

400.00 TIME OFF

PAID TIME OFF AND HOLIDAYS WILL NOT BE COUNTED AS HOURS WORKED FOR PURPOSES OF CALCULATING OVERTIME.

400.01 PAID TIME OFF (PTO)

Time off with pay is available to eligible employees to use as they choose for vacation, sick leave, dependent sick leave, or other personal needs. It is extremely important that employees build up and save a reasonable amount of time to be used in case of illnesses or emergency. Approval of time off without pay is only given in rare instances and is not guaranteed. It will result in a loss of pay and may jeopardize employment status. Employees in the following employment classification(s) are eligible to earn and use Paid Time Off (PTO) as described in this policy:

Regular full-time employees
Regular part-time employees **(prorated)**
Time-limited full-time employees
Time-limited part-time employees **(prorated)**

The amount of paid time employees receive each year increases with the length of their eligible employment as shown in the following schedule.

The Health District Board of Directors has declared that in any year where there is not enough anticipated funding for Intermediate Medical Leave (IML) the earning schedule for employees with more than one year of service may be reduced by one day per year. Employees will be notified by the end of the year prior to the change.

PAID TIME OFF EARNING SCHEDULE Beginning 2011		
Years of Eligible Service	**Monthly Paid Time Off**	**Yearly Paid Time Off**
Upon initial eligibility	1.0 days	12 days
After **one** year	1.5 days	18 days
After **two** years	2 days	24 days

Once employees enter an eligible employment classification, they begin to earn paid time off according to the schedule.

For accrual purposes, a day is defined as the number of hours that an employee is allocated to work weekly divided by five.

Eligible employees will start accruing PTO on the first day of employment and it may not be used until earned. In general, (PTO) may not be requested until earned. However, in compelling cases, supervisors may give conditional approval to requests for PTO from employees if by the date of the planned absence the employee expects to have accrued sufficient PTO to cover the time off.

It is strongly recommended that employees keep a minimum of three working days of PTO to ensure that employees have a reasonable amount of paid time off available in case of unexpected illness or other emergencies, either before or after the requested time off. Leave without pay is not guaranteed and PTO is for both vacation and sick leave.

Paid Time Off can be used in minimum increments of one-quarter hour. To take paid time off, EMPLOYEES MUST REQUEST ADVANCE APPROVAL FROM THEIR SUPERVISORS except in the case of illness or emergency. Requests will be reviewed based on a number of factors, including business needs and staffing requirements. Any time-off requests of three or more days, or those surrounding designated holidays, should normally be submitted through the on-line time keeping system to the supervisor at least two weeks prior to the start of the requested time off. No more than two weeks of paid time off may be taken at any one time, except in special circumstances approved by the Executive Director. If PTO is taken due to an illness or emergency, a request form must be promptly filed with the supervisor, who will sign and send it to the Finance Department.

Paid Time Off is paid at the employee's base pay rate at the time that it occurs. It does not include overtime or any special forms of compensation.

Paid Time Off accrues only while the employee is in an active pay status. Active pay status is defined as any pay period that includes wages for actual time worked, wages for approved PTO and wages for eligible holiday pay. Active pay status does not include wages paid under worker's compensation benefits, payments made in lieu of health insurance coverage, wages paid with donated PTO, or wages paid for Intermediate Medical Leave.

Full time employees who work 40 hours per week may accumulate up to 25 days (200 hours) of paid time off. Employees who work less than 40 hours per week may accumulate a prorated amount of PTO.

For example:

#Hours per week	Days in week	#Hours worked per day	X 25 days =	Total # hours employee may accumulate
40 ÷	5	= 8	8 x 25 =	200 hours
32 ÷	5	= 6.4	6.4 x 25 =	160 hours
30 ÷	5	= 6	6 x 25 =	150 hours
20 ÷	5	= 4	4 x 25 =	100 hours

Time-Limited Full-Time or Time-Limited Part-Time employees hired under a special project or funding source with a defined ending date are expected to use all accrued PTO during the project period. Such employees may not take more than two days of PTO during the last two weeks of the project without their supervisor's written approval.

If an employee voluntarily terminates and is re-hired within one year, they will retain their years of eligible service for the purpose of calculating paid time off.

400.02 EMERGENCY TIME OFF BANK (ETOB)

Any time accrued above the applicable limit (see above) will be placed in the employees' Emergency Time Off Bank (ETOB) which may be used for verifiable personal emergencies approved by the Executive Director. An employee may request use for the following reasons:

1. Covering all or part of the two weeks before Intermediate Medical Leave becomes effective. See Section 400.12 Intermediate Medical Leave.
2. Paying the difference between the 66% and 100% of salary during Intermediate Medical Leave. See Section 400.12 Intermediate Medical Leave.
3. Time off when an employee requires extended time away from work in order to care for a family member in a situation allowed by FMLA.
4. Other personal emergency situations approved by the Executive Director.

Accrual of emergency banked ETOB will stop when it reaches the cap of 90 days (or applicable prorated amount below). When the employee has been approved to use paid time off from the ETOB and brings the available amount below the 90-day cap (or applicable prorated amount below), accrual will begin again.

For example:

#Hrs. per week	Days in week	#Hrs. worked per day	X 90 days =	Total # hours employee may accumulate in Emergency Bank
40 ÷	5	= 8.0	8 x 90 =	720 hours
32 ÷	5	= 6.4	6.4 x 90 =	576 hours
30 ÷	5	= 6.0	6 x 90 =	540 hours
20 ÷	5	= 4.0	4 x 90 =	360 hours

ETOB days under this section may be taken only after all regular accrued paid time off days have been used with the exception of retained PTO leave allowable under Intermediate Medical Leave (IML) or Family and Medical Leave (FMLA) policy.

ETOB will not be paid upon termination of employment.

400.03 HOLIDAYS

The Health District will be closed on designated holidays, to be determined and communicated to staff by the Director responsible for Human Resources, and posted on In the Loop. In addition to the recognized holidays previously designated, eligible employees may receive one or more floating holidays in each calendar year. The floating holiday(s) must be taken in one work-day increments. Floating holidays are not considered accrued leave and must be used within the calendar year. The total number of holidays and floating holiday(s) will be eleven holidays a year. These holidays must be scheduled with the prior approval of the employee's supervisor. Benefited new employees are eligible for holiday time off upon commencement of employment. See also 400.09 Leave Without Pay.

The Health District will grant paid holiday time off to all eligible employees immediately upon assignment to an eligible employment classification. Holiday pay will be calculated based on the employee's straight-time pay rate (as of the date of the holiday) times the number of hours the employee would otherwise have worked on that day. Eligible employee classifications include:

Regular full-time employees
Regular part-time employees
Time-limited full-time employees
Time-limited part-time employees

Employees working less than 20 hours per week will not receive holiday pay. Hourly employees working 20 hours or more a week will receive holiday pay equal to the number of hours they would normally work on the scheduled day. Eligible exempt employees will receive their regular pay, and may take the holiday off if it falls on a day they normally work.

All part-time employees and those that work other than an 8:00 a.m. to 5:00 p.m., Monday through Friday schedule must declare a regular schedule, approved by their director, and submit it to payroll. Supervisors may not change work schedules solely for the purpose of allowing an employee to be paid for holidays.

Employees cannot begin or end their employment on a paid holiday. If a recognized holiday falls during an eligible employee's paid absence (such as flexible paid time off), holiday pay will be provided instead of the paid time off benefit that would otherwise have applied. Employees who are on unpaid leave on their normal working day before a holiday are not eligible for holiday pay.

If eligible Overtime Eligible employees are required to work on a recognized holiday they will receive holiday pay at one and one-half times their straight-time rate for the hours worked on the holiday.

The Health District will make reasonable accommodation for religious observance and practice to the extent that it does not result in an undue hardship on the regular conduct of business. Employees should submit a Time Off request at least one week in advance noting that the request is for religious leave. Employees granted religious leave may use floating holidays, PTO or unpaid leave as provided in Section 400.09 Leave Without Pay for observance of religious observance and practices. A supervisor may make accommodations including voluntary exchange of hours or alternate work time as long as they do not result in an undue hardship to the Health District and are appropriate to the job functions.

Paid time off for holidays will not be counted as hours worked for the purposes of determining overtime.

400.04 BEREAVEMENT LEAVE

Bereavement leave time is granted for such things as making funeral arrangements, attending the funeral or alternative to a funeral, dealing with ancillary matters necessitated by the death of a family member, for the immediate and after care of the deceased's survivors, and to grieve the loss of a family member.

Paid bereavement leave will be provided to eligible employees in the following categories:
Regular full-time employees
Regular part-time employees
Time-limited full-time employees
Time-limited part-time employees

Bereavement pay is calculated based on the base pay rate at the time of absence.

Up to 15 work days within a 6 month period	Spouse, domestic partner, partner in a civil union, or child
Up to five work days within a 6 month period	Employee's: ▪ Parent ▪ Grandparent or grandchild ▪ Sibling ▪ Daughter-in-law or son-in-law Employee's spouse's, domestic partner's, or partner in a civil union's: ▪ Parent ▪ Child or step child ▪ Sibling

A partner in a civil union must meet the requirements of the Colorado Civil Union Act.

A domestic partnership, for this purpose, is defined as two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. The additional requirements of a domestic partnership are:

1. The two must live together
2. Neither person may be married or a member of another domestic partnership
3. The two must not be related in a way which would prevent them from being married to each other
4. Both must be over 18
5. Neither person had a different domestic partner in the previous six months (this requirement does not apply if the partner died)

Employees claiming this benefit will be required to submit an affidavit stating that their relationship meets these criteria.

Employees may, with their supervisor's approval, use any available paid leave for additional time off as necessary.

400.05 TIME OFF TO VOTE

Voting is an important responsibility we all assume as citizens. We encourage employees to exercise their voting rights in all municipal, state, and federal elections.

The Health District, upon request the day before a general or municipal election, will provide employees up to two hours off with pay only if the voter does not have three or more non-scheduled work hours between 7:00 a.m. and 7:00 p.m. in which to vote.

400.06 JURY DUTY

The Health District recognizes jury duty as a civic responsibility of everyone. When summoned for jury duty, the employee is granted leave to perform their duty as a juror. Employees must show the jury duty summons to their supervisor as soon as possible so that the supervisor may make arrangements to accommodate their absence. If the employee is excused from jury duty during regular work hours, they are expected to report to work promptly.

The employee receives regular pay for the first three days of jury duty if they were scheduled to work and submitted a juror service certificate. Beginning the fourth day and thereafter, as a juror they are paid the approved amount by the State of Colorado for state, district or county court jury duty. While on jury duty, employees will receive their regular pay. Any compensation received by the employee for time spent performing jury duty on working days must be turned over to the Health District Finance Department, except for mileage and expenses. If the compensation received by the employee includes such expenses, the employee should document this to the Finance Department. In such a case, the employee should cash the check covering the total compensation and pay the Health District the remainder after the expenses have been deducted.

Employees who are subpoenaed or must appear in an official Health District capacity as witnesses in a court or official governmental hearing are granted court leave with pay for the period of such service. Compensation received by the individual on working days is required to be turned over to the Health District except for mileage and expenses.

Employees who serve as witnesses in an individual, rather than an official capacity, are charged PTO or leave without pay. The employee retains compensation received for such services.

400.07 FAMILY AND MEDICAL LEAVE

Family and Medical Leave (FMLA Leave)

The Health District provides up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- Incapacity due to pregnancy, prenatal medical care, or childbirth
- To care for the employee's child after birth, or placement for adoption or foster care
- To care for the employee's spouse, son or daughter, domestic partner, partner in a civil union, or parent, who has a serious health condition (see section 400.04 Bereavement Leave for the definition of a domestic partner or partner in a civil union)
- Serious health condition that makes the employee unable to perform the employee's job

Military Family Leave Entitlements

Eligible employees with a spouse, domestic partner, son, daughter, or parent on active duty or called to active duty status in the Armed Forces, National Guard, or Reserves may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

Eligible employees may also take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, National Guard, or Reserves, who has a serious injury or illness incurred or aggravated in the line of duty on active duty. Covered service member also includes veterans who were members of the Armed Forces, National Guard, or Reserves at any time during the period of five years preceding the start of treatment, recuperation, or therapy.

The injury or illness must make the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list. In the case of a veteran, the qualifying illness or injury must be incurred or aggravated in the line of duty and manifest itself before or after the service member became a veteran.

Benefits and Protections

During FMLA leave, the Health District maintains the employee's health coverage under any group health plan on the same terms as if the employee had continued

to work. While on leave, employees must continue to pay the same portion of any insurance premium that they typically pay.

If an employee fails to return from FMLA leave after the period of leave has expired and the failure to return is not caused by the continuation, recurrence of onset of a serious health condition or other circumstances beyond the employee's control, the employee will be required to reimburse the Health District for payment of health insurance premiums paid by the Health District during leave. An employee must work for at least 30 calendar days to be considered as having returned to work.

Upon return from FMLA leave, most employees are restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Certain highly compensated employees (key employees) may have limited reinstatement rights.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave. PTO will not accrue during the unpaid FMLA leave. Holidays, bereavement leave, or employer's jury duty pay are not granted while on unpaid leave.

Eligibility Requirements
Employees are eligible if they have worked for the Health District for at least 12 months. Employment does not have to have been continuous. The employee must have worked at least 1,250 hours during the 12-month period preceding the leave.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or requires the care of a qualified family member with a serious health condition.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive full calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
The maximum time allowed for FMLA leave is either 12 weeks in the 12-month period as defined by the Health District, or 26 weeks for military family leave.

Employees are entitled to a total of 12 work weeks of FMLA leave per 12-month period, starting the first day leave is taken.

Intermittent Leave for FMLA
When medically necessary, for an employee or for the care of a family member, FMLA leave can be taken in increments of time or as a reduced schedule. Time taken for intermittent FMLA does not have to be a full day. Time may be taken in minimum increments of one-quarter hour.

Employees must make reasonable efforts to schedule intermittent leave so as not to unduly disrupt the Health District's operations. Leave due to “qualifying exigencies” may also be taken on an intermittent basis. “Qualifying exigencies,” as defined in the FMLA rules, may arise when the spouse, son, daughter, or parent of an employee is on covered active duty in the Armed Forces, or has been notified of an impending call or order to covered active duty.

If intermittent leave is required, the employee must meet with their supervisor to establish a work schedule in advance. In circumstances where it is not possible to follow the predetermined schedule, the employee must notify the supervisor as soon as the need is realized.

Employees taking intermittent or reduced schedule leave based on planned medical treatment or for the care of a family member may be required to temporarily transfer to another job with equivalent pay and benefits that better accommodates that type of leave.

Substitution of Paid Leave for Unpaid Leave
The Health District requires employees to use accrued PTO while on FMLA leave, with the following exception. The employee may retain up to one week’s worth of accrued PTO based on the number of hours they normally work each week. This selection must be made prior to going out on FMLA leave and cannot be changed. If the employee is not capable of making the decision about holding back flex time within the first week of FMLA leave, PTO will be used to cover the absence.

An employee who will be taking FMLA leave as a single continuous period of time cannot request to retain more PTO than they have accrued at the time they start FMLA. FMLA leave is without pay when paid leave benefits are exhausted. When the employee is released to return to work their regular schedule, or as intermittent leave, the PTO they requested to be retained will be available for use.

While on paid PTO employees will continue to accrue PTO and receive holiday pay. Once an employee has used all of their available PTO, the employee will no

longer accrue PTO and will not be eligible for holiday pay until the employee returns to work.

Employee Responsibilities
Employees must provide at least 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30-days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with the Health District's normal call-in procedures.

Employees must provide sufficient information for the Health District to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities; the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the Health District if the requested leave is for a reason for which FMLA leave was previously taken or certified.

Employees also may be required to provide a certification and periodic recertification supporting the need for leave. The Health District may require second and third medical opinions at the Health District's expense. Documentation confirming family relationship, adoption, or foster care may be required. If notification and appropriate certification are not provided in a timely manner, approval for leave may be denied. Continued absence after denial of leave may result in disciplinary action in accordance with the Health District's attendance guideline. Employees on leave must contact Human Resources and their supervisor at least two days before their first day of return.

The Health District's Responsibilities
The Health District will inform employees requesting leave whether they are eligible under FMLA. If they are, the notice will specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the Health District will provide a reason for the ineligibility.

The Health District will inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the Health District determines that the leave is not FMLA-protected, the Health District will notify the employee.

Unlawful Acts
FMLA makes it unlawful for the Health District to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA

- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA

Enforcement of FMLA
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against the Health District.

FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights.

400.08 LEAVE FOR VICTIMS OF DOMESTIC VIOLENCE

Upon reasonable advance notice (except in cases of imminent danger to the health or safety of an employee), an employee may request up to three working days of leave from work in any 12-month period. This leave is unpaid unless the employee chooses to use PTO. This leave applies to employees who are the victims of the following statutorily defined events:

- Domestic violence or abuse
- Stalking
- Sexual assault
- A crime found by a court on the record to include an act of domestic violence

The employee must use the leave from work to protect him or herself by:

- Seeking services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence
- Seeking a civil protection order to prevent domestic abuse
- Obtaining medical care or mental health counseling for himself or herself or his or her children to address physical or psychological injuries resulting from the act of domestic abuse, stalking, sexual assault or other crimes involving domestic violence
- Making his or her home secure from the perpetrator or seeking new housing to escape the perpetrator
- Seeking legal assistance, attending or preparing for court-related proceedings arising from domestic violence acts

Employees should notify their supervisor as soon as possible to request domestic violence leave. Supervisors will work directly with the Payroll and Benefits representative to ensure state law is followed. The Health District will make reasonable efforts to maintain the confidentiality of all information related to

an employee's leave pursuant to this policy. The Health District will seek certification to verify the need for leave. The following documentation shall serve as certification for consideration of domestic violence leave:

- A police report indicating that the employee was a victim of domestic violence
- A court order protecting or separating the employee from the perpetrator of an act of domestic violence, or other evidence from the court or prosecuting attorney that the employee appeared in court
- Documentation from a medical professional, domestic violence advocate, health care provider, or counselor that the employee was undergoing treatment for physical or mental injuries or abuse resulting in victimization from an act of domestic violence

400.09 LEAVE WITHOUT PAY

When all other resources are exhausted, Leave Without Pay may be requested for compelling reason. Approval by an employee's supervisor or by the Executive Director is not guaranteed.

Supervisors may occasionally approve leave without pay that is one workday or less, not to exceed 16 hours total in a calendar year.

The Executive Director will consider leave without pay beyond one day only for emergency or other compelling reasons and may require support documentation for the request. Leave without pay may be granted for a period of up to six weeks per 12 month period.

To request leave without pay, employees must make a request via email to their supervisor, noting the reason for the request. Requests for leave without pay will be evaluated based on a number of factors, including reasons for the request and impact on the organization including anticipated workload requirements and staffing considerations during the proposed period of absence.

For leave without pay exceeding one day, supervisors will review the request, and if they support it, will forward it to the director along with relevant policy, analysis of impact to the organization and a coverage plan. If approved by the director, the request is forwarded to the Executive Director for final consideration. Employees taking unpaid leave under Executive Director-approval must first use any accrued paid leave time.

If an employee fails to report to work promptly at the expiration of the approved leave period, the employee shall be deemed to have resigned from his/her employment with the Health District.

Subject to the terms and conditions of the applicable plans, insurance benefits previously provided by the Health District will continue until the end of the month in which the approved leave without pay begins. At that time, employees will become responsible for the full cost of these benefits if they wish coverage to continue. When the employee returns from personal leave, the Health District, according to the applicable plans, will again provide benefits based on the employee's eligibility.

Leave without pay that has been granted for a serious medical condition when the employee is not eligible for FMLA or IML will require written documentation from a health care provider and return to work approval before the employee can resume their duties.

Leave without pay may also be granted as part of hiring negotiations for compelling reasons (e.g., a wedding or trip planned before the job offer was made), but the director must inform the Executive Director of the length and reason. The request must be in writing and presented at the time of the hiring negotiations and be included in the employee's offer letter.

400.10 AMERICAN WITH DISABILITIES ACT (ADA) AND REASONABLE ACCOMMODATION

To ensure equal employment opportunities to qualified individuals with a disability, the Health District will make reasonable accommodations for the known disability of an otherwise qualified individual, unless undue hardship on the operation of the business would result.

Employees who may require a reasonable accommodation should contact the Designated EEO/ADA compliance officer or the Human Resources Department.

400.11 ACCOMMODATIONS FOR PREGNANCY

The Health District will make reasonable accommodations for employees and applicants for conditions related to pregnancy or physical recovery from childbirth if the employee requests a reasonable accommodation, unless the requested accommodation would impose an undue hardship on the Health District's business. If an applicant or an employee requests such an accommodation, the Health District will engage in a timely, good-faith, and interactive process to determine effective, reasonable accommodations that can be made. The Health District may require an employee or applicant to provide a note stating the necessity of a reasonable accommodation from an applicable licensed health care provider before providing such a reasonable accommodation.

400.12 WORKPLACE ACCOMMODATIONS FOR NURSING MOTHERS

Under Colorado law, employees are allowed reasonable time for mothers to express milk at work for up to two years after the birth of the child. If paid break

and/or meal time is not sufficient for this, then the employee must take PTO, unpaid time, or the employee may be required to begin working earlier and/or leave work later to make up for the time spent expressing milk beyond meal and break times. The Health District will make every reasonable effort to provide a private space that is not a bathroom, is shielded from view, is free from intrusion from coworkers and the public, and is in close proximity to the work area.

400.13 MILITARY LEAVE

A military leave of absence will be granted to employees to attend scheduled drills or training or if called to active duty with the U.S. armed services. A copy of military orders must be provided to the Human Resources Department. The Health District complies with all federal and state regulations regarding military leaves of absence, and veterans' re-employment rights.

Employees will receive partial pay for two-week training assignments and shorter absences, for up to 15 days per year. Upon presentation of satisfactory military pay verification data, employees will be paid the difference between their normal base compensation and the pay (excluding expense pay) received while on military duty. The portion of any military leaves of absence in excess of 15 days will be unpaid. However, employees may use any available paid time off for the absence.

Subject to the terms, conditions and limitations of the applicable plans for which the employee is otherwise eligible, the Health District will provide health insurance or other benefits in compliance with regulations published by the U.S. Department of Labor under the Uniformed Services Employment and Reemployment Rights Act.

Employees on active duty training assignments are required to return to work for the first regularly scheduled shift after the end of training, allowing reasonable travel time. Employees on longer military leave must apply for reinstatement in accordance with all applicable state and federal laws. Every reasonable effort will be made to return eligible employees to their previous position, and employees will be returned to at least a comparable one. They will be treated as though they were continuously employed for purposes of determining benefits based on length of service, such as the rate of paid time off and job seniority rights.

400.14 DONATION OF PAID TIME OFF PTO

The Health District recognizes that occasionally personal crises or family traumas may occur in an employee's life that cause them to need more paid time off than their accumulated leave time. For that reason, the Health District will allow employees to voluntarily donate some of their accumulated PTO for the benefit of other employees for the following situations not covered by Intermediate Medical Leave (IML), if approved by the Executive Director:

- If a benefited employee has worked for the Health District for less than one year and is experiencing a medical emergency or other crisis requiring a prolonged absence from work.
- If a benefited employee has an extreme emergency relating to an immediate family member and the employee is required to be away from work in order to provide direct care or attention to that family member.

Employees may receive donated PTO only after they have been off work for two consecutive work weeks. Employees must use all accrued PTO (including ETOB) before receiving any donated PTO. Donated PTO will be paid to the employee at 66% of their regular pay. During the time the employee is receiving donated PTO they will continue to be eligible for benefits but will not accrue PTO.

To request donated PTO, employees (or their supervisor, on behalf of the employee, with the employees consent) must make a request via email to their supervisor, noting the reason for the request. Requests for donated PTO will be evaluated based on a number of factors, including reasons for the request and impact on the organization including anticipated workload requirements and staffing considerations during the proposed period of absence.

Supervisors will review the request, and if they support it, will forward it to the director along with relevant policy, analysis of impact to the organization and a coverage plan. If approved by the director, the request is forwarded to the Executive Director for final consideration. The Executive Director will decide whether to approve the request, and may set a limit to the number of donated hours that the employee may take off, based on the seriousness of the emergency and/or the impact on the agency. Employees taking donated PTO after Executive Director approval must first use any accrued paid leave time.

In the event that the employee requesting the donation of PTO is the Executive Director, such request, which shall be in writing, shall be directed to and acted upon by the Board of Directors.

After the request is approved, and the employee has exhausted all of their paid leave, the employee is eligible to receive additional paid leave (to be paid at 66% his or her normal rate of compensation) with respect to leave donated by other employees.

In order to donate leave, an employee must submit a written request to the Finance Director, noting the amount they wish to donate, and the employee to whom they are donating their PTO. The maximum amount that any one employee may donate per calendar year is the equivalent of one week's PTO. Employees must retain at least one week’s worth of PTO in their account.

Donated PTO is available to the employee only during the time of the designated medical emergency or other crisis. If the person to whom the PTO has been donated does not use the full amount of PTO donated for that purpose, those hours will be returned to donors on a pro rata basis.

400.15 INTERMEDIATE MEDICAL LEAVE PAY

Employees who have completed one year of service with the Health District, and are eligible for PTO, are eligible for Intermediate Medical Leave Pay (IML). IML is available only to employees who are experiencing a serious verifiable medical problem that will result in them being unable to work for a period lasting more than fifteen consecutive days up to a maximum of 90 consecutive days. Medical conditions that result in the employee not being able to work must be verified by a physician (M.D. or D.O.). The certification must be re-verified every thirty (30) days. The Health District reserves the right to request an independent medical analysis of the employee's medical condition, paid for by the Health District.

IML does not apply to medical conditions covered under Workers' Compensation. It also does not apply to other conditions covered under FMLA other than the employee's own serious medical condition.

Intermediate Medical Leave will not start until after the employee has been off work for two consecutive work weeks with a serious verifiable medical condition. During the first two weeks, an employee will need to use their PTO in order to be paid. If the employee runs out of PTO during the first two weeks, the gap between PTO and the start of IML will be unpaid. Once IML applies, the employee will receive 66% of their normal pay. IML is available only one time within a 12-month period starting the first day of the 90 day eligibility period.

The Health District requires employees to use accrued PTO while on IML leave, with the following exception. The employee may retain up to one week's worth of accrued PTO based on the number of hours they normally work each week. This selection must be made prior to going out on IML leave and cannot be changed.

If an employee has been off work for two consecutive work weeks, and the medical condition requires a physician-ordered reduction in hours for a specific period of time, then upon returning to work IML will pay as follows:

- The employee will be paid at 66% of the amount of time the employee worked before the medical incident, less the amount of the time that the employee is able to work. IML under a physician-ordered reduced work schedule is available for a period of up to 90 days (including the initial two weeks waiting period) only one time within a 12-month period starting the first day IML leave is taken. It should be noted that if the person returns to

work, long-term disability will not apply, and the benefit would end after 90 days.

- If the employee receives more than 66% of their regular pay during a period of reduced hours, IML will not be paid.
- The Health District reserves the right to use a physician of its own selection, paid for by the Health District, to determine whether the reduction in hours is medically warranted.
- Flexible Paid Time Off does not accrue during IML.

500.00 BENEFITS

500.01 EMPLOYEE INSURANCE AND EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Health District offers the following benefits to eligible employees. Additional coverage for dependents of eligible employees may be purchased.

Group Insurance

For each **regular full-time employee and time-limited full-time employee** the Health District currently covers the cost of the following group insurance benefits. Employees become eligible for benefits the first of the month following date of employment.

The Health District will cover a prorated amount toward the cost of benefits as shown in the chart below for regular part-time and time-limited part-time employees who elect coverage under a Health District group insurance plan. If an employee temporarily has approved fluctuations in time worked for a period of less than four weeks, this will not change an employee's status for receiving benefits. A longer-term change in hours worked must be noted on an Employee Status Change form and benefit status will change accordingly.

Hours Worked Per Week	Portion of Benefits Paid by Health District	Portion of Benefits Paid by Employee
20 hrs/wk	50%	50%
21 hrs/wk	52.5%	47.5%
22 hrs/wk	55%	45%
23 hrs/wk	57.5%	42.5%
24 hrs/wk	60%	40%
25 hrs/wk	62.5%	37.5%
26 hrs/wk	65%	35%
27 hrs/wk	67.5%	32.5%
28 hrs/wk	70%	30%
29 hrs/wk	72.5%	27.5%
30 hrs/wk or more	100%	0

Part-time employees, temporary employees, and casual/PRN employees (as defined in section 200.02) **are not eligible** for the following benefits.

In the event the provisions under the group insurance policy contradict any provision in this Employee Handbook, the provision in the insurance policy shall prevail.

Section A - Health Insurance

The Health District currently covers either 100%, or the prorated portion, of the cost of the employee's health insurance on the Health District's group health insurance plan, as shown in the chart in section 500.01.

Regular and Time-Limited Full-Time employees who work 30-40 hours per week unless "grandfathered" in (see below) must participate in the Health District's group health insurance plan. The Health District pays the full cost of the base insurance plan premium for the employee. Any employee who works 30 or more hours per week and later reduces their hours to between 20 and 29 hours per week must remain on the Health District's group insurance plan until the next open enrollment period.

Regular and Time-Limited Part-Time employees who work 20-29 hours per week have the choice to participate in the Health District's group health insurance plan or purchase health insurance at their own expense. Part-time employees who choose to participate in the Health District's group health insurance plan will receive a prorated amount towards the cost of the base insurance plan premium as shown in the chart in section 500.01. Part-time employees who have health insurance coverage from outside the Health District must provide proof of coverage at the time of hire or at the time the employee becomes eligible for benefits and on an annual basis thereafter during the open enrollment period.

Grandfathered status applies to those employees who were receiving "cash in lieu" of health insurance coverage payments prior to June 30, 2013. As of July 1, 2013, this benefit is not available to new or returning employees. For those who were "grandfathered" effective January 1, 2014 the Health District will begin phasing out the benefit and the cash in lieu of payment received in 2013 will be frozen and reduced 10% each year over the next ten years. Benefited employees "grandfathered" into the policy that are currently receiving cash in lieu of health insurance coverage must provide proof of other insurance coverage on an annual basis during the open enrollment period. If a "grandfathered" employee chooses to be covered under the Health District's health insurance plan their "grandfathered" status will end.

Section B - Dental Insurance

The Health District currently covers either 100%, or the prorated portion, of the cost of the employee's participation in the Health District's mandatory group dental plan, or (at the employee's request) will apply the same dollar amount that it would have spent on the employee to a family plan; the remainder of the cost of the family plan to be deducted from the employee's pay.

Section C - Long Term Disability and Life Insurance

The Health District currently covers either 100%, or the prorated portion, of the cost of long-term disability and life insurance for the employee in the Health District's group long-term disability and life insurance plan.

Section D - Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is a resource designed to provide highly confidential and experienced help for employees in dealing with issues that affect their lives and the quality of their job performance. The Health District wants employees to be able to maintain a healthy balance of work and family that allows them to enjoy life. The EAP is a confidential counseling and referral service that can help employees successfully deal with life's challenges.

Information on the current EAP program can be found on the benefits link on the sidebar of In the Loop or by contacting Payroll and Benefits.

500.02 FLEXIBLE SPENDING ACCOUNTS (reduces taxable income)

The Health District has set up the following Flexible Spending Accounts. Employees may **voluntarily** use any one or all of the Flexible Spending Accounts. Check the current Health District Flexible Spending Account Plan Document (Cafeteria Plan) to determine minimum and maximum contribution requirements and regulations.

Section A - Dependent Care Spending Account (Section 125)

Allows an employee to voluntarily set up a Dependent Care Flexible Spending Account that allows them to pay for dependent care on a pre-tax basis.

Section B - Health Care Flexible Spending Account (Section 125)

Allows an employee to voluntarily set up a Health Care Flexible Spending Account, which allows them to pay for IRS allowed health care on a pre-tax basis.

Section C - Transportation Fringe Reimbursement Account (Sec. 132)

Allows employee to voluntarily set up Transportation Fringe Reimbursement Account that allows them to pay for IRS allowed mass transit expenses on a pre-tax basis.

500.03 RETIREMENT

Section A - 401(a) PENSION PLAN (government qualified plan; does not reduce FICA)

The Health District currently contributes 5% of the employee's gross salary to the 401(a) Pension Plan that the Health District participates in; there is a required employee contribution of 3% of gross salary. Employees will be fully vested after two years.

Section B - DEFERRED COMPENSATION PROGRAM (not a qualified plan; does not reduce FICA)

Employees may voluntarily make tax-deferred contributions at the level of their choice into the deferred compensation program that the Health District participates in. Check the current deferred compensation manual for minimum and maximum contributions.

500.04 WORKERS' COMPENSATION INSURANCE

Employees who sustain work-related injuries or illnesses should **inform their supervisor immediately.** The supervisor will then notify Finance/Risk Management. No matter how minor an on-the-job injury may appear, it is important that it be reported immediately. Information for reporting the work-related injury and all required forms can be found on the sidebar of In The Loop under "Report An Injury". The employee must report the injury by telephone to the Health District's Workers' Compensation provider. The employee must also complete an Employee Written Notice of Injury and give it to their supervisor within 24 hours after the incident. The supervisor must complete the Supervisor's Accident/Incident Report and give the Employee's Written Notice of Injury and the Supervisor's Accident/Incident Report to Finance/Risk Management. This will help enable an eligible employee to qualify for Workers' Compensation Insurance coverage as quickly as possible.

The Health District provides a comprehensive workers' compensation insurance program at no cost to employees. This program covers any injury or illness sustained in the course of employment that requires medical, surgical, or hospital treatment. The Health District will refer employees to a designated provider. Subject to applicable legal or other requirements, workers' compensation insurance provides benefits after a short waiting period or, if the employee is hospitalized, immediately.

Neither the Health District nor the insurance carrier will be liable for the payment of workers' compensation benefits for injuries that occur during an employee's voluntary participation in any off-duty recreational, social, or athletic activity sponsored by the Health District.

500.05 CHILD CARE RESOURCES AND REFERRAL

The Colorado Department of Human Services provides a service to help parents find quality child care through the Colorado Shines Child Care Referral Program. Colorado Shines is the state's system that rates the quality of Colorado's early childhood services. The program provides families a free, online search tool to find high-quality early learning programs in local communities.

The Mile High United Way is a Child Care Resource and Referral agency for the Colorado Shines project. Mile High United Way provides consumer education in

the selection of child care and a list of referrals (though not recommendations) to licensed child care providers in the area of the family's request. For more information refer to the Colorado Shines website.

For an additional resource refer to the services provided through the Employee Assistance Program (EAP).

The Health District cannot guarantee the quality of childcare provided by any provider referred to the Health District employees by the Colorado Shines Referral Program or the EAP; the selection of a provider must be made by the parent, and at the parent's sole risk. The Health District strongly encourages parents to visit any potential provider and to screen the quality of care carefully.

600.00 BUSINESS TRAVEL

600.01 USE OF PERSONAL VEHICLE

Health District employees who use or who are required to use their personal vehicle for Health District business must follow these procedures:

- Wear seat belts and have passengers wear seat belts
- Obey all laws and practice courteous and safe driving habits
- Possess valid and sufficient auto insurance
- Possess a valid Colorado operator's license
- **The Health District prohibits texting and other cell phone use while driving**

Employees who have had their driver's license revoked or suspended must notify their supervisor the next working day. Under no circumstances will any employee carry or imbibe any form of alcoholic beverage or any substance that impairs the individual's ability to drive safely while driving on Health District business. Employees are solely responsible for any tickets caused by their own behavior (e.g., speeding, parking).

Health District employees are not authorized to transport clients in the employee's personal vehicles or any vehicle not owned by the Health District.

The Health District will grant **mileage reimbursement** to employees in accordance with Section 600.03, Business Travel, Meals and Mileage in this Handbook and Policy 1-34, Business Travel, Planning and Reimbursement.

Accidents

If while operating a privately owned vehicle in the performance of official duties, an employee is involved in an accident resulting in personal or property damage he/she shall:

- Request that all parties and properties concerned remain at the scene of the accident until a law enforcement officer releases them
- Check for registration and proof of insurance from other parties involved
- If the accident occurs within the city limits, notify the Fort Collins Police Services immediately; otherwise notify the appropriate local law enforcement agency
- Report the accident to his/her immediate supervisor as soon as practical, but no later than the next day, and complete an incident report.
- Notify Risk Management within twenty-four (24) hours.

- Refrain from discussing the accident with anyone other than the investigating officer, appropriate city officials, and representatives of your/our insurance company.
- File a claim with the employee's automobile insurance company.

Insurance
Proof of insurance must be kept in the vehicle at all times.

- State law requires that privately owned vehicles carry liability insurance and proof of such insurance be kept in the vehicle. **The Health District does not insure privately owned vehicles.**
- Workers' Compensation covers injuries sustained by a Health District employee while on Health District business in a Health District or privately owned vehicle. Employees must report accidents as required in Section 600.01 Use of Personal Vehicle and Mileage Reimbursement.

Annual Driver's License and Automobile Insurance Check
On an annual basis, the Health District requires a current copy of the employee's driver's license and automobile insurance. If an employee does not have a valid driver's license and current insurance on their private vehicle, it will disqualify them from driving a vehicle on Health District business, and could impact employment if needed for their job.

600.02 USE OF HEALTH DISTRICT OWNED VEHICLES
The policy for driving Health District owned vehicles is detailed in Internal Policy 1-51 Health District Owned Vehicle Usage. All vehicles owned, rented, or leased by the Health District must be checked out through the Human Resources Department after all driving requirements have been met. Please allow a week before intended use to meet these requirements.

The transporting of clients in Health District vehicles cannot be done without the explicit permission from the appropriate director and the knowledge of the Risk Manager. Employees whose job description does not include client transport must have a second Health District employee in the vehicle whenever transporting a client.

600.03 BUSINESS TRAVEL, MEALS, AND MILEAGE
Where applicable, the Health District will reimburse employees and Board Members for reasonable business travel, meals and mileage expenses incurred while on official Health District business. All employees and Board members must refer to and follow internal policy 1-34, *Business Travel Planning and Reimbursement* which includes detailed procedures for travel.

For those employees who are nonexempt and travel for Health District business, *Policy 1-35: Travel Policy for Nonexempt and Hourly Personnel* applies for calculating paid hours while traveling.

600.04 BUSINESS TRAVEL COMPLIANCE

Abuse of policies and procedures contained in this business travel section of the Handbook, including falsifying the Travel Reconciliation Form or Mileage Reimbursement Form to reflect costs not incurred by the employee, will be subject to disciplinary action up to and including termination.

For further information see Internal Policy 1-34: Business Travel Planning and Reimbursement and1-35: Travel Policy for Nonexempt and Hourly Personnel.

600.00 BUSINESS TRAVEL

Approved by Board of Directors
Health District of Northern Larimer County
March 27, 2018

700.00 BUSINESS ETHICS

700.01 CONFLICT OF INTEREST

Employees have an obligation to conduct the public's business in compliance with the provisions of Colorado law prohibiting actual or potential conflict of interest. This section establishes only the framework within which the Health District wishes the business to operate. The purpose of these guidelines is to provide general direction so those employees can seek further clarification on issues related to the subject of acceptable standards of operation. Contact the Executive Director for more information or questions about conflict of interest.

An actual or potential conflict of interest occurs when an employee is in a position to influence a Board or Health District decision that may result in a personal gain for that employee or for a relative, which personal gain is different and separate from the gain to the general public, as a result of the Health District's business dealings, and which personal gain would not have been attained but for the relationship of the employee with the Health District. For the purposes of this provision**,** a relative is any person who is related by blood or marriage, or whose relationship with the employee is similar to that of persons who are related by blood or marriage.

Personal gain may result not only in cases where an employee or relative has a significant ownership in a firm with which the Health District does business, but also when an employee or relative receives any rebate, profit participation, over-ride, substantial gift, or special direct or indirect consideration, financial or otherwise, as a result of any transaction or business dealings involving the Health District.

“Presumption of guilt” is not normally created by the mere existence of a relationship with outside firms. However, if employees have any influence, either direct or indirect, on transactions involving purchases, contracts, or leases, between such firm and the Health District, it is imperative that they disclose to the Executive Director of the Health District immediately the existence of that relationship and of any actual or potential conflict of interest so that safeguards can be established to protect the best interests of the residents of the Health District.

Some employees may have outside businesses that provide similar services to those that they provide at the Health District. When this is the case, those employees are prohibited from referring or soliciting customers seeking services from the Health District to their own businesses or another employee’s personal business unless the appropriate director grants specific permission. In addition, such employees are prohibited from utilizing the Health District client lists for

client solicitation purposes. Client lists are to remain the property of the Health District.

700.02 CLIENT CONFIDENTIALITY

All employees have the legal responsibility to protect confidential client information. This is vital to the interests and success of the Health District and may be subject to protection through Colorado State and United States law.

Clients have the right to expect that the Health District and its employees will respect clients' interests with respect to confidential information, which is personal information disclosed to or known to an employee because of their duties with the Health District that is not generally known to others.

Employees have the obligation and responsibility to understand and follow all policies and practices to protect client confidentiality. When Confidential client information has been compromised the employee has the obligation to immediately report it to their supervisor, who must report it to the HIPAA Officer.

An employee who improperly accesses, uses or discloses confidential client information may be subject to disciplinary action up to and including termination of employment or legal action, even if he or she does not actually benefit from the disclosed information. Willful breach of client or Health District confidentiality or violation of data security regulations will not be tolerated.

Contact the Health Insurance Portability and Accountability Act (HIPAA) Officer for additional information.

For additional information see *Internal Policy 4-3 Case Record Confidentiality*

700.03 GIFTS AND FREEBIES

Gifts and freebies are items given to a staff member to give thanks or show appreciation, such as a thank you lunch, gift basket, tickets, gift card or other item of value. Generally, there are two main factors that staff should consider before accepting a gift: influence and value.

Staff should ask themselves whether accepting the gift would potentially influence a decision or create a perceived obligation to give special treatment or future business. If so, staff should either turn down the gift or discuss with their department director to take measures to protect against that influence.

Staff should estimate whether a gift is of "nominal" or "significant" value. Gifts of nominal value are estimated to be worth $50.00 or less in a calendar year. Gifts of nominal value generally can be accepted by staff, if influence is not determined to be a factor, but should be reported to the supervisor.

700.04 SALE OF ITEMS IN THE WORKPLACE

The Health District recognizes that while our workplace is not a market for the sale of goods and services, some activities like raising funds for non-profit organizations, selling hand-made items to interested co-workers, and offering items no longer needed by the employee may be helpful to Health District staff and appropriate on a limited basis. Active solicitation of items from third party, for-profit businesses by employees is generally not allowed on Health District premises (for example Mary Kay, Pampered Chef or any other similar parties) without the Management Team approval. *For further information see Internal Policy 3-19: Sale of Items in the Workplace.*

700.05 EMPLOYEE POLITICAL ACTIVITY

As a public entity under the Fair Campaign Practices Act ("FCPA") the Health District is prohibited from expending public moneys to influence the outcome of elections. This means the Health District cannot spend any money – including staff time – urging a vote to elect or defeat a candidate or to support or defeat a ballot initiative. This is true even when the election is for Health District board members or when the ballot issue impacts the Health District's funding or operation. The FCPA provides only limited exceptions to this prohibition. Employees are encouraged to contact the Policy Coordinator if they are unsure whether an activity would violate the FCPA.

The following is a partial list of actions that are prohibited by the FCPA because it qualifies as "spending public money."

- Sending or forwarding an email through the Health District email system about a ballot issue or candidate ;
- Using work phones to make campaign-related calls;
- Collecting petition signatures on work time;
- Urging another employee or community member to vote for a particular candidate or ballot issue when on work time;
- Copying election, ballot or candidate information on the Health District copier;

Only the Board of Directors can determine the Health District's official policy positions. Only designated staff members are authorized to discuss the Health District's policy positions with policy makers.

Detailed information about political activity which all employees should make themselves familiar with is included in *Internal Policy 1-23: Political Activity*. If you have questions or concerns, talk with the Policy Coordinator.

700.06 SEXUAL INTIMACY WITH CLIENTS

700.00 BUSINESS ETHICS

Employees have the obligation to act in an ethical manner in their interactions with and conduct toward clients. The employee assumes the full burden of setting clear, appropriate and culturally sensitive boundaries.

Specific employees of the Health District who are in a position of trust or power with regards to clients of the Health District also have the obligation to follow certain ethical guidelines with regard to their personal relationship with clients.

For further information see Internal Policy 3-20: Sexual Intimacy with Clients.

800.00 CONDUCT

800.01 APPEARANCE/HYGIENE/DRESS CODE

At the Health District, personal appearance, hygiene, and attire are very important. A professional image must be maintained to instill confidence in the minds of our customers. This helps ensure the Health District's success. Employee appearance, hygiene, and attire should be what the Health District considers professional at all times. Employees are expected to follow the Internal Employee Dress Code, and are subject to the policies and procedures contained therein.

Dress at remote locations where Health District employees work should conform to the accepted policies or standards of that site but not less than accepted Health District policies.

For further information see Internal Policy 3-21: Employee Dress Code.

800.02 NAME BADGES

Clients have a right to know the name and title of those who are serving them. Name badges must be worn consistently by all staff when on duty at the Health District to ensure proper identification and convey a professional image for the agency. Each staff member will be issued a photo name badge**.**

For further information see Internal Policy 1-25: Name Badge Policy.

800.03 SMOKING

In keeping with the **Colorado Clean Indoor Act**, the City of Fort Collins **Smoking Ordinance** and the Health District's intent to provide a safe and healthful work environment, smoking including all forms of tobacco and e-cigarettes is prohibited on all properties under Health District control. (See HB 06-1175 and City of Fort Collins Ordinance, Sec. 12-60 and 12-61). This restriction applies to all employees and visitors, at all times, including non-business hours.

800.04 EMPLOYEE CONDUCT AND WORK RULES

To ensure orderly operations and provide the best possible work environment, the Health District expects employees to follow rules of conduct that will protect the interests and safety of all employees and the organization. It is not possible to list all the forms of behavior that are considered unacceptable in the workplace. The following are examples of infractions of rules of conduct that may result in disciplinary action, up to and including termination of employment.

This list is meant for illustrative purposes and is not all inclusive:

- Violating the Drug and Alcohol Policy detailed in section 800.05 of this Handbook.
- Conviction or violation of any state, federal, or local law involving commission of a felony or crime of moral turpitude.
- Insubordination or other disrespectful conduct.
- Sexual or other unlawful or unwelcome harassment.
- Excessive absenteeism or any absences without notice.
- Unsatisfactory performance or conduct.
- Violation of any of the provisions of this Employee Handbook.
- Willful breach of client or Health District confidentiality or violation of data security regulations.
- Unauthorized personal use of Health District property.

Employment with the Health District is at the mutual consent of the Health District and the employee, and either party may terminate that relationship at any time, with or without cause, and with or without advance notice.

800.05 COMPUTER ACCESS AND PASSWORDS

Passwords are an important aspect of computer security. They are the front line of protection for user accounts. All Health District employees are responsible for taking the appropriate steps, as outlined below, to select and secure their passwords.

It is the policy of the Health District that employees create strong passwords, protect those passwords, and change them as frequently as directed. Because a poorly chosen password may result in the compromise of Health District's entire computer network, strong computer password guidelines should always be followed.

Passwords must not be shared or discussed with anyone, including any Health District employee or family member. All passwords are to be treated as sensitive and should never be written down or stored in an unsecure manner electronically. Use of an encrypted password storage application is acceptable with the approval of the Information Systems Manager. Additionally, if Health District email is accessed on a personal cell phone, the phone must be password protected.

The computer network is intended for business use only. If the Health District discovers individuals misusing any computer system, they may be subject to

disciplinary action, up to and including termination of computing privileges and/or suspension or termination of employment.

The Health District of Northern Larimer County is a public entity and therefore subject to the public records act, CRS 24-72-202 (6) and (7). Work created and stored using Health District computing resources, or on a cell phone, may be considered a public record and subject to disclosure. All employees must know and follow State policies for saving and retaining documents as outlined in *Policy 1-55, Document Retention.*

For additional information s*ee Internal Policy 1-42: Computer Access and Password Policy and Policy 1-55, Document Retention Policy.*

800.06 ANTIVIOLENCE

The Health District strives to maintain a work environment free from intimidation, threats, or violent acts. This includes, but is not limited to, intimidating, threatening or hostile behaviors, physical abuse, vandalism, arson, sabotage, use of weapons, carrying weapons onto Health District property, or any other act, which, in management's opinion, is inappropriate to the workplace. In addition, bizarre or offensive comments regarding violent events and/or behavior will not be tolerated. Employees should directly contact proper law enforcement authorities if they believe there is a serious threat to the safety and health of themselves or others.

800.07 DRUG AND ALCOHOL USE

It is the Health District's policy to provide a drug-free, healthful, and safe workplace. To promote this goal, employees are required to report to work in appropriate mental and physical condition to perform their jobs in a satisfactory manner.

While on the Health District premises or while conducting official Health District business off the Health District premises, no employee may use, possess, distribute, sell, transfer or be under the influence of any intoxicating substance including alcohol, illegal drugs, or marijuana. This includes the use of marijuana, whether or not the employee is a recreational or lawfully registered user. The legal use of prescribed drugs is permitted on the job only if it does not impair an employee's ability to perform the essential functions of the job effectively and in a safe manner that does not endanger other individuals in the workplace. Health District employees located at other agencies will be held to the drug and alcohol policies of that agency but not less than Health District accepted policies. Violations of this policy will not be tolerated and may result in disciplinary action, up to and including termination of employment.

The Health District is supportive of any individual seeking help or support for a substance use issue. They are encouraged to seek assistance or referrals to appropriate resources in the community, which might include the Mental Health Connections Program, and the Health District's confidential Employee Assistance Program. Employees with questions or concerns about their substance dependency or abuse are encouraged to discuss these matters with their supervisor or the Director responsible for Human Resources.

The Health District is committed to complying with the Drug Free Workplace Act of 1988. In accordance with this law, an employee must notify the Health District of a criminal conviction for drug-related activity occurring in the workplace. The report must be made within five days of the conviction.

Employees with questions on this policy or issues related to drug or alcohol use in the workplace should raise their concerns with their supervisor or the Director responsible for Human Resources without fear of reprisal.

Federal law may require an additional drug testing policy for employees required to maintain a Commercial Driver's License.

800.08 PROBLEM RESOLUTION

The Health District is committed to providing the best possible working conditions for its employees. Part of this commitment is to encourage an open and frank atmosphere in which any problem, complaint, suggestion, or question can be raised.

Supervisors and employees are expected to treat each other with mutual respect. Employees are encouraged to offer positive and constructive input for improvement.

If employees disagree with established rules of conduct, policies, or practices, they can express their concern through the problem resolution procedure as outlined below. No employee will be penalized, formally or informally, for voicing a complaint with the Health District in a reasonable, professional manner, or for using the problem resolution procedure.

Procedure:

1. Employees are encouraged to first try to work out problems directly with the other party themselves, with both parties approaching the issue in a respectful, problem-solving manner.
2. Should a direct approach not work or not be appropriate, employees are strongly encouraged to take any problems or complaints first to their direct supervisor on a timely basis.

3. If the problem is not resolved to the mutual satisfaction of the supervisor and the employee, or if it is inappropriate to go to the supervisor, the employee may appeal to their supervisor's supervisor.
4. If the employee is not satisfied with the decision issued in step 2, they may take their concern to the Executive Director for a final decision.
5. If the employee's direct supervisor is the Executive Director, and they cannot resolve the issue with the Executive Director in step 1, they may appeal to the Board of Directors in step 2 above. The Board will take final action and issue a written decision.

800.09 DISCIPLINARY/DISMISSAL PROCEDURES

Any employee who is disciplined for any reason, or who is terminated by the Health District, may request a pre-disciplinary meeting with his/her supervisor prior to the imposition of such discipline.

Occasionally performance or other behavior falls short of our standards and/or expectations. When this occurs, a director takes action, which in management's opinion, seems appropriate.

Disciplinary actions can range from a formal discussion with the employee about the matter to immediate discharge. Action taken by management in an individual case does not establish a precedent in other circumstances.

800.10 OUTSIDE EMPLOYMENT

Employees are permitted to work a second job as long as it does not interfere with their Health District job performance. Employees with a second job are expected to work their assigned Health District schedules. A second job will not be considered an excuse for poor job performance, absenteeism, tardiness, leaving early, refusal to travel, or refusal to work overtime or different hours.

If outside employment could represent a conflict of interest as defined in section 700.01, it may not be permissible.

If outside work activity causes or contributes to job-related problems, it must be discontinued, or the employee may be subject to disciplinary action, up to and including termination.

900.00 COMMUNICATIONS

900.01 MEDIA RELATIONS

As a public institution, the Health District has a responsibility to provide the news media accurate and timely information on its programs and services. It is also important that a consistent image of the agency is projected and protects the privacy of its clients within legally established guidelines. Therefore, if the media contacts a staff member, it is their responsibility to **refer them to the Communications Director** and, in their absence, to the Executive Director or Assistant Director, and if not available, to the most appropriate or available director.

For more information see Internal Policy 1-32 Media Policy.

900.02 SOCIAL MEDIA USE

(to be developed)

900.03 USE OF HEALTH DISTRICT EQUIPMENT

Personal long distance calls must be made using a personal cell phone or personal long distance calling card. Employees may not use Health District cell phones for personal use except in emergencies. Excessive personal or inappropriate use of the telephone, long distance, FAX, email or Internet and photo copier will not be tolerated.

For further information see Internal Policy 1-31: Internal Email, and 1-37: Computer Usage Policy.

900.04 PERSONAL MAIL

Employees are requested not to receive personal letters or packages through the Health District. Personal mail should be received at the employee's home and not at the Health District office. All mail coming to the office is presumed to be for the employer and may be subject to opening. Employees may put stamped envelopes in the outgoing mail container.

900.05 COMMUNICATION SYSTEMS

The communication systems are property of the Health District and intended for business use. Therefore, the Health District maintains the ability to access any computer files, use of software, Internet usage, email, and voice mail. Although employees may select individual passwords, employees should not assume that such files are confidential. A director may give permission to the Information Systems/Network Manager to access the employee's computer, Internet files, email, or voice mail. Employees should not attempt to gain access to another employee's computer, Internet files, email, or voice mail. All information regarding access to the Health District's computer resources, such as user

identifications, access codes, and passwords are Health District information and may not be disclosed to non-Health District personnel.

1000.00 SEPARATION OF EMPLOYMENT

1000.01 RESIGNATION

Resignation is a voluntary act initiated by the employee to terminate employment with the Health District. The Health District requests at least two weeks written resignation notice from all employees, and an additional six weeks from medical and behavioral health professionals, dentists, and director level positions in order to fill positions without disruption of services.

PTO may not be used during the last two weeks of employment without written approval of the supervisor. An employee's last day of employment cannot be on a paid holiday.

Upon separation from employment or change in status from a benefited employee to non-benefited employee, employees will be paid for up to twenty-five (25) days of accrued and unused PTO earned through the last day of work, or effective date of change in employee status. See the chart in section 400.01 on Flexible Paid Time Off for more information on the maximum number of hours that can be paid at separation.

1000.02 INSURANCE CONVERSION PRIVILEGES

According to the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, in the event of termination of employment with the Health District, or loss of eligibility to remain covered under our group health insurance program, an employee and their eligible dependents may have the right to continued coverage under the Health District's health insurance program for a limited period of time at their own expense.

The Health District will provide each employee with written notice as to their COBRA rights, so an employee may decide if they wish to continue the insurance coverage benefits they currently have as an employee/dependent that is eligible for continuation.

1000.00 SEPARATION OF EMPLOYMENT

EMPLOYEE ACKNOWLEDGMENT FORM

I HAVE RECEIVED A COPY OF THE EMPLOYEE HANDBOOK DATED MARCH 27, 2018. I UNDERSTAND THAT I AM TO BECOME FAMILIAR WITH ITS CONTENTS.

Further, I understand:

- Employment with the Health District is at-will. I have the right to end my work relationship with the Health District, with or without advance notice, and with or without cause at any time. The Health District has the same right.
- The language used in this handbook and any verbal statements of management are not intended to constitute a contract of employment, either express or implied, nor are they a guarantee of employment for a specific duration.
- The handbook is not all inclusive, but is intended to be a summary of some of the Health District's guidelines.
- This edition replaces all previously issued handbooks. The need may arise to change the guidelines described in the handbook, except for the at-will nature of employment. The Health District therefore reserves the right to interpret them or change them without prior notice.
- No employee of the Health District has the authority to enter into an agreement of employment for any specified period. Only the Board of Directors may enter into such agreements, and such agreement must be in writing, approved by the Board, and signed by the Board President.

_____

Employee Signature

_____ _____

Employee Name (Typed or Printed) **Date**

Larimer County Community Health Improvement Plan Update

March 2018

Included In this Update:

- New CHIP Priorities Identified
- Thank You to Summit Participants
- Links to Summit Presentations and Fact Sheets
- Larimer Health Tracker
- What is CHIP?

Community priorities are identified for the 2018 Community Health Improvement Plan

Larimer County Department of Health and Environment is excited to announce the new priorities for the 2018-2023 Community Health Improvement Plan!

In an Equitable and Culturally Responsive Manner,

1. Promote Mental Health and Emotional Well-being Across the Lifespan

2. Provide Access to Quality Childcare

On Jan. 24, 2018, over 180 community partners from across Larimer County attended the Healthy Larimer Summit, a day long public event focused on looking at community health data, identifying and prioritizing community health needs, and learning about community resources. At the Healthy Larimer Summit, community partners worked together at tables of diverse partners to identify and prioritize community health needs. Once each table identified a top priority, tables reported out and participants ranked each priority individually.

After the Healthy Larimer Summit, the rankings of these priorities were evaluated, and three top priorities were identified. These were Promoting

Mental and Emotional Well-being, Access to Quality Childcare, and Access to Affordable Housing.

These three priorities were presented to a committee of leaders representing, government, healthcare, and large non-profit entities, who met and discussed the priorities. They focused on upcoming funding, community and political will, and the role of CHIP in these priorities. The Leadership Team determined that due to capacity, the Community Health Improvement Plan should focus on two priorities and narrowed and refined the priorities. Even through Access to Affordable Housing was important to the Leadership Team, they decided to focus on Promoting Mental and Emotional Well-being across the Lifespan and Access to Quality Childcare. The Leadership Team provided additional guidance in identifying focus areas within each priority area:

Promoting Mental and Emotional Well-Being Across the Lifespan

- Address Gaps in Required Continuum of Care
- Substance Use Disorder and Treatment
- Primary Prevention

Access to Quality Childcare

- Affordability
- Recruitment and Retention of the Childcare Workforce
- Infant and Toddler Care

These priorities then were approved by the CHIP Equity Committee, with the decision to add **"In an equitable and culturally responsive manner"** as a preface, to maintain the focus on equity throughout the CHIP process.

These priorities received final and required approval by the Larimer County Board of Health at a public meeting on March 15, 2018.

The CHIP team is excited to begin working on these priority areas and look forward to meeting with community partners, the CHIP Equity Committee, and interested residents to begin developing key strategies and a detailed collaborative plan for the work that lies ahead.

Thank you to all participants at the Healthy Larimer Summit!

Thank to the almost 180 participants that chose to spend their day exploring community health data, networking, engaging in other community health efforts,

and prioritizing and identifying priority areas for the Community Health Improvement Plan. We knew it was going to be an extraordinary time commitment and are so encouraged by all of your participation to help us kick off this next five-year plan!

Thank you to our sponsors:

UCHealth

Clear View Behavioral Health

Kaiser Permanente

Representation from organizations that registered:

Alliance for Suicide Prevention of Larimer County, Alternatives to Violence, McKee Medical Center, Bethesda Lutheran Communities, Larimer County Board of Health, Bohemian Foundation, Boys & Girls Clubs of Larimer County, Catholic Charities, Centennial AHEC, Center for Family Outreach, Children's Speech and Reading Center, City of Fort Collins, UCHealth, City of Loveland, Clear View Behavioral Health, Colorado School of Public Health, Colorado State University, Community Volunteer, Colorado State University Extension, Diversity Solutions, Inc., Early Childhood Council of Larimer County, Easterseals Colorado, Elderhaus Adult Day Program, Inc., Estes Pak, Estes Park High School, Estes Park Medical Center, Estes Valley Library, Foothills Gateway, Garcia Consulting, GreenPath Financial Wellness, Grief Support of the Rockies, Imagine Zero Coalition, Harmony Foundation, Inc., Health District of Northern Larimer County, Larimer County Department of Health and Environment, Healthy Hearts, Healthy Kids Club, InnovAge PACE of Northern Colorado, Institute for the Built Environment, Junior Achievement, Kaiser Permanente, Kids at Heart, KidsPak - Loveland Rotary Club, Larimer County

Board of Health, Larimer County Department of Human Services, Larimer County Office on Aging, Larimer County Planning Commission, Leap Coalition of Larimer County, Loveland Housing Authority, Loveland Public Library, Mountain View Presbyterian Church, Neighbor to Neighbor, North Colorado Health Alliance, Partnership for Age Friendly Communities in Larimer County, PFLAG, Plymouth Congregational UCC, Poudre River Public Library District, Poudre School District, Project 31:25, RMSI Group, Rocky Mountain Health Plans, Salud Family Health Centers, Sexual Assault Victim Advocate Center, Simple Strategies for Family Living, Sunrise Loveland Community Health Center, Teaching Tree Early Childhood Learning Center, TEAM Wellness & Prevention, The Arc of Larimer County, The Family Center/La Familia, The Health and Wellness Center at Centennial High School - Rocky Mountain Youth Clinics, The Matthews House, The Wellness Champions - Square ONE health, Thompson School District, Thompson Valley EMS, UCHealth Aspen Club, United Way of Larimer County, Vida Sana, Volunteers of America, Weld County Department of Health and Environment

Summit slides and fact sheets

Click on each button to access a downloadable copy.

Data Slide Presentation

Fact Sheet: What Influences Health?

Fact Sheet: Access to Healthcare

Fact Sheet: Mental Health

Fact Sheet: Tobacco

Fact Sheet: Marijuana

Fact Sheet: Alcohol

Fact Sheet: Suicide

Fact Sheet: Built Environment

Fact Sheet: Environmental Quality

Larimer Health Tracker

In 2015, Larimer County Department of Health and Environment, in partnership with the Health District of Northern Colorado, surveyed residents of Larimer County around barriers to health and health outcomes as part of the triennial Community Health Survey. The results of this survey for 2016 (trend data going back as far as 1998, comparisons to state and national health indicators, and data displayed by age, gender, income, and education level) where available are now updated and searchable on Larimer Health Tracker.

Take me to the data!

What is CHIP?

The Community Health Improvement Plan (CHIP), is a 5-year plan that began after Colorado passed the Public Health Reauthorization Act in 2008. This legislation requires local public health agencies to create a health improvement plan, based on a community health assessment and with community input about priorities, at least every five years.

In 2013, the Larimer County Community Health Improvement team collected health focused data specific to Larimer County, and disseminated a Community Health Assessment. Following this assessment, community partners worked

collaboratively to develop a Community Health Improvement Plan (CHIP) focused on two action areas within the community.

Upcoming Meetings

The CHIP team is always willing to present at meetings or meet one on one, if you or your organization would like to learn more, please contact Kelsey Lyon at conlonkt@co.larimer.co.us

chip summit

Our mailing address is:

Larimer County Department of Health and Environment - CHIP

HEALTH DISTRICT
of Northern Larimer County
January 2018
Summary Financial Narrative

Revenues

The Health District is 85.9% ahead of year-to-date tax revenue projections. Interest income is 18.1% ahead of year-to-date projections. Lease revenue is at year-to-date projections. Yield rates on investment earnings increased slightly from the previous month from 1.38% to 1.40% (based on the weighted average of all investments). Fee for service revenue from clients is 5.3% behind year-to-date projections and revenue from third party reimbursements is 18.4% behind year-to-date projections. Total operating revenues for the Health District (excluding grants and special projects) are 39.7% ahead of year-to-date projections.

Expenditures

Operating expenditures (excluding grants and special projects) are 17.2% behind year-to-date projections. Program variances are as follows: Administration 3.6%; Board 71.5%; Connections: Mental Health/Substance Issues Services 36.8%; Dental Services 16.0%; Integrated Care 12.5%; Health Promotion 7.7%; Community Impact 8.2%; Program Assessment and Evaluation 11.3%; Health Care Access 19.8%; HealthInfoSource 16.2%; and Resource Development (operational) 15.4%.

Capital Outlay

No capital expenditures have been made year-to-date.

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

BALANCE SHEET

As of 1/31/2018

ASSETS

Current Assets:	
Cash & Investments	$6,480,654.51
Accounts Receivable	187,958.05
Property Taxes Receivable	7,188,431.00
Specific Ownership Taxes Receivable	52,717.00
Prepaid Expenses and Deposits	82,479.52
Total Current Assets	13,992,240.08
Other Assets:	
Direct Financing Lease	4,047,875.00
Total Other Assets	4,047,875.00
Property and Equipment	
Land	544,720.02
Building and Leasehold Improvements	4,421,115.73
Equipment	1,217,002.79
Accumulated Depreciation	(2,577,095.31)
Total Property and Equipment	3,605,743.23
Total Assets	$21,645,858.31

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

BALANCE SHEET

As of 1/31/2018

LIABILITIES AND EQUITY

Current Liabilities:	
Accounts Payable	$730,456.52
Deposits	1,000.00
Deferred Revenue	612,731.45
Total Current Liabilities	1,344,187.97
Long-term Liabilities:	
Compensated Absences Payable	15,410.00
Total Long-term Liabilities	15,410.00
Deferred Inflows of Resources	
Deferred Property Tax Revenue	6,732,167.81
Total Deferred Inflows of Resources	6,732,167.81
Total Liabilities & Deferred Inflows of Resource	8,091,765.78
EQUITY	
Retained Earnings	13,717,362.05
Net Income	(163,269.52)
Total Equity	13,554,092.53
Total Liabilities & Equity	$21,645,858.31

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF REVENUES AND EXPENSES

For 1/1/2018 To 1/31/2018

	Current Month	Year to Date
Revenue:		
Property Taxes	$456,263.19	$456,263.19
Specific Ownership Taxes	52,716.20	52,716.20
Lease Revenue	88,491.25	88,491.25
Interest Income	7,871.61	7,871.61
Sales Revenue	44.73	44.73
Fee For Services Income	14,084.30	14,084.30
Third Party Reimbursements	63,203.21	63,203.21
Grant Revenue	56,394.25	56,394.25
Partnerships	5,902.01	5,902.01
Miscellaneous Income	1,075.06	1,075.06
Gain on Investment	1,239.15	1,239.15
Total Revenue	747,284.96	747,284.96
Expenses:		
Operating Expenses		
Administration	$60,438.73	$60,438.73
Board Expenses	880.73	880.73
Connections: MentalHealth/Substance Issues Svcs	88,708.02	88,708.02
Dental Services	309,849.24	309,849.24
Integrated Care (MHSA/PC)	86,335.90	86,335.90
Health Promotion	68,756.47	68,756.47
Community Impact	52,708.79	52,708.79
Program Assessment & Evaluation	16,494.96	16,494.96
Health Care Access	80,486.89	80,486.89
HealthInfoSource	6,962.55	6,962.55
Resource Development	12,948.38	12,948.38
Special Projects	62,281.67	62,281.67
Grant Projects	63,702.15	63,702.15
Total Operating Expenses	910,554.48	910,554.48
Depreciation and Amortization		
Total Depreciation and Amortization	0.00	0.00
Total Expenses	910,554.48	910,554.48
Net Income	($163,269.52)	($163,269.52)

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 1/31/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Annual Funds Remaining
Revenue:								
Property Taxes	$235,474	$456,263	$220,789	$235,474	$456,263	$220,789	$7,188,431	$6,732,168
Specific Ownership Taxes	38,283	52,716	14,433	38,283	52,716	14,433	580,000	527,284
Lease Revenue	88,491	88,491	0	88,491	88,491	0	1,083,133	994,642
Interest Income	6,667	7,872	1,205	6,667	7,872	1,205	80,000	72,128
Sales Revenue	27	45	18	27	45	18	325	280
Fee For Services Income	14,881	14,085	(796)	14,881	14,085	(796)	234,606	220,521
Third Party Reimbursements	77,432	63,203	(14,229)	77,432	63,203	(14,229)	943,354	880,151
Grant Revenue	143,959	56,394	(87,565)	143,959	56,394	(87,565)	1,695,319	1,638,925
Partnership Revenue	3,708	5,902	2,194	3,708	5,902	2,194	44,498	38,596
Miscellaneous Income	1,661	1,075	(586)	1,661	1,075	(586)	19,930	18,855
Gain on Investment	0	1,239	1,239	0	1,239	1,239	0	(1,239)
Total Revenue	$610,583	$747,285	$136,702	$610,583	$747,285	$136,702	$11,869,596	$11,122,311
Expenditures:								
Operating Expenditures								
Administration	62,670	60,439	2,231	62,670	60,439	2,231	825,915	765,476
Board Expenses	3,095	846	2,249	3,095	846	2,249	46,476	45,630
Election Expenses	0	35	(35)	0	35	(35)	18,000	17,965
Connections: Mental Health/Substance Issues Sv	140,290	88,708	51,582	140,290	88,708	51,582	1,564,904	1,476,196
Dental Services	368,915	309,850	59,065	368,915	309,850	59,065	3,847,166	3,537,316
Integrated Care (MHSA/PC)	98,642	86,336	12,306	98,642	86,336	12,306	1,083,230	996,894
Health Promotion	74,469	68,756	5,713	74,469	68,756	5,713	826,433	757,677
Community Impact	57,439	52,709	4,730	57,439	52,709	4,730	635,016	582,307
Program Assessment & Evaluation	18,597	16,495	2,102	18,597	16,495	2,102	205,411	188,916
Health Care Access	100,359	80,487	19,872	100,359	80,487	19,872	1,101,355	1,020,868
HealthInfoSource	8,313	6,963	1,350	8,313	6,963	1,350	82,850	75,887
Resource Development	15,302	12,949	2,353	15,302	12,949	2,353	169,844	156,895
Contingency (Operations)	0	0	0	0	0	0	239,000	239,000
Special Projects	156,611	62,282	94,329	156,611	62,282	94,329	1,879,519	1,817,237
Grant Projects	143,959	63,702	80,257	143,959	63,702	80,257	1,695,319	1,631,617
Total Operating Expenditures	1,248,661	910,557	338,104	1,248,661	910,557	338,104	14,220,438	13,309,881
Net Income	($638,078)	($163,272)	$474,806	($638,078)	($163,272)	$474,806	($2,350,842)	($2,187,570)

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF NON OPERATIONAL EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 1/31/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Annual Funds Remaining
Non-Operating Expenditures								
Building	0	0	0	0	0	0	3,020,000	3,020,000
General Office Equipment	0	0	0	0	0	0	20,000	20,000
Medical & Dental Equipment	7,830	0	7,830	7,830	0	7,830	13,797	13,797
Computer Equipment	11,600	0	11,600	11,600	0	11,600	11,600	11,600
Computer Software	0	0	0	0	0	0	7,300	7,300
Furniture	0	0	0	0	0	0	10,000	10,000
Total Non-Operating Expenditures	19,430	0	19,430	19,430	0	19,430	3,082,697	3,082,697

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 1/31/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Remaining Funds
Administration								
Revenue:								
Miscellaneous Income	$792	$0	($792)	$792	$0	($792)	$9,500	$9,500
Total Revenue	$792	$0	($792)	$792	$0	($792)	$9,500	$9,500
Expenditures:								
Salaries and Benefits	42,815	40,553	2,262	42,815	40,553	2,262	513,783	473,230
Supplies and Purchased Services	19,855	19,886	(31)	19,855	19,886	(31)	312,132	292,246
Total Expenditures	$62,670	$60,439	$2,231	$62,670	$60,439	$2,231	$825,915	$765,476
Board of Directors								
Expenditures:								
Salaries and Benefits	$0	$0	$0	$0	$0	$0	$8,632	$8,632
Supplies and Purchased Services	3,096	846	2,250	3,096	846	2,250	37,844	36,998
Election Expenses	0	35	(35)	0	35	(35)	18,000	17,965
Total Expenditures	$3,096	$881	$2,215	$3,096	$881	$2,215	$64,476	$63,595
Community Impact								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$46,138	$45,390	$748	$46,138	$45,390	$748	$553,661	$508,271
Supplies and Purchased Services	11,300	7,318	3,982	11,300	7,318	3,982	81,355	74,037
Total Expenditures	$57,438	$52,708	$4,730	$57,438	$52,708	$4,730	$635,016	$582,308

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 1/31/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Remaining Funds
Program Assessment & Evaluation								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$14,997	$14,308	$689	$14,997	$14,308	$689	$179,969	$165,661
Supplies and Purchased Services	3,599	2,187	1,412	3,599	2,187	1,412	25,442	23,255
Total Expenditures	$18,596	$16,495	$2,101	$18,596	$16,495	$2,101	$205,411	$188,916
Connections: Mental Health/Substance Issue								
Revenue:								
Fees, Reimbursements & Other Income	$2,080	$1,610	($470)	$2,080	$1,610	($470)	$24,960	$23,350
Total Revenue	$2,080	$1,610	($470)	$2,080	$1,610	($470)	$24,960	$23,350
Expenditures:								
Salaries and Beneftis	$106,720	$67,777	$38,943	$106,720	$67,777	$38,943	$1,280,635	$1,212,858
Supplies and Purchased Services	33,570	20,931	12,639	33,570	20,931	12,639	284,269	263,338
Total Expenditures	$140,290	$88,708	$51,582	$140,290	$88,708	$51,582	$1,564,904	$1,476,196
Dental Services								
Revenue:								
Fees, Reimbursements & Other Income	$87,040	$74,824	($12,216)	$87,040	$74,824	($12,216)	$1,114,692	$1,039,868
Total Revenue	$87,040	$74,824	($12,216)	$87,040	$74,824	($12,216)	$1,114,692	$1,039,868
Expenditures:								
Salaries and Benefits	$246,118	$223,781	$22,337	$246,118	$223,781	$22,337	$2,953,411	$2,729,630
Supplies and Purchased Services	122,797	86,068	36,729	122,797	86,068	36,729	893,755	807,687
Total Expenditures	$368,915	$309,849	$59,066	$368,915	$309,849	$59,066	$3,847,166	$3,537,317

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 1/31/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Remaining Funds
Integrated Care (MHSA/PC)								
Revenue:								
Fees, Reimbursements & Other Income	$2,917	$866	($2,051)	$2,917	$866	($2,051)	$35,000	$34,134
Total Revenue	$2,917	$866	($2,051)	$2,917	$866	($2,051)	$35,000	$34,134
Expenditures:								
Salaries and Benefits	$79,098	$73,329	$5,769	$79,098	$73,329	$5,769	$949,180	$875,851
Supplies and Purchased Services	19,478	12,049	7,429	19,478	12,049	7,429	133,264	121,215
Total Expenditures	$98,576	$85,378	$13,198	$98,576	$85,378	$13,198	$1,082,444	$997,066
Health Promotion								
Revenue:								
Fees, Reimbursements & Other Income	$1,172	$1,078	($94)	$1,172	$1,078	($94)	$14,063	$12,985
Total Revenue	$1,172	$1,078	($94)	$1,172	$1,078	($94)	$14,063	$12,985
Expenditures:								
Salaries and Benefits	$52,710	$47,204	$5,506	$52,710	$47,204	$5,506	$632,516	$585,312
Supplies and Purchased Services	21,759	21,552	207	21,759	21,552	207	193,917	172,365
Total Expenditures	$74,469	$68,756	$5,713	$74,469	$68,756	$5,713	$826,433	$757,677

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 1/31/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Remaining Funds
Health Care Access								
Revenue:								
Fees, Reimbursements & Other Income	$0	$30	$30	$0	$30	$30	$0	($30)
Total Revenue	$0	$30	$30	$0	$30	$30	$0	($30)
Expenditures:								
Salaries and Benefits	$72,715	$66,915	$5,800	$72,715	$66,915	$5,800	$872,574	$805,659
Supplies and Purchased Services	27,645	13,571	14,074	27,645	13,571	14,074	228,781	215,210
Total Expenditures	$100,360	$80,486	$19,874	$100,360	$80,486	$19,874	$1,101,355	$1,020,869
Health Info Source								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$4,989	$4,669	$320	$4,989	$4,669	$320	$59,865	$55,196
Supplies and Purchased Services	3,324	2,294	1,030	3,324	2,294	1,030	22,985	20,691
Total Expenditures	$8,313	$6,963	$1,350	$8,313	$6,963	$1,350	$82,850	$75,887
Resource Development								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$12,048	$11,323	$725	$12,048	$11,323	$725	$144,574	$133,251
Supplies and Purchased Services	3,254	1,625	1,629	3,254	1,625	1,629	25,270	23,645
Total Expenditures	$15,302	$12,948	$2,354	$15,302	$12,948	$2,354	$169,844	$156,896

Health District of Northern Larimer County

Investment Schedule
January 2018

Investment	Institution	Current Value	%	Current Yield	Maturity
Local Government Investment Pool	COLOTRUST	$ 1,327	0.021%	1.24%	N/A
Local Government Investment Pool	COLOTRUST	$ 4,535,424	72.275%	1.55%	N/A
Local Government Investment Pool (Children's Oral Health Care Assistance Fund)	COLOTRUST	$ 7,981	0.127%	1.55%	N/A
Local Government Investment Pool (Oral Health Care Assistance Fund)	COLOTRUST	$ 22,601	0.360%	1.55%	N/A
Flex Savings Account	First National Bank	$ 364,267	5.805%	0.90%	N/A
Certificate of Deposit - #714626	Advantage Bank	$ 134,504	2.143%	0.80%	6/27/2018
Certificate of Deposit - #742487	Advantage Bank	$ 107,525	1.713%	1.09%	3/2/2018
Certificate of Deposit - #35083766	First National Bank	$ 110,435	1.760%	1.35%	9/6/2019
Certificate of Deposit - #40010527	Points West	$ 111,205	1.772%	0.80%	6/4/2018
Certificate of Deposit - #40010448	Points West	$ 150,853	2.404%	0.80%	4/2/2018
Certificate of Deposit - #23002918	Adams State Bank	$ 229,145	3.652%	1.29%	10/7/2019
Certificate of Deposit - #824149	Cache Bank & Trust	$ 250,000	3.984%	0.80%	12/27/2018
Certificate of Deposit - #1100000578	Farmers Bank	$ 250,000	3.984%	1.20%	6/27/2018
Total/Weighted Average		$ 6,275,267	100.000%	1.40%	

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.

HEALTH DISTRICT
of Northern Larimer County
February 2018
Summary Financial Narrative

Revenues

The Health District is 3.8% ahead of year-to-date tax revenue projections. Interest income is 11.9% ahead of year-to-date projections. Lease revenue is at year-to-date projections. Yield rates on investment earnings increased slightly from the previous month from 1.40% to 1.47% (based on the weighted average of all investments). Fee for service revenue from clients is 3.9% behind year-to-date projections and revenue from third party reimbursements is 22.9% behind year-to-date projections. Total operating revenues for the Health District (excluding grants and special projects) are 2.3% ahead of year-to-date projections.

Expenditures

Operating expenditures (excluding grants and special projects) are 17.5% behind year-to-date projections. Program variances are as follows: Administration 7.8%; Board 70.5%; Connections: Mental Health/Substance Issues Services 35.2%; Dental Services 18.8%; Integrated Care 11.6%; Health Promotion 12.4%; Community Impact 4.7%; Program Assessment and Evaluation 11.4%; Health Care Access 13.5%; HealthInfoSource 16.3%; and Resource Development 13.6%.

Capital Outlay

No capital expenditures have been made year-to-date.

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

BALANCE SHEET

As of 2/28/2018

ASSETS

Current Assets:	
Cash & Investments	$6,345,731.65
Accounts Receivable	79,484.84
Property Taxes Receivable	6,732,167.81
Specific Ownership Taxes Receivable	50,122.00
Prepaid Expenses and Deposits	76,844.91
Total Current Assets	13,284,351.21
Other Assets:	
Direct Financing Lease	4,047,875.00
Total Other Assets	4,047,875.00
Property and Equipment	
Land	544,720.02
Building and Leasehold Improvements	4,421,115.73
Equipment	1,217,002.79
Accumulated Depreciation	(2,577,095.31)
Total Property and Equipment	3,605,743.23
Total Assets	$20,937,969.44

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

BALANCE SHEET

As of 2/28/2018

LIABILITIES AND EQUITY

Current Liabilities:	
Accounts Payable	$675,829.77
Deposits	1,000.00
Deferred Revenue	551,968.60
Total Current Liabilities	1,228,798.37
Long-term Liabilities:	
Compensated Absences Payable	15,410.00
Total Long-term Liabilities	15,410.00
Deferred Inflows of Resources	
Deferred Property Tax Revenue	4,562,870.95
Total Deferred Inflows of Resources	4,562,870.95
Total Liabilities & Deferred Inflows of Resource	5,807,079.32
EQUITY	
Retained Earnings	13,717,362.05
Net Income	1,413,528.07
Total Equity	15,130,890.12
Total Liabilities & Equity	$20,937,969.44

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF REVENUES AND EXPENSES

For 1/1/2018 To 2/28/2018

	Current Month	Year to Date
Revenue:		
Property Taxes	$2,169,296.86	$2,625,560.05
Specific Ownership Taxes	50,121.20	102,837.40
Lease Revenue	88,491.25	176,982.50
Interest Income	7,050.25	14,921.86
Sales Revenue	20.34	65.07
Fee For Services Income	16,758.07	30,842.37
Third Party Reimbursements	65,996.71	129,199.92
Grant Revenue	23,372.22	79,766.47
Partnerships	3,786.36	9,688.37
Miscellaneous Income	8,733.68	9,808.74
Gain on Investment	0.00	1,239.15
Total Revenue	2,433,626.94	3,180,911.90
Expenses:		
Operating Expenses		
Administration	$95,280.99	$155,719.72
Board Expenses	945.82	1,826.55
Connections: MentalHealth/Substance Issues Svcs	87,772.11	176,480.13
Dental Services	262,939.81	572,789.05
Integrated Care (MHSA/PC)	81,315.56	167,651.46
Health Promotion	57,098.61	125,855.08
Community Impact	53,145.30	105,854.09
Program Assessment & Evaluation	15,567.76	32,062.72
Health Care Access	87,279.52	167,766.41
HealthInfoSource	5,505.03	12,467.58
Resource Development	12,592.57	25,540.95
Special Projects	39,371.64	101,653.31
Grant Projects	58,014.63	121,716.78
Total Operating Expenses	856,829.35	1,767,383.83
Depreciation and Amortization		
Total Depreciation and Amortization	0.00	0.00
Total Expenses	856,829.35	1,767,383.83
Net Income	$1,576,797.59	$1,413,528.07

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 2/28/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Annual Funds Remaining
Revenue:								
Property Taxes	$2,308,831	$2,169,297	($139,534)	$2,544,305	$2,625,560	$81,255	$7,188,431	$4,562,871
Specific Ownership Taxes	45,931	50,121	4,190	84,214	102,837	18,623	580,000	477,163
Lease Revenue	88,491	88,491	0	176,983	176,983	0	1,083,133	906,150
Interest Income	6,667	7,050	383	13,334	14,922	1,588	80,000	65,078
Sales Revenue	27	20	(7)	54	65	11	325	260
Fee For Services Income	17,205	16,759	(446)	32,085	30,842	(1,243)	234,606	203,764
Third Party Reimbursements	90,150	65,997	(24,153)	167,581	129,200	(38,381)	943,354	814,154
Grant Revenue	143,959	23,372	(120,587)	287,917	79,766	(208,151)	1,695,319	1,615,553
Partnership Revenue	3,708	3,786	78	7,416	9,688	2,272	44,498	34,810
Miscellaneous Income	1,661	8,734	7,073	3,321	9,809	6,488	19,930	10,121
Gain on Investment	0	0	0	0	1,239	1,239	0	(1,239)
Total Revenue	$2,706,630	$2,433,627	($273,003)	$3,317,210	$3,180,911	($136,299)	$11,869,596	$8,688,685
Expenditures:								
Operating Expenditures								
Administration	106,297	95,281	11,016	168,967	155,719	13,248	825,915	670,196
Board Expenses	3,095	946	2,149	6,191	1,792	4,399	46,476	44,684
Election Expenses	0	0	0	0	35	(35)	18,000	17,965
Connections: Mental Health/Substance Issues Sv	131,965	87,772	44,193	272,255	176,480	95,775	1,564,904	1,388,424
Dental Services	336,115	262,940	73,175	705,030	572,789	132,241	3,847,166	3,274,377
Integrated Care (MHSA/PC)	91,022	81,315	9,707	189,664	167,651	22,013	1,083,230	915,579
Health Promotion	69,158	57,099	12,059	143,628	125,855	17,773	826,433	700,578
Community Impact	53,588	53,145	443	111,027	105,854	5,173	635,016	529,162
Program Assessment & Evaluation	17,580	15,568	2,012	36,177	32,063	4,114	205,411	173,348
Health Care Access	93,590	87,279	6,311	193,949	167,766	26,183	1,101,355	933,589
HealthInfoSource	6,590	5,505	1,085	14,903	12,467	2,436	82,850	70,383
Resource Development	14,264	12,592	1,672	29,566	25,541	4,025	169,844	144,303
Contingency (Operations)	0	0	0	0	0	0	239,000	239,000
Special Projects	153,911	39,372	114,539	310,524	101,654	208,870	1,879,519	1,777,865
Grant Projects	143,959	58,015	85,944	287,917	121,717	166,200	1,695,319	1,573,602
Total Operating Expenditures	1,221,134	856,829	364,305	2,469,798	1,767,383	702,415	14,220,438	12,453,055
Net Income	$1,485,496	$1,576,798	$91,302	$847,412	$1,413,528	$566,116	($2,350,842)	($3,764,370)

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF NON OPERATIONAL EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 2/28/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Annual Funds Remaining
Non-Operating Expenditures								
Building	0	0	0	0	0	0	3,020,000	3,020,000
General Office Equipment	20,000	0	20,000	20,000	0	20,000	20,000	20,000
Medical & Dental Equipment	0	0	0	7,830	0	7,830	13,797	13,797
Computer Equipment	0	0	0	11,600	0	11,600	11,600	11,600
Computer Software	0	0	0	0	0	0	7,300	7,300
Furniture	0	0	0	0	0	0	10,000	10,000
Total Non-Operating Expenditures	20,000	0	20,000	39,430	0	39,430	3,082,697	3,082,697

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 2/28/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Remaining Funds
Administration								
Revenue:								
Miscellaneous Income	$792	$8,734	$7,942	$1,583	$8,734	$7,151	$9,500	$766
Total Revenue	$792	$8,734	$7,942	$1,583	$8,734	$7,151	$9,500	$766
Expenditures:								
Salaries and Benefits	42,815	38,834	3,981	85,631	79,388	6,243	513,783	434,395
Supplies and Purchased Services	63,482	56,447	7,035	83,337	76,332	7,005	312,132	235,800
Total Expenditures	$106,297	$95,281	$11,016	$168,968	$155,720	$13,248	$825,915	$670,195
Board of Directors								
Expenditures:								
Salaries and Benefits	$0	$0	$0	$0	$0	$0	$8,632	$8,632
Supplies and Purchased Services	3,096	946	2,150	6,190	1,792	4,398	37,844	36,052
Election Expenses	0	0	0	0	35	(35)	18,000	17,965
Total Expenditures	$3,096	$946	$2,150	$6,190	$1,827	$4,363	$64,476	$62,649
Community Impact								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$46,138	$47,669	($1,531)	$92,277	$93,059	($782)	$553,661	$460,602
Supplies and Purchased Services	7,449	5,476	1,973	18,750	12,795	5,955	81,355	68,560
Total Expenditures	$53,587	$53,145	$442	$111,027	$105,854	$5,173	$635,016	$529,162

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 2/28/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Remaining Funds
Program Assessment & Evaluation								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$14,997	$13,896	$1,101	$29,995	$28,204	$1,791	$179,969	$151,765
Supplies and Purchased Services	2,583	1,672	911	6,182	3,858	2,324	25,442	21,584
Total Expenditures	$17,580	$15,568	$2,012	$36,177	$32,062	$4,115	$205,411	$173,349
Connections: Mental Health/Substance Issue								
Revenue:								
Fees, Reimbursements & Other Income	$2,080	$1,136	($944)	$4,160	$2,746	($1,414)	$24,960	$22,214
Total Revenue	$2,080	$1,136	($944)	$4,160	$2,746	($1,414)	$24,960	$22,214
Expenditures:								
Salaries and Beneftis	$106,720	$70,010	$36,710	$213,439	$137,787	$75,652	$1,280,635	$1,142,848
Supplies and Purchased Services	25,245	17,762	7,483	58,816	38,694	20,122	284,269	245,575
Total Expenditures	$131,965	$87,772	$44,193	$272,255	$176,481	$95,774	$1,564,904	$1,388,423
Dental Services								
Revenue:								
Fees, Reimbursements & Other Income	$102,082	$78,831	($23,251)	$189,122	$153,655	($35,467)	$1,114,692	$961,037
Total Revenue	$102,082	$78,831	($23,251)	$189,122	$153,655	($35,467)	$1,114,692	$961,037
Expenditures:								
Salaries and Benefits	$246,118	$212,668	$33,450	$492,235	$436,449	$55,786	$2,953,411	$2,516,962
Supplies and Purchased Services	89,998	50,272	39,726	212,795	136,340	76,455	893,755	757,415
Total Expenditures	$336,116	$262,940	$73,176	$705,030	$572,789	$132,241	$3,847,166	$3,274,377

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 2/28/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Remaining Funds
Integrated Care (MHSA/PC)								
Revenue:								
Fees, Reimbursements & Other Income	$2,917	$2,518	($399)	$5,833	$3,384	($2,449)	$35,000	$31,616
Total Revenue	$2,917	$2,518	($399)	$5,833	$3,384	($2,449)	$35,000	$31,616
Expenditures:								
Salaries and Benefits	$79,098	$72,329	$6,769	$158,197	$145,658	$12,539	$949,180	$803,522
Supplies and Purchased Services	11,858	8,986	2,872	31,336	21,035	10,301	133,264	112,229
Total Expenditures	$90,956	$81,315	$9,641	$189,533	$166,693	$22,840	$1,082,444	$915,751
Health Promotion								
Revenue:								
Fees, Reimbursements & Other Income	$1,172	$180	($992)	$2,344	$1,258	($1,086)	$14,063	$12,805
Total Revenue	$1,172	$180	($992)	$2,344	$1,258	($1,086)	$14,063	$12,805
Expenditures:								
Salaries and Benefits	$52,710	$45,396	$7,314	$105,419	$92,600	$12,819	$632,516	$539,916
Supplies and Purchased Services	16,449	11,703	4,746	38,208	33,255	4,953	193,917	160,662
Total Expenditures	$69,159	$57,099	$12,060	$143,627	$125,855	$17,772	$826,433	$700,578

HEALTH DISTRICT OF NORTHERN LARIMER COUNTY

STATEMENT OF PROGRAM REVENUES AND EXPENDITURES - BUDGET AND ACTUAL

For 1/1/2018 To 2/28/2018

	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Remaining Funds
Health Care Access								
Revenue:								
Fees, Reimbursements & Other Income	$0	$110	$110	$0	$139	$139	$0	($139)
Total Revenue	$0	$110	$110	$0	$139	$139	$0	($139)
Expenditures:								
Salaries and Benefits	$72,715	$65,109	$7,606	$145,429	$132,025	$13,404	$872,574	$740,549
Supplies and Purchased Services	20,875	22,170	(1,295)	48,520	35,741	12,779	228,781	193,040
Total Expenditures	$93,590	$87,279	$6,311	$193,949	$167,766	$26,183	$1,101,355	$933,589
Health Info Source								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$4,989	$4,346	$643	$9,978	$9,015	$963	$59,865	$50,850
Supplies and Purchased Services	1,602	1,159	443	4,926	3,452	1,474	22,985	19,533
Total Expenditures	$6,591	$5,505	$1,086	$14,904	$12,467	$2,437	$82,850	$70,383
Resource Development								
Revenue:								
Total Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Expenditures:								
Salaries and Benefits	$12,048	$11,212	$836	$24,096	$22,535	$1,561	$144,574	$122,039
Supplies and Purchased Services	2,216	1,380	836	5,470	3,006	2,464	25,270	22,264
Total Expenditures	$14,264	$12,592	$1,672	$29,566	$25,541	$4,025	$169,844	$144,303

Health District of Northern Larimer County

Investment Schedule
February 2018

Investment	Institution	Current Value	%	Current Yield	Maturity
Local Government Investment Pool	COLOTRUST	$ 1,328	0.023%	1.32%	N/A
Local Government Investment Pool	COLOTRUST	$ 4,040,591	70.813%	1.66%	N/A
Local Government Investment Pool (Children's Oral Health Care Assistance Fund)	COLOTRUST	$ 7,991	0.140%	1.66%	N/A
Local Government Investment Pool (Oral Health Care Assistance Fund)	COLOTRUST	$ 22,629	0.397%	1.66%	N/A
Flex Savings Account	First National Bank	$ 289,505	5.074%	0.90%	N/A
Certificate of Deposit - #714626	Advantage Bank	$ 134,504	2.357%	0.80%	6/27/2018
Certificate of Deposit - #742487	Advantage Bank	$ 107,820	1.890%	1.09%	3/2/2018
Certificate of Deposit - #35083766	First National Bank	$ 110,435	1.935%	1.35%	9/6/2019
Certificate of Deposit - #40010527	Points West	$ 111,205	1.949%	0.80%	6/4/2018
Certificate of Deposit - #40010448	Points West	$ 150,853	2.644%	0.80%	4/2/2018
Certificate of Deposit - #23002918	Adams State Bank	$ 229,145	4.016%	1.29%	10/7/2019
Certificate of Deposit - #824149	Cache Bank & Trust	$ 250,000	4.381%	0.80%	12/27/2018
Certificate of Deposit - #1100000578	Farmers Bank	$ 250,000	4.381%	1.20%	6/27/2018
Total/Weighted Average		$ 5,706,007	100.000%	1.47%	

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.

Health District
OF NORTHERN LARIMER COUNTY

JOINT MEETING OF THE BOARDS OF DIRECTORS OF THE HEALTH DISTRICT AND UCHEALTH-PVHS

February 21, 2018

Redstone Building
2315 E. Harmony Road, Suite 200

MINUTES

HEALTH DISTRICT

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

BOARD MEMBERS ABSENT: Deirdre Sullivan, Secretary

HEALTH DISTRICT STAFF: Carol Plock, Executive Director
Bruce Cooper, MD, Medical Director
Lin Wilder, Director of Community Impact
Nancy Stirling, Assistant to ED and Board

UCHEALTH-PVHS
BOARD MEMBERS & STAFF PRESENT:
Jim Sprowell, Chris Osborn, Lisa Clay, Dennis Houska (Vice Chair), Mike Dellenbach (Chair), Kevin Unger (President/CEO, PVH and MCR), Christine Chin (Past Chair), Dan Stroh, Doug Erion, Jim Parke, Bill Neff (Chief Medical Officer, UCHealth), Jim Hoyt (MCR Vice Chief of Staff), Christie Johnston (PVH Chief of Staff), Jamie Teumer (MCR Chief of Staff); Lisa White (Assistant to Kevin Unger)

CALL TO ORDER; APPROVAL OF AGENDA

President Michael Liggett called the meeting to order at 4:23 p.m.

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

WELCOME & INTRODUCTIONS

PVHS Board Chair Mike Dellenbach welcomed all and invited everyone to introduce themselves. On behalf of the Health District Board members, Board President Mike Liggett offered his appreciation for the opportunity to have this joint meeting.

REMARKS

Kevin Unger, President and CEO of PVH and MCR, noted that he had met with the Health District Board at their meeting last month and he expressed his appreciation for the partnership between the Health District and PVHS and welcomed the Health District board members today.

He noted that he and Carol Plock worked together to settle on a topic for today's meeting, and found that efforts to impact opioid misuse was one of high interest to both organizations. It seemed important to share what is being done to address the issue in the hospital system as well as in the community and statewide.

PRESENTATIONS

Current Focus of the Health District – Carol Plock

Ms. Plock provided a brief overview of the Health District and some of its programs. The mission of the Health District is simple, though a tough charge – to enhance the health of the community. Every three years the Health District conducts a community health assessment which guides many of the programs and objectives of the organization. The District also looks at what are some interventions that might be accomplished in conjunction with community partners. The Health District has five basic areas of focus that address the biggest health burdens in the community.

1) **Connecting people to affordable health care**. The Health District's Larimer Health Connect program helps individuals and families to navigate the state's health insurance marketplace and assists with enrollment into marketplace health plans and Medicaid. Between 2013 and 2016 the state saw a dramatic drop in the number of uninsured from 12% to 4%. Though this year's open enrollment period was 3 weeks shorter, staff assisted more people than during last year's enrollment.
2) **Dental Services**. The Health District's Dental Clinic provides dental care for those who can't afford the full cost of care. With the help of new payer sources, however, access to dental care for some people is getting better. The Health District's Dental Connections program is a collaboration with several local community dentists who donate care to eligible persons. The Dental Clinic also provides screenings for school children at schools with the highest percentage of low income families.
3) **Mental Health**. The Health District's mental health programs address both mental health and substance use disorders issues. There are three direct service programs. *The Connections program* initially worked with families and individuals in helping them to get connected to the services they need. Over the years we heard from families about how difficult it is to find and get appropriate services for their children. In close collaboration with a community ad hoc group, the *CAYAC (Child, Adolescent, and Young Adult Connections) program* was developed. This program assists families and youth in getting appropriate care by providing assessments, connecting them to appropriate services and providers, and providing some services. It includes diagnostic services from child psychiatrists, as well as psychological testing. Now that it has been in the community for a couple of years, it is "busting at the seams" in terms of capacity to meet the needs of the community in this area. The Health District's *Integrating Mental Health into Primary Care program (Integrated Care)* places mental health professionals (including a psychiatrist) at the community's two safety net clinics, Salud Family Health Centers and UCHealth's Family Medicine Center.

   In addition to providing services, the Health District also seeks to address mental health and substance use disorders by helping the community make long-term sustainable change through its *Healthy Mind Matters program*. There are three major focuses the program is working on right now:

1) Helping the community understand what the needs and gaps are in regard to the continuum of care for mental health and substance use disorders. The program is currently working with other community partners on a report, "What Will It Take? Solutions to Mental Health Services Gaps in Larimer County," which revises an earlier report that looks at gaps of services in our community and offers recommendations to address the gaps.
2) Helping the community understand substance use disorders (SUDs) and support adequate treatment. While we are slowly starting to see additional services for SUDs come into our community, we still have a long way to go to provide best practice services and to fill in all the gaps for a continuum of care.
3) Helping people with complex needs. Several organizations are working together to bring mental health services and housing needs together to help individuals become more independent.

4) **Health Promotion**. The Health District's Health Promotion program provides identification and intervention for some of the biggest health risk factors. *Tobacco Cessation* provides evidence-based approaches to help individuals quit tobacco, and the *Cardiovascular* program provides cholesterol and other screenings to help identify potential heart disease risk, and to counsel participants on effective management of risk.

5) **Advance Care Planning**. The Health District's Advance Care Planning program is a community initiative helping to make it easier for people to think about and record their end of life preferences. It also assists with making these preferences known and followed, including getting them into client medical records. The program has exceeded all its goals and was just awarded a major grant to continue our efforts from NextFifty.

A question was raised about the relationship between the Health District and the PVHS system. The history of the Health District is that it owned and operated the hospital when it was a public hospital. In 1994, Poudre Valley Hospital and the PVHS health system was privatized by the board. Today, the Health District maintains the ownership of the PVHS assets but there is a 50 year lease in place between the organizations, and a consent agreement that includes UCHealth. The Health District does not have any responsibility for the day-to-day management of the hospital, but does oversee covenants between the two organizations that require the continuation of high quality care and that the health system continues to serve people who cannot afford the full cost of care.

Battling the Opioid Epidemic

The UCHealth System Approach

Dr. Christine Johnson, PVH Chief of Staff, and Dr. Jaime Teumer, MCR Chief of Staff presented information on the scope of the opioid crisis and how the PVHS and UCHealth systems are addressing this issue.

"Overdose is the number one killer of Americans under the age of 50, and Colorado is significantly affected by the opioid epidemic. According to data from the Colorado Department of Health Care Policy and Financing, in 2015, approximately one Coloradan died every 36 hours from opioid overdose. Additionally, risk from illicit drugs has increased, and in 2016, heroin overdose deaths increased by 23 percent from 2010. Neonatal abstinence syndrome has risen 91 percent among Colorado Medicaid members." (*Colorado Hospital Association, 2017 report*)

The hospital system has implemented several strategies to address opioid use and pain management, including: PDMP (prescription drug monitoring program) access through the EPIC electronic medical records system for EDs and primary care offices; Electronic Prescription of Controlled Substances where scripts must be done by computer (not paper); Joint Commission Requirements which updates order sets with clear indications of use of opioids and provider and nursing education; Population Management tools with opioid registry embedded into EPIC; Decision Support Tools for inpatient and outpatient opioid prescriptions (use opioids only as a last option after an order set); and identification of high risk patients, and providing them with education and naloxone prescriptions at discharge.

Some of the specific strategies being implemented at UCHealth-North include: hospital-based provider education on how to use other meds besides opioids; neonatal evidence-based protocol for identifying and treating substance exposed newborns; anesthesia guidelines for patients on buprenorphine maintenance; limits on inpatient prescribing requiring phone call to pharmacy; and partnerships with the Health District and other providers in Larimer and Weld Counties on substance abuse treatment resources.

The ALTO Project with Colorado Hospital Association

In January 2016, the Colorado Hospital Association (CHA) conducted a survey to better understand the state of the current opioid work being done by member hospitals and health systems across Colorado. Nearly 80 percent of survey respondents indicated they were actively working on opioid safety. The Emergency Department (ED) was identified as the number one area in which opioid safety was a concern, and more than 90 percent of participants wanted more information on how CHA could assist with opioid safety. Following the survey, CHA created an Opioid Safety Steering Committee, with the goal of identifying how CHA could bring value to its hospital partners and work towards combating the ever-growing Colorado opioid epidemic. The CHA also developed key strategic partnerships with various organizations to form the Colorado Opioid Safety Collaborative to improve opioid safety in Colorado EDs.

The goal of the project is to reduce administration of opioid medications by ED clinicians through implementation of the ALTO approach from the *Colorado ACEP 2017 Opioid Prescribing & Treatment Guidelines*. The key target of the project was to reduce administration of opioids by 15 percent, over the 2017 six-month pilot. The ALTO approach includes: using non-opiate first line therapies to treat pain in the ED, educate patients (helping patients to truly understand their level of pain and buy in to more appropriate non-opiate treatments), and utilize opiates as "rescue" medications.

The pilot was implemented with 10 different facilities, 5 of them UCHealth hospitals. It was challenging as providers had to adapt their 'old school' thinking to remembering to try other options, which took a while. On average, the participating hospitals hit about a 36% reduction in prescribing opiates (compared to a goal of 15%), with UCHealth hospitals achieving about a 48% reduction across the board.

The Larimer/Weld County Community Approach

Ms. Lin Wilder, Health District Community Impact Director, provided an overview of some community efforts to reversing the opioid epidemic in northern Colorado. The Health District has been providing staffing and support to the Mental Health and Substance Use Alliance in Larimer County since 1999. The Alliance includes representatives from over 20 organizations and individuals who work together to improve mental health and substance use disorder care in our

community. Most recently the Alliance has collaborated with several other organizations, including SummitStone Health Partners, the North Colorado Health Alliance, Sunrise Community Health, and the Colorado Consortium for Prescription Drug Abuse Prevention, to implement strategies that address the Opioid Crisis in Northern Colorado – strategies that pertain to four areas: prevention, early identification, treatment and recovery, and harm reduction. Examples of strategies:

- Prevention – The Prescription Drug Overdose Prevention for Communities Grant from the Colorado Department of Public Health and Environment (CDPHE) is a two-year grant to provide provider education (safe opioid prescribing, CDC guidelines, Medication Assisted Treatment – MAT) and coalition building in both Larimer and Weld Counties.
- Identification & Treatment – Improving identification and treatment of opioid use disorders for criminal justice-involved individuals. Work has begun with criminal justice to evaluate current practices, barriers, and limitations to the use of medication-assisted treatment in their programs and jails – with the aim to increase MAT in their settings, and to make sure individuals are connected to medications when they are released into the community. [The Health District is also working with Criminal Justice representatives and SummitStone, the Larimer County public mental health provider, on a special grant to increase the use of evidence-based substance use treatment practices in the community.]
- Harm Reduction – Naloxone distribution and education workgroup. Naloxone is a drug that is used to temporarily reverse the effects of an opioid overdose, giving enough time to get further emergency help. It saves lives, but must be administered immediately. This program educates people on use of naloxone and distributes Naloxone kits, focusing particularly on those who are at risk for overdose, their friends and families, and community organizations where they may go for help.

Another strategy being implemented is to raise public awareness around the risk of opioids through messaging. In Larimer County there is a group of public education professionals developing messaging for web sites, the press, and the public. In addition to that, the MHSU Alliance is currently working on a broader public awareness campaign to help people better understand substance use disorders.

The update of the study done a couple of years ago to determine what gaps exist in mental health and substance use disorder services (which will be released in the next couple of months) came to the same conclusion: Although Larimer County has many quality services, we do not have the range of services and facilities that should be available in order to effectively meet the needs of thousands of residents who need treatment for mental illness and substance use disorders. The study points out the areas where more capacity is needed or where certain services just don't exist in our community right now. The study will detail what services need to be expanded or created in Larimer County.

A question was asked about whether the Health District provides any direct mental health treatment services. In our Integrated Care Program, the Health District's Behavioral Health Specialists work side-by-side with physicians in the primary care safety net clinics including the Family Medicine Center and Salud, also providing individual and group treatment services. The Health District's Connections program connects people to the right kind of care for their needs, provides care coordination to help people navigate through the complex system, and also provides some short-term mental health services. CAYAC and the Integrated Care program both have psychiatrists on staff, and CAYAC has a psychologist doing psychological testing.

GENERAL DISCUSSION

President Liggett shared an example of a young adult client of his who was an excellent student but developed a substance use disorder and is now involved with criminal justice and has been assessed to need residential treatment. Unfortunately such treatment is not available in our community, and going out of their insurance network is unaffordable for the family.

Chair Dellenbach expressed concern over a recent newspaper article that suggests a connection between community drug problems and immigrants, and transients were also mentioned. While there is some of that, the reality in our community is that substance use disorders are not isolated to any particular group or locality – they are an 'equal opportunity' disorder that can impact anyone at any time. How fortunate it is that the community and the hospital system are taking this concern very seriously and doing what they can to affect change in our community that help individuals and families and will save lives.

ADJOURN

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

The meeting was adjourned at 6:15 p.m.

Respectfully submitted:

Nancy Stirling, Assistant to the Board of Directors

Michael Liggett, President

Tracy Nelson, Vice President

[Absent]

Deirdre Sullivan, Secretary

Faraz Naqvi, M.D., Treasurer

Tess Heffernan, UCHealth-North (PVHS) Board Liaison

Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS MEETING
February 27, 2018

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 (via phone)
Faraz Naqvi, M.D., Treasurer
Tess Heffernan, Liaison to UCHealth-North/PVHS Board

Staff Present:
Carol Plock, Executive Director
Karen Spink, Assistant Director
Bruce Cooper, Medical Director
Richard Cox, Communications Director
Lorraine Haywood, Finance Director
Chris Sheafor, Support Services Director
Nancy Stirling, Assistant to Board & ED
Sarah Tilleman, Dental Services Director
Lin Wilder, Community Impact Director
Brian Ferrans, Community Impact Manager
Sue Hewitt, Evaluation Coordinator
Laura Mai, Assistant Finance Director
Jessica Shannon, Resource Development
Alyson Williams, Policy Coordinator

Others Present:
Laurie Stolen, Larimer County Criminal Justice
Nina Bodenhamer, Consultant
Sarah Tarver, Oncology Research RN/Student

CALL TO ORDER; APPROVAL OF AGENDA
President Michael Liggett called the meeting to order at 4:02 p.m. No changes were made to the meeting agenda.

PUBLIC COMMENT
None.

PRESENTATIONS
What Will It Take? Solutions to Mental Health Services Gaps in Larimer County
Ms. Lin Wilder, Community Impact Director, provided a brief overview on the work to update the 2016 report regarding critical gaps in mental health and substance use disorders services in Larimer County, and recommendations for addressing key gaps. Staff, working with consultants, and under the direction of a Guidance Team, have been reviewing and updating data and information from the original 2016 report. The update process also included meetings and data gathering with other community organizations and leaders, meetings to project staffing, operational costs, facility size, etc., and updating the Pro Forma Budget/Facilities Plan. The Guidance Team is recommending changes to the 2016 recommendations, and they will be listed in the new updated report, "What Will It Take? Solutions to Mental Health Services Gaps in

Larimer County." Ms. Wilder briefly reviewed the key changes, listed below (changes are in *italics*). The full report will be completed in March/April.

- Thorough Assessments *and the ability to do Medical Clearance on-site.*
- ~~Acute Treatment Unit (ATU)~~ *Move existing Crisis Stabilization Unit (CSU) (walk-in and stabilization beds) to combined facility (rather than start a new ATU; CSUs and ATUs are similar).*
- Medically Monitored Withdrawal Management (Detox) ~~and continue sending lower level needs to Weld County Detox facility~~ *and Social Model Detox services plus engagement activities (meet most Larimer County detox needs here*).
- Short Term Intensive Residential Treatment for SUDs.
- Client Assistance for Treatment Costs.
- Moderately Intensive to Intensive Care Coordination.
- Supportive Services for those in Permanent Supportive Housing.
- Encourage development of Step Down Housing options in community for Addictions (with limited funding for clinical staffing).
- Encourage expansion of outpatient, intensive outpatient, and medication assisted treatment for SUDs (funding to come from existing payer sources).

Add:

- *Financial support for youth/family prevention and early identification services and initiatives.*
- *Financial support for suicide prevention activities.*

Ms. Wilder reviewed with the board some of the solutions to mental health services gaps that a behavioral health facility would provide, gave estimated service numbers and costs, and discussed services that would be offered in the community. She presented a visual of what the current behavioral health service continuum looks like compared to the potential, more complete service continuum, if the recommendations are implemented.

If all recommendations were to be implemented, the community would make major strides in having a full continuum of services needed. Having more comprehensive, evidence-based, successful services would have a big impact on not only the individuals receiving care (and their circle of family, friends, and work), but would also affect many other organizations and systems, reducing unnecessary overuse. Utilization of hospital emergency departments, law enforcement, the criminal justice system, and the health and human services system is anticipated to change significantly; reducing inappropriate use and focusing an individual's use to the portion of the system that can be most effective. In one community conversation about how this might divert inappropriate use of certain parts of the system, it was noted that PVH alone has about 2300 ED visits per year that are largely alcohol-related.

Larimer County Behavioral Health Update

Ms. Laurie Stolen, with Larimer County Criminal Justice, and Ms. Nina Bodenhamer, a consultant, attended this meeting to share with the board the county's work on learning from and sharing information with the public about the need for expanded mental health services. The County's interest in the issue began when the County Strategic Plan was up for renewal, and county leaders heard in community focus group meetings with about 350 community members that behavioral health was one of the top community concerns. Behavioral health was placed in

the safety and well-being category, which became one of the County's top objectives. In 2016, a ballot initiative to build a new mental health and detox facility was presented but did not pass. In follow-up, the County Commissioners expressed their continued support for adequate quality mental health care to meet the needs of county residents and subsequently assigned Ms. Stolen to a two-year project to engage the community to learn more and raise awareness and support around mental health and substance use and a facility.

Focus group meetings with the public and various groups are being held to learn people's perspectives and understandings of the issues. The learnings are being gathered and recommendations developed to be presented to the County as a "road map" for what it will take to bring about the increase in services. The road map will be shared with other local municipalities, such as Fort Collins and Loveland, to discuss respective priorities and where they think they could contribute to a county-wide solution. The ultimate goal will be to take the information gathered from the community, the Health District, the municipalities, the hospital system, and other service providers to the County Commissioners this summer, when it is anticipated that they will determine whether to put the issue back on the ballot for 2018.

The Board asked if there were specific issues or concerns being heard as to why there was not more support for the ballot initiative. In focus group conversations, it was discovered that the issue was lost from communities outside of Fort Collins, and key reasons were that people didn't understand the extent of the problem; in some cases didn't have much knowledge about mental health itself (or understand the term 'behavioral health'), and how it impacts families and the community; and in other cases, didn't understand the impact of the changes on both individuals and systems, including potentially reducing costs for the criminal justice system.

Those who have had a family experience with mental health or substance use disorders seem to understand the issue, and understand that with the proper intervention and treatment, people can get better. Another challenge was a crowded 2016 ballot, including several state level tax questions; those who were opposed to those may have just lumped all tax issues together, even important local ones. They are finding in discussion groups that when given the opportunity to learn more, many voters are willing to re-think their votes. Things that people do care very much about is that these issues impact everyone – including our own loved ones, right here in our own community; and that it is important to protect our youth, help families intervene early, lower suicide, and work to prevent homelessness.

Dental Outreach Project: An Initial Report

Mr. Richard Cox, Communications Director, and Ms. Sarah Tilleman, Dental Services Director, presented on recent Dental Services marketing and outreach. The Dental Clinic currently has unfilled capacity, but recognizes that there are still people in the community who need dental care and can't afford its full cost. Revenue from Medicaid and other primary funding assistance sources (i.e., Senior Dental Program grant, Larimer County on Aging funding) helps fund dental services. The number of clients the Clinic serves can be impacted by a wide variety of factors, such as disruptions in funding (e.g., delay in aging funding due to federal budget uncertainty), seasonal variations throughout the year (i.e., timing of Head Start and Project Smile screenings is dependent on school district calendar year), patients who no-show for appointments, requests for providers to participate in events, thus taking them outside of the clinic (school screenings, speaking engagements with undergrad and dental students, community outreach events),etc., which all impact clinic utilization.

Give all that, however, the clinic is available to serve more clients, and in July 2017, staff embarked on an outreach campaign to get the word out. Marketing efforts included various mediums, including: KRFC spots, Compass newsletter and other community newsletters and magazines (Scene, Coloradoan, Recreator, Rocky Mountain Parent), Transfort posters, Facebook posts, restroom posters and movie ads. Since launching the campaign, between July 2017 and December 2017, the clinic experienced a slight increase (3%) in total number of visits. Also for that same time period there was a 15% increase of new patient evaluations and 20% increase in emergency exams. When clients were asked where they heard about us, the number one response was through referrals or word of mouth; the second highest response was via our marketing and outreach efforts. Since a lot of people heard about us through a health and human service agency, efforts in 2018 will focus on getting more information to these agencies. Also in 2018, marketing efforts will include more detailed online targeting of consumers, outdoor advertising, in-depth analysis of available data, and continued tracking of the impact of efforts.

Other goals will be to lower the rate of no-shows, and do our best to convert those who come in for emergency care to ongoing patients. Given that we are 6 months into a 12-15 month plan, it will be important to keep efforts high and see what impact is made.

Mr. Liggett commented that providing access to dental care continues to be a priority for the Board and appreciates the efforts to promote our services as well as the efforts of all the dental staff who provide excellent care and services.

DISCUSSION AND ACTIONS

Policy

Federal Issues

The Dickey Amendment – This amendment passed in 1996 in a federal funding bill and states that none of the funds available for injury prevention and control at the CDC may be used to advocate for or promote gun control. Since the bill also withdrew CDC funding for gun violence research, many interpreted the two actions to mean that the CDC was banned from performing gun violence research. Given significant increases in multiple-victim gun violence, recently there have been discussions that this stance may be modified in order to allow research and create evidence-based gun violence prevention programs. The Board asked that the issue of gun violence be kept on our agenda for further consideration and discussion.

Updates

- **SB18-108: iDrive** – Moved to appropriations and passed out of appropriations this morning with a couple of minor amendments.
- **SB18-146**: **Free-Standing Emergency Departments (FSED) Transparency** – Passed out of appropriations with amendments.
- **SB18-040**: **Opioid Harm Reduction** – Postponed indefinitely (killed).
- **SB18-132**: **Catastrophic Plans** – Passed out of appropriations with amendments that would require actuarial analysis, and would not allow them unless: “the total amount of advanced premium tax credits received by Colorado residents will not decline and the average premiums of individual health plans in Colorado will not increase”. A benefit will be having actuarial analysis data, however there is a slim chance the analysis would be favorable to the expansion of catastrophic plans, which would mean the waiver process would go forward. Potential negative impacts include high deductibles, high levels of cost sharing, difficulty

affording care, destabilization of the individual market. In light of this change, Staff suggests the Board may want to reconsider its previous position on this bill to Strongly Oppose and change it to just Oppose.

MOTION: To change the position for Senate Bill 2018-132 to OPPOSE.
Motion/Seconded/Carried Unanimously

Other Bills for Board Consideration

- **Senior Dental Program Funding** – A request has been put in for the state budget to include an increase of $1 million in funding for the Senior Dental Program. This would make a considerable difference in providing much-needed dental care funding for seniors; in our program, the funding is usually spent halfway into the program year.

  MOTION: To STRONGLY SUPPORT Senior Dental Program Funding.
  Motion/Seconded/Carried Unanimously

- **SB2018-1182: Statewide System for Advance Directives** – This bill would direct the Colorado Department of Public Health and Environment to create a statewide electronic system as a repository for medical professionals and individuals to access and store advance directives. This would be a separate registry and would not interact with or duplicate other electronic records systems. While having such a registry would be beneficial for individuals and providers alike, there is a concern that medical providers may not access a separate registry outside of their own electronic records system. Staff agreed, however, that the potential benefits outweigh the concerns at this point.

  MOTION: To SUPPORT Senate Bill 2018-1182.
  Motion/Seconded/Carried Unanimously

- **HB2018-1177: Youth Suicide Prevention** – This bill is the only suicide-related bill still alive in the legislature; it would create opportunities for suicide prevention training programs, coordination of a statewide awareness campaign regarding youth suicide, and mandates a decrease in the age of consent for outpatient psychotherapy services without permission from an adult or legal guardian from 15 years of age to 12 years of age. Staff recommendation is to 1) support the suicide prevention piece; and 2) take a neutral position pertaining to the lowering of the age of consent. Those who oppose the age lowering believe that a 12-year-old would not have the understanding to make such a decision, and there are complications regarding issues of billing of insurance (confidentiality would be lost when parents are billed) and transfer of care.

  MOTION: To SUPPORT the Prevention Training and Awareness piece and take no position on mental health age of consent in House Bill 2018-1177.
  Motion/Seconded/Carried Unanimously

- **HB2018-1212: Freestanding Emergency Departments Licensure** – This bill creates a new type of license, "freestanding emergency department licensure", to be issued by the CDPHE. The Colorado Board of Health would adopt rules for this license type including requirements and fees. Facilities licensed under this new category would be limited in the amount of facility fees they would be allowed to charge patients. Staff recommendation is to support this legislation.

MOTION: **To SUPPORT HB2018-1212.**
Motion/Seconded/Carried Unanimously

The Board made a request to receive staff recommendations in writing ahead of the meetings to allow time for consideration, and for staff to monitor how often the Board is in alignment with staff's recommendations and when they disagree. The Board also supported staff's suggestion of providing the lengthy legislative matrix documents only once a month at the special board meetings rather than every meeting.

Update: Consultant, HD Public Awareness
In response to a board discussion at the last retreat, an RFP will be released soon for a consultant to help consider ways to increase awareness of the Health District in the community. The consultant will work with staff to review current Health District activities and develop recommendations for strategies and activities.

Grant Application with Community Partners to Coordinate Community Medication-Assisted SUD Treatment Process; Potential Match
Staff report that the grant application will not be submitted at this time, but that it spurred local organizations to work together to develop a plan to submit it in the future. The opportunity is to apply for a grant with the Denver Foundation to improve our medication assisted treatment (MAT) system of care, increasing the number of individuals receiving MAT services in the community and coordinating how services are provided and assisting clients in navigating the right level of care at the right time. Timing for the first cycle was too tight to be able to secure commitments and match, but work will continue in order to be ready for the second cycle.

In the midst of discussions, Mental Health Matters staff, along with partners from SummitStone Health Partners and the North Colorado Health Alliance, and a representative from Rocky Mountain Health Partners, attended an event in Denver where Vermont presented their MAT Hub and Spoke Model, an emerging MAT best practice centered around a well-coordinated system between the local opioid treatment programs, community behavioral health providers and primary care practices. Staff and partners came back excited to plan how a similar model could work for our community.

Moving forward, the plan is to: refocus some of the Northern Colorado Opioid Prevention Workgroup efforts towards planning and implementation of the Hub and Spoke model; identify key players to partner with on this grant and get commitments for matching funds; and reach out to Signal (MSO) to see if would provide some funding this year to support our planning and possibly put some pieces into place. If a decision is made next year to submit a grant proposal, the Health District's role would likely be similar to our role with the MACC program – providing staffing support to pull together a collaborative group of partners and assist with grant writing, helping to develop a concept and sustainability, as well as organizing and facilitating.

UPDATES & REPORTS

Fourth Quarter Report and other Executive Director Updates
The 2017 4th Quarter Report is not ready; other updates:

- **Medicaid Accountable Care Collaborative (MACC)** – Efforts are underway to transition to Regional Accountable Entities (RAEs) by July 1. Major conversations are happening at state, local and regional levels to figure out how RAEs, which will now include both physical and

mental health, will work. One of the key questions is how the community MACC team will be funded – currently physician clinics receive (in addition to fee for service) a per member per month (PMPM) rate for their Medicaid clients, and have been pooling most of it to support the MACC Team, with Rocky Mountain Health Plans matching much of that funding. After the state transitions to RAEs, physicians will get a lower PMPM from the state, but will be eligible for more from the RAE. It is not yet clear what amounts will be provided, nor has the funding for the MACC team been finalized.

- **Substance Use Disorders Public Awareness Campaign** – A vendor, Toolbox Creative, has been selected to work with staff to develop a public awareness campaign. A MindJam meeting is scheduled to kick off the planning.
- **HealthInfoSource Project** – Staff are in the process of selecting a vendor to create an initial blueprint. Staff are also starting a plan to organize input into the process.
- Ms. Williams is developing comments on the national Association Health Plans regulations. The Board should receive that document early next week; if there are comments, please share them with the Chair, who has already been authorized to approve comments before submission.
- Ms. Cherrilyn Wallace, Employee Development and Wellness Coordinator, has worked hard to develop a financial planning educational series for personnel with high-quality presenters presenting on topics such as retirement planning, understanding social security, investments, etc. The sessions thus far have been well attended and successful.
- **Board Election** – we currently have four candidates, including incumbents Tess Heffernan and Michael Liggett, and two new candidates, Dr. Joseph Prows and Molly Gutilla. Friday is the deadline to enter the election as a regular candidate; Monday to be a write-in candidate.

UCHealth-North/PVHS Board Liaison Report

Ms. Heffernan shared the following:

- Poudre Valley Hospital has been designated a Magnet hospital for some time and is submitting for re-designation; a site visit is upcoming and they should know in July.
- In April, they will be going live with "Wearables" – a new technology where vitals can be recorded and sent to the nursing station, reducing the need to wake people up in the night to take their vital signs.
- The hospital system has been conducting extra disaster drills lately.
- All hospitals in the UCHealth system are operating at high capacity, in part because of the high level of flu and other illnesses.

December 2017 Preliminary Financials

Financials can't be approved until the audit is complete, but were provided for the Board's review.

PUBLIC COMMENT (2nd opportunity)

None.

CONSENT AGENDA

- Approval of the January 23 and February 13, 2018 Board Meeting Minutes.

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

ANNOUNCEMENTS

- March 13, 4:00 pm, Board of Directors Special Meeting
- March 27, 4:00 pm, Board of Directors Regular Meeting

Ms. Nelson informed that she will be out of town and unable to attend the March 13 meeting. Ms. Heffernan also mentioned that she will miss the March 27 meeting.

ADJOURN

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

The meeting was adjourned at 5:52 p.m.

Respectfully submitted:

Nancy Stirling, Assistant to the Board of Directors

Michael Liggett, President

Tracy Nelson, Vice President

Deirdre Sullivan, Secretary

Faraz Naqvi, M.D., Treasurer

Tess Heffernan, UCHealth-North (PVHS) Board Liaison

Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS MEETING
March 13, 2018

Health District Office Building
120 Bristlecone Drive, Fort Collins

MINUTES

BOARD MEMBERS PRESENT: Michael D. Liggett, Esq., President
Faraz Naqvi, M.D., Treasurer
Tess Heffernan, Liaison to UCHealth-North/PVHS Board

BOARD MEMBERS ABSENT: Tracy L. Nelson, Ph.D., Vice President
Deirdre Sullivan, Secretary

Staff Present:

Carol Plock, Executive Director
Karen Spink, Assistant Director
Bruce Cooper, Medical Director
Lorraine Haywood, Finance Director
Chris Sheafor, Support Services Director
Nancy Stirling, Assistant to Board & ED
Sarah Tilleman, Dental Services Director
Alyson Williams, Policy Coordinator
Devin Nelson, Policy Assistant

CALL TO ORDER; APPROVAL OF AGENDA

President Michael Liggett called the meeting to order at 4:00 p.m. Ms. Nelson and Ms. Sullivan were both excused from the meeting.

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

DISCUSSION AND ACTIONS

Policy

Ms. Devin Nelson was introduced to the Board. She is the Public Policy Assistant and helping Ms. Williams with policy reports and bill monitoring.

Federal Issues

- **Proposed Rule: Short-Term, Limited-Duration Insurance** – Current regulations allow short-term health plans to be exempt from ACA mandates and have a maximum duration of 3 months. The proposed rule would lengthen the duration of short-term plans to 364 days and allow for re-application for such plans. Possible consequences of this proposed change could see an increase in premiums in ACA compliant plans and a decrease in the number of people with ACA compliant coverage. The proposed rule is open to public comment through April 23. Staff asked the Board to allow them to develop and submit comments of concerns with the proposed regulation.

MOTION: To develop and submit comments for the Proposed Short-Term, Limited-Duration Health Insurance Rules as discussed above.
Motion/Seconded/Carried Unanimously

State Issues

The legislative session is now past the half-way mark at 63 days. The number of bills that have been introduced thus far is 488 and 81 of them have been PI'd (postponed indefinitely, or killed).

Update on Prior Bills

Several bills are soon to be heard, including Drug Price Transparency (passed committee), Substance Use Disorder Bill to increase residential treatment, Youth Suicide Prevention, Advance Directives, and Free-Standing Emergency Department bills. Staff testified for two of those bills. SB18-132: 1332 Waiver for Catastrophic Plans passed the Senate and has moved on to the House HIE Committee. The iDrive bill is in Appropriations and the bill to change the date of special district elections is on its way to the Governor for signature.

Other Bills for Board Consideration

- **HB2018-1007: Substance Use Disorder Payment and Coverage** – This bill is being heard today and is likely to pass out of the House. There are many parts to this bill - which aims to help those who seek care and treatment for their opioid use disorder - by minimizing delays or interruptions which could impact that person's initiation or continuation of Medication Assisted Treatment (MAT) and of naloxone.

  MOTION: To SUPPORT HB2018-1007: Substance Use Disorder Payment and Coverage.
  Motion/Seconded/Carried Unanimously

- **HB2018-1097: Patient Choice of Pharmacy** – This bill prohibits health insurance carriers and pharmacy benefits managers from imposing certain restrictions on patients, pharmacists, and pharmacies, such as which pharmacy to utilize or where to access pharmacy services if the pharmacy/pharmacist has a signed contract with a carrier. This could allow for increased access for consumers and increased competition between pharmacies, but it could also result in higher costs for the consumer. The Board remained neutral on this bill; staff will monitor.

- **SB2018-022: Clinical Practice for Opioid Prescribing** – The main points of this bill limit initial opioid prescriptions to a 7-day supply (with some exceptions); requires reporting of specialty for providers using PDMP; stipulates mandatory PDMP querying for first refill; and mandates a report be made to the General Assembly regarding findings of a federal grant. The bill has received a great deal of support from people and there is no known opposition.

  MOTION: To SUPPORT SB2018-022: Clinical Practice for Opioid Prescribing.
  Motion/Seconded/Carried Unanimously

- **SB2018-136: Health Insurance Producer Fees and Fee Disclosure** – This bill would allow an insurance producer or broker advising a client on individual health benefit plans to charge the client a fee if they do not receive a commission related to the plan selected and if they disclose the fee to the client. The Commissioner of Insurance would be required to promulgate rules, including a prohibition on charging a fee for assisting a clinet to enroll in Medicaid or the Child Health Plan Plus (CHP+). This issue could have an impact on the state's health insurance program, Connect for Health Colorado (C4HCO), and since the Health District is a grant recipient of C4HCO, they are not allowed to take a position on this issue. The Board remained neutral, but asked staff to monitor. Concerns were expressed

regarding the fees brokers could charge – in particular, if the fees were unaffordable and played a role in driving people away from choosing and obtaining health insurance.

- **SB2018-168: Medication-Assisted Treatment Through Pharmacies** – This bill requires medication-assisted treatment (MAT) for substance use disorder to be covered under the Colorado Medicaid program, Health First Colorado. It also increases reimbursement rate to pharmacists who administer injectable MAT.

  MOTION: To SUPPORT SB2018-168: Medication-Assisted Treatment Through Pharmacies.
  Motion/Seconded/Carried Unanimously

The Board expressed its appreciation to Ms. Williams and staff for the bill analyses and summaries.

ANNOUNCEMENTS

- March 27, 4:00 pm, Board of Directors Regular Meeting

Board members were reminded that the April 24 board meeting had been moved to May 1 as several staff members will be attending the National Council on Behavioral Health conference. President Liggett also informed the board members that the May board meeting is being extended to include a brief Executive Session to conduct a shorter annual Executive Director review.

ADJOURN

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

The meeting was adjourned at 4:25 p.m.

Respectfully submitted:

Nancy Stirling, Assistant to the Board of Directors

Michael Liggett, President

[Absent]

Tracy Nelson, Vice President

[Absent]

Deirdre Sullivan, Secretary

Faraz Naqvi, M.D., Treasurer

Tess Heffernan, UCHealth-North (PVHS) Board Liaison