



Peninsula Health Care District

BOARD OF DIRECTORS REGULAR MEETING Thursday, July 22, 2010

CALL TO ORDER:

Chair Ulyot called the meeting to order at 17:55 hours at the Millbrae City Hall Council Chambers, 621 Magnolia Avenue, Millbrae. He welcomed everyone and acknowledged the large audience turn-out.

ROLL CALL: On roll call there were present Dan Ulyot, MD, Chair, Rick Navarro, MD, Vice-Chair Don Newman, MD, Past Chair, Helen Galligan, RN, Secretary, and Larry Cappel, PhD, Treasurer. **Also present were:** Cheryl A. Fama, Chief Executive Officer, Colin Coffey, General Legal Counsel, and Jan Matejcek, District Administrative Assistant.

AGENDA REVISION: **Chair Ulyot** announced a change in the order of the agenda; with the exception of Community Education, all Agenda items will be dispensed with first, leaving Dr. Helgeson's talk to be followed by questions at the end. He also invited the audience to a reception following the meeting where they could speak further with Dr. Helgeson.

Chair Ulyot acknowledged the following officials: Brian Perkins, from Congresswoman Jackie Speier's office, Marcia Raines, Millbrae City Manager, Daniel Quigg, Vice Mayor, Millbrae, Marge Colapietro, Millbrae City Councilmember, Pedro Gonzalez, South San Francisco Councilmember and Darnell Turner, Board President, Los Medanos Community Healthcare District. [All but Mr. Turner was present.]

ORAL COMMUNICATIONS:

Pat Giorni, Burlingame thanked the District for generously supporting *Bike to Work Day*, which took place in May. She then acknowledged the attendance of Brian Perkins, from Representative Jackie Speier's office, stating that Representative Speier has always been a great friend to the District. She stated that dental health is something that this county really needs to look at. Finally, she offered her condolences to Director Galligan on the loss of her father-in-law, Joseph Galligan.

Chair Ulyot thanked Ms. Giorni and asked if there were any other comments from the public. There were none.

COMMITTEE REPORTS:

Long Term Planning, Chair Ulyot, Committee Chair: No meeting.

Sutter Health Oversight, Director Newman, Committee Chair: No meeting.

Building Committee: **Director Newman** stated the next meeting would take place on 7/27/10.

Community Health Investment, Director Galligan, Committee Chair: Nothing to report.

CONSENT CALENDAR: The Consent Calendar consisting of the Regular Session minutes for June 24, 2010 was presented.

DIRECTOR NAVARRO MOVED AND DIRECTOR NEWMAN SECONDED THE MOTION TO APPROVE THE CONSENT CALENDAR AS PRESENTED. THE MOTION CARRIED UNANIMOUSLY.

CEO REPORT: Ms. Fama thanked everyone for coming, especially Dr. Dick Gregory and Ms. Tippy Irwin who were instrumental in inviting tonight's audience. She hoped attendees would find the presentation of interest and time would allow for a spirited question and answer period to help everyone learn and understand the Apple Tree Dental program. She announced that there is no August Board meeting; the next meeting will be on September 23rd in Foster City. The speaker will be Mr. Merwin, CEO, MPHS, who will give his MPHS-Quarterly Report.

OLD BUSINESS:

Sutter Health Branding Program:

Chair Ulyot asked Director Newman if he would like to comment. **Director Newman** answered no, stating the potential problem he raised at the last meeting is gone, and therefore there was no point in talking about it further.

NEW BUSINESS:

Conflict of Interest Code Biennial Review:

Chair Ulyot asked Colin Coffey, District Counsel, to explain why the Board needs to revise its Conflict of Interest Code. **Mr. Coffey** stated that the State requires every local agency review its Conflict of Interest Code every two years to determine whether there have been any changes in the makeup of its Directors, Officers and employees for the purposes of various disclosure categories required by the State's Conflict of Interest laws, and that particular conflict codes are designed to be unique to each agency and allow each agency to customize its disclosure and conflicts rules. **Mr. Coffey** explained that the proposal before the Board is straight forward. There have been changes in the operations of the District, with regard to two positions in particular, that would warrant a revision of the District's code. The District now has a Chief Executive Officer and its time that its Code clearly designates the CEO position. The other is that the position of Legal Counsel correspondingly has shifted from one in which the Counsel provided services that were the equivalent of a staff management position, and since the advent of true management within the District, that position has shifted to the more traditional consulting role and so the proposed Code revision is now reflecting that. The other minor revision on the Appendix is simple additional language to correspond to those changes for purposes of economic disclosures.

Chair Ulyot thanked Mr. Coffey and asked the relationship of this Code to the required Ethics Training for Directors. **Mr. Coffey** responded, one of the provisions in the Code reflects a fairly new state law and requires the elected Board members attend Ethics training every two years. **Chair Ulyot** asked if the CEO would need to attend Ethics Training as well. **Mr. Coffey** responded, yes.

DIRECTOR CAPPEL MOVED AND DIRECTOR GALLIGAN SECONDED THE MOTION TO APPROVE RESOLUTION NO. 2010-05 "RESOLUTION CONFIRMING REVIEW AND ACCURACY OF THE CONFLICT OF INTEREST CODE" THE MOTION CARRIED UNANIMOUSLY.

COMMUNITY EDUCATION: APPLE TREE DENTAL, Dr. Michael Helgeson, DDS presenter

Chair Ulyot introduced the topic stating that the Board considers dental care an important and integral part of healthcare. Last year in one of the District's public meetings this notion was amplified in a talk by

Dr. Dick Gregory entitled, “Dentistry in Medicine: A New Crossing Point” in which he presented data linking periodontal disease with a number of medical conditions including cardiovascular, kidney, and metabolic; he also noted that periodontal disease can effect insulin resistance in diabetes and various chronic inflammatory conditions. Dr. Gregory also alerted the Board to Dr. Michael Helgeson’s work in Minnesota in removing barriers to dental care for those unable to obtain such care due to financial and other reasons. This Board wanted to know more about the “Apple Tree Program” and invited Dr. Helgeson to speak today. **Chair Ulyot** introduced Dr. Gregory noting that he is a dentist in this community who heads the dental clinic at Samaritan House, Chairs the Senior Focus Community Committee and the San Mateo Dental Coalition, and plays an important role in the provision of dental services to Mills-Peninsula Hospital Services in its Skilled Nursing Facility. He asked Dr. Gregory to introduce Dr. Helgeson.

Dr. Gregory thanked Chair Ulyot, acknowledged the large audience and thanked them for coming. He then expressed the importance of the subject of tonight’s presentation on the health of everyone in the room and their families. He stated that in California we think of ourselves as leading the nation, and in a lot of ways we do; however, the one area where we do not is in healthcare, particularly in access to care and the capacity to provide that care to the elderly and special needs patients. Dr. Helgeson has been working on access to dental care and has succeeded in removing barriers to receiving services. He has done so in a staff model dental practice that has been successful for more than 20 years in the large metropolitan area of Minneapolis. Dr. Helgeson is the CEO of this innovative, non-profit dental care model that encompasses 5 different programs with a staff of more than 100 employees who provide year-round dental care to 100 Head Start Centers, schools, group homes, and nursing facilities. The structure is defined as a “community collaborative practice”, has been replicated in North Carolina and Louisiana, and has been recognized by the Surgeon General, American Dental Association, Oral Health America, and Robert Wood Johnson and Kellogg Foundations. Dr. Helgeson grew up in Oakland, CA and, in addition to his BS and DDS credentials; he completed a two-year fellowship in geriatric dentistry and a mini-MBA with nonprofit focus. He is the past President of the American Society for Geriatric Dentistry and Special Care Dentistry Association and currently serves on the American Dental Association’s new National Elder Care Advisory Council.

Dr. Helgeson opened by thanking the audience for attending and offering his email address to encourage all in attendance to contact him with any questions that may not get covered during this presentation and the Q&A. [mhelgeson@appletreedental.org] He covered the following questions:

- ***Who isn’t getting good dental care?*** 82 million or 30% of Americans are underserved by dental care services based on the 2000 census data. 50% of the underserved have untreated disease. “Underserved” do not access care because they don’t know the importance of seeking care before problems arise; their health status prevents travel to traditional clinics, and/or they do not have financial resources to pay for care.
- ***Why does it matter? How are people’s lives impacted?*** He gave the example of Fridley Hospital in the Twin Cities area that lowered its patient death rate over three years from one of the highest to one of the lowest in the area by cleaning the teeth and gums of all ICU ventilator patients. He also commented on the increasing body of evidence about the role of gum disease in metabolic problems and Alzheimer’s disease.
- ***How does the Apple Tree Dental Program work?*** It is a community collaborative practice that delivers oral health services where people live, work, go to school, or receive other health and social services. The three key partners are community – nursing facility and group homes; dental practice – private office and safety net clinics; and the oral health team- staff on site. It overcomes the barriers to care through early education and prevention, special care in collaboration with other providers, and drawing financial resources from the whole community. It is structured as a nonprofit, which aligns

accountability with mission. It uses a hub and spoke model with the clinic and operations at the center and multiple on-site clinics/mobile offices linked using tele-health technologies. The model removes barriers to care and reduces costs.

- ***How does the Apple Tree model reduce costs?***
 - It provides less costly education, prevention and assessment
 - Optimizes the roles of all care providers – dental and medical
 - Optimizes the frequency of preventive care, based on risk assessment
 - Reduces the use of ineffective treatments
 - Reduces downstream medical and transportation costs
 - Reduces administrative costs while improving accountability.
- ***What has Apple Tree accomplished?*** The number of dental visits and screenings provided has steadily increased to nearly 70,000 per year in 2009. The ages served are roughly 1/3 children, 1/3 adults, and 1/3 seniors. It has established a sustainable financial model that is open to all, regardless of financial status. There are five programs in Minnesota, one in North Carolina and one in Louisiana.
- ***How is Apple Tree sustained?*** By managing the payer mix of patients at 30% fully insured and 70% under-insured or uninsured. Total care rendered in 2009 was \$11.7M compensated and \$5.4M “charity care”. As a nonprofit, fundraising is an important part of annual revenues. Operating expenses break down as follows: 93% for programs/direct services, 6% for management and 1% for fundraising.
- ***How could a new program be launched in the District?*** The key stakeholders in this community, along with the Apple Tree Board, need to determine if sufficient interest exists to pursue the next step – launching the Business Planning Process. It is recommended that an Advisory Committee be established to provide oversight of this process and be empowered to help provide information, provide advice to shape the planning process, review preliminary plans, approve and endorse a final Business Plan, and identify potential sources of startup funding. The steps in the Business Planning process are:
 - Assessing local unmet needs
 - Analyzing existing programs and gaps
 - Designing the start-up program
 - Determining the dental clinic location
 - Preparing financial projections
 - Recruiting management and staff
 - Determining start-up timeline

Dr. Helgeson wrapped up his presentation by referencing the vision, values, and mission of the District noting the congruence with Apple Tree’s mission and then opened for questions.

Esther Koch, San Mateo asked a number of financial questions; the questions and answers are summarized below.

Q. Does Apple Tree take private pay insurance patients? **A.** Yes, about 30% of patients are either private pay or have other types of insurance and about 70% are either uninsured or on the equivalent of Denta-Cal.

Q. What is the composition of the revenue sources? **A.** There is a mix of revenues sources including insurance, state and federal reimbursement, contributions and grants. The payer mix/facility varies widely; however, they do not serve facilities that are all private pay. The net revenue per unit of service for private pay or commercially insured patient is roughly double the average dental practice because Apple Tree charges the going rate in the community, so as not to undercut the local dentists, and can deliver the services at a lower cost. Even though these patients represent about 30% of those seen, they generate about 50% of the revenue.

Q. *What percent is contributions?* **A.** That varies year to year; it averages between 10-15%. The goal is to raise contributions for capital, infrastructure, and growth; not to support clinical operations. Apple Tree keeps the operating expenses very low by efficient scheduling; it also charges the long term care facilities a very nominal fee per occupied bed per month to cover non-dental costs, i.e., the medical director, screenings, and education – services not reimbursed by public or private payers. These fees do not subsidize the Dental-Cal type patients; they cover important non-reimbursed service and the Apple Tree care coordination.

Dr. Helgeson stated that 30% of their patients require a medical/dental consult; 75% of the nursing facility patients do not make their own treatment decisions; 100% of all Minnesota residents are covered by 10 different health plans with more than 30 different dental plans. This creates complex communications needs that the Apple Tree staff play an important role in coordinating between the families, facilities, and the Apple Tree team.

Q. *How do you hold down expenses?* **A.** It is complex and includes the “staff model” structure for the dentists which means each dentist gets a certain salary rather than a fee-for-service and the salary rates are driven by productivity, special skills, and/or uniqueness of position. This model also allows for all revenues to come into the clinic and then get allocated to the operational needs. Dr. Helgeson gave the example of reimbursement for an exam and cleaning of a child’s teeth which is two to three times more than the same service for a geriatric patient in a nursing home. The first can be done in about 5 minutes; the latter can take five times longer. That is why Apple Tree has programs for children and school-based services; the surplus revenues generated from these services can be redistributed to cover the geriatric services which are woefully underfunded.

Tippy Irwin, Executive Director, Ombudsmen Services asked *what have been some of the major barriers to implementing the Apple Tree services.* **A.** The best lesson has been to set the bar high when picking projects and partners. The Apple Tree Board has a detailed process for examining any potential new projects; an Apple Tree Program in this District is on that list. Dr. Helgeson will take his experience from this site visit back to the Board for their consideration. They get requests from all over Minnesota and the country; at the root of their decision-making is their mission to achieve system change. The Apple Tree Board wants to see the dental profession, dental education, and dental care delivery transformed. They want to see the Medicaid dental policy completely rewritten. California is a nation-leading state that can impact national public policy. Bottom-line – The Apple Tree Board does not launch a project unless it’s pretty sure it’s going to be successful. Getting back to what is needed for success – there needs to be a good relationship with the local dental community, which has been started here under Dr. Gregory’s leadership, and committed funding support from the community, foundations, long term care facilities, and individuals to meet the first threshold.

Q. *What kind of barriers do communities encounter in trying to get something like this up and running?* **A.** In his experience, long term care facilities want to do the right thing, but they face unfunded mandates to meet needs in an environment where a dental care delivery system does not exist. All long term care facilities are struggling financially; however, he believes it would cost facilities less to pay a small retainer to an Apple Tree model system and have their dental health mandates addressed and resident oral health needs met, than to allow patients dental care needs to go unaddressed until they become urgent problems requiring expensive intervention.

Q. *Unknown Audience Member* asked *Please explain how the tele-dentistry program works in the children’s programs you presented.* Using the Head Start example, the Apple Tree hygienist teams work with Head Start staff to get consents to do the screenings and so forth. They come in at the start of the school year to do screenings and are equipped with laptop computers, intra-oral cameras that are the size of a thin toothbrush, digital radiography capability and other informational gathering technologies. The hygienists do a screening to determine if the child has cavities or is high risk, and they collect other

information the dentist needs to do a diagnosis. The supervising dentist, who will be treating the child, reviews all the tele-health information and does a treatment plan sufficient to get consent from the family. On the day that the big truck arrives with Apple Tree dentists and assistants, 100% of the kids have been evaluated; the kids with their own dentists have been referred to them, and the kids with no other source of care have a treatment plan and parental consent in place. The dentists have a very busy and productive day doing treatment. It reduces visits by almost half and definitely reduces costs. Seventy percent of the kids are found to be perfectly healthy which saves \$100-\$200 per child for a comprehensive exam, x-rays and cleaning.

Chair Ullyot asked if an Informed Consent was needed for the exam by the hygienist or just for the dentist's treatment. A. It varies based on the site. The Head Start requirements are different than in the long term care facilities. For school-aged children, consent is needed up front. In the long term care facilities, the first screening is performed by the Apple Tree staff as part of the required exam the nurse would usually do on every patient, whether oriented or suffering from dementia. If dental treatments are needed, consent would need to be obtained.

Chair Ullyot asked about recruiting dentists into the staff model– where do they come from? A. “Everywhere”, they have been able to hire recent graduates, dentists that have completed general practice residencies and AEG programs, and community dentists winding down their private practices. Generally speaking, they are all salaried. Apple Tree does do some special projects where they team up with the dental community to provide pro bono services.

Director Cappel asked if there had been any push-back from the local dentists who felt that the program was an intrusion into the status quo or push-back from long term care facilities who felt that their current program was adequate. A. Yes, some dentists felt Apple Tree was a competitive threat, but in his experience, it was a small minority of dentists. Organizations that represent the majority of the Dental Association members support this program.

Director Cappel commented that we have seen programs like this come and go, leaving additional fragmentation within the system. We won't be able to mend things together until we get the state and county to come down to the local level with programs like this that have value. The literature regarding public health development will bear this out –we have to reallocate what we currently do and create one basic system and funding mechanism. Fragmented approaches have competed for funding and have prevented truly comprehensive approaches from getting adequate funding to survive.

Dr. Gregory commented that he thought there was legitimate excitement over this program. It has been successful for over two decades, and has been improved over that time and replicated in other communities with continuing success.

Director Cappel asked if Denta-Cal currently only serves children. A. Yes and it has taken major cuts this past year.

Director Cappel directed a question to **Brian Perkins** asking *what the chances might be for the state to give money that was originally allocated to county dental services to an Apple Tree program. How would the county feel about that and how would the state address something like that?*

Mr. Perkins responded that if something novel were to be developed, it could always be pitched to the state. It would get listened to and there would be at least some chance that it could get adopted as a pilot. That is the way many of these things get started. Rather than speculating, come up with something that is a saleable proposition and go to the people in the legislature that can support such a pilot project.

Chair Ullyot thanked Mr. Perkins for his response. He then thanked Dr. Helgeson again for his talk and responses to the many questions.

ADJOURNMENT:

The meeting was adjourned by Chair Ullyot at 19:40 hours. All attendees were invited to a reception in the adjacent Chetcuti Community Room.

By:

Jan Matejcik, Administrative Assistant

Approved:

Helen C. Galligan, Secretary

Daniel J. Ullyot, M.D., Chair