ESTES PARK HEALTH

ESTES PARK HEALTH
BOARD OF DIRECTORS'
Special Tele Town Hall Board Meeting Minutes – September 23, 2020

Board Members in Attendance
Dr. David Batey, Chair
Ms. Sandy Begley, Vice Chair (via webinar)
Ms. Diane Muno, Secretary
Mr. William Pinkham, Member-at-Large
Dr. Steve Alper, Director Elect

Senior Leadership Attendees
Mr. Vern Carda, CEO
Mr. Tim Cashman, CFO
Ms. Pat Samples, CNO
Mr. Gary Hall, CIO (via webinar)

Community Attendees (via webinar)
Claire Kreider, Leslie Roberts, Mark Smith, Rosemary Robinson, Julie Lee, Sheila Husted, Mark Purdy, Cathy Alper, Guy Beesley, Daniel Sewell, Kent Smith, Deb Kubichek, John Meyer, Anne Rogers, Helen Garcia, Philip Moenning, Deb Barlow, Matthew Makelky, David Brewer, Linda Metzler, Pat Ferrier, Lesta Johnson, Jessica Jenkins, Don Shelley, Andrea Rangel, Rodney Unruh, Areewan George, Shayne Hatzenbuhler, Diane Darmody, Deborah Blackman, Carl Robicheaux, Wendy Rigby, Karen Sackett, Joseph Curtin, Karin Swanlund, Wendy Ash, Christy Florence, Joann Batey, Nikki Mesey, Monica Sigler, Andrea Thomas, Jessica Portillo, Nicki Murray, Karlye Pope, Connie Phipps, Wendy Smith, Ron Keas, Eric Owen, Miles and Bonnie Mewherter, Mandy Fellman, Laurie Forys-Wenzel, Juli Schneider, Deborah Gerson, Judith Schaffer, Stacy Ferree, Michelle Gordon, Meagan Lopez, Lori Greening, Linda Newman, Sara Walker, Roger & Susan Toy, Heather Bird, Aileen Campbell, Gretchen Mitterer, Carla Ellis, Eric White, Teresa McMorton, Jeanne Allen, Wendy Koenig Schuett, Blake Nicholson, John Phipps, Tony Palmer, Barbara Bailey, Barbara Gebhardt, Nancy Curtiss, Wendy Sollod, Elizabeth Sarow, Barbara Keilty, Michael Keilty, Laura Rustin, Anne Slack, Ann Dinsmoor, Shelley Powers, Gerald Mayo, Kay and Lowell Rosenthal, John and Dona Cooper, LoAnne Forschmiedt, Barbara Widrig, Drew Webb, Sarah Rhode, Nancy Matson, Kaci Yoh, Wendye Sykes, David Standerfer, Alice Reuman, Judith Beechy, Peggy Lynch, Roger and Susan Toy, Tara Schulze, Jim and Gail Cozette, Randy Brigham, Sharon Coleman, Cindy Leaycraft, Bill Solms, Larry Leaming, Kevin Mullin and Cynthia Sisson

1. **Call to Order**
   The Special Tele Town Hall Board meeting was called to order at 6:05 p.m. by Dr. Batey, Chairman of the Board of Directors; there was a quorum present. Notice of the Special Board meeting was posted in accordance with the SUNSHINE Law Regulation.

2. **Introductions**

The Board and the Senior Leadership Team introduced themselves to the community members.

3. **Cameron Peak Fire Status Evacuation Plans**

The Incident Command team has prepared a comprehensive evacuation plan that is ready for activation should it be necessary. If a voluntary evacuation is called, all LC residents will be transported together along with the care staff down to the valley and family members will be notified accordingly. Additionally, all inpatients will also be transported down to the valley. The LC residents will go to a facility in Greeley where arrangements have been made for them to occupy a wing at a nursing facility.

4. **Executive Summary**

- EPH 2020 loss of $10M mitigated by US Govt assistance. EPH 2021 projected loss of $7.5M.
- $7.5M projected 2021 loss requires difficult decisions to reduce expenses and enable EPH to survive.
- Expected 2021 losses require examination of all possible expense reduction options.
- Plan for expected $1.4M EPHLC loss in 2020 and beyond is one of many proposals being evaluated to reduce expenses.
- Estes Park Health Living Center (EPHLC) expected to have a loss of $1.4M in 2020.
- Expected 2020 $1.4M loss continues a long-term trend.
- Decreasing Revenues
  - Declining bed occupancy percent
  - Increasing percent Medicaid payments
- Increasing Expenses
  - Increasing use of temporary contract labor
  - Increasing regulatory requirements
- Even filled to 38 bed capacity, EPHLC does not have sufficient scale to be independently financially viable.

5. **Discuss Viable Alternative Plans**

The list of 19 alternative plans for the Estes Park Health Living Center (EPHLC) below was compiled from suggestions in emails and letters from the Estes Valley Community as well as from the Estes Park Health (EPH) Senior Leadership Team and the EPH Board of Directors.

The EPH Senior Leadership Team and the EPH Board of Directors preliminarily placed the alternative plans into one of three categories: 1. Not Feasible, 2. Unlikely, or 3. Possible but Challenging. Each alternative plan includes the reason for placing the alternative plan in one of these three categories.

1. Not Feasible

1.1. Close the EPH hospital, keep EPHLC open

The mission of EPH is to serve our entire community of about 13,500 residents and visitors. The 28 residents in the EPHLC and their families are a part of the 13,500 members of our community. This was not considered to be a feasible alternative plan.

1.2. Close the Urgent Care Center to pay for EPHLC

Based on data since its opening at the end of May 2020, the Urgent Care Center provides an important, effective, and considerably less expensive alternative to the Emergency Department for members of our community and visitors. As in alternative plan 1.1 above, the mission of EPH is to serve our entire community of about 13,500 residents. The 28 residents in the EPHLC and their families are a part of

the 13,500 members of our community. Given the importance of the urgent care services provided to large numbers of our community, this was not considered to be a feasible alternative plan.

1.3. Make Private pay and Insurance cover EPHLC financial losses

Eighteen (18) of the 28 current EPHLC residents are funded by Medicaid. Medicaid will not pay more than their standard rate. For those funded by insurance, the insurance companies will not pay more than their negotiated rate. It is not realistic or just to cost shift the expected EPHLC financial loss of $1.4 million in 2020 to the small number of private pay residents in addition to what they currently pay. This was not considered to be a feasible alternative plan.

1.4. Reduce EPHLC staffing to reduce expenses and make EPHLC break even

Current EPHLC staffing is consistent with the required baseline staffing model. Any reduction from current EPHLC staffing would adversely affect the quality of care, so this was not considered to be a feasible alternative plan.

1.5. Move EPHLC to a different location, reducing expenses so EPHLC breaks even

The cost to construct an alternative 48 bed facility for EPHLC in a different location has been estimated to be in the range of $22 to $25 million, and it is not clear that the alternate location operational expenses would be significantly lower. Given the significant estimated cost and uncertainly about where the construction and operations funding would come from, this was not considered to be a feasible alternative plan.

1.6. Create an endowment that could cover EPHLC financial losses

The expected EPHLC financial loss in 2020 is $1.4 million. It is anticipated the annual loss will continue to increase over time. So, assuming a 4% annual return on the endowment, it would require an endowment of about $30 million to cover the annual EPHLC operational loss. Given the anticipated challenge of raising an endowment of this size, this was not considered to be a feasible alternative plan.

1.7. Get charitable contributions to cover EPHLC financial losses

If the $1.4 million EPHLC financial loss for 2020 continues or increases as anticipated, it would be necessary to raise charitable contributions of $1.4 million or more every year to cover these losses. Given the large charitable contributions needed on into the future and the general understanding of the practical limitations of charitable fundraising in our community, this was not considered to be a feasible alternative plan.

1.8. Get grant funding to cover EPHLC financial losses

Grant funding organizations generally do not fund operational expenses. Like the charitable contributions alternative plan in 1.7 above, it would be necessary to apply for and get grant funding of $1.4 million or more annually to cover anticipated EPHLC operational losses. Given the large grant funding needed annually and the understanding that grant funding organizations generally do not fund operational expenses, this was not considered to be a feasible alternative plan.

1.9. Advertise to attract more residents to EPHLC, so it EPLC breaks even financially

Based on experience in other locations, advertising can change the public perception of a nursing home, but it has not increased the bed occupancy percent. This was not considered to be a feasible alternative plan. Also see 2.4 below, that to break even, 10 beds would need to be added to the current 38 bed capacity at an estimated cost of $10 million.

1.10. Wait to see if EPH financial performance returns to pre-pandemic levels so EPH can resume subsidizing EPHLC

First, EPH revenues are not expected to recover beyond the current forecast of 80% of pre-pandemic levels. The expectation that 80% of pre-pandemic levels is expected to be the "new normal" is based on multiple expert financial forecasting sources. So, EPH's capacity to subsidize EPHLC losses is not expected to be restored. Second, EPHLC's anticipated financial losses, like the $1.4 million loss forecast for 2020, are expected to continue and increase. Considering these two expectations, this was not considered to be a feasible alternative plan.

2. Unlikely

2.1. Sell EPHLC to a national corporation

Five regional or national organizations with deep experience owning and running continuity-of-care facilities including skilled nursing facilities were approached about the possibility of purchasing and running the EPHLC. None were interested. Some mentioned that the small size of EPHLC would make its financial viability questionable, and another mentioned that skilled nursing facilities as a service are in long-term decline and are therefore not a good investment. This was considered an unlikely alternative plan.

2.2. Get national experts to manage or consult EPHLC to financial health

One of the largest not-for-profit providers of senior housing and services in America was contracted for 19 months to manage EPHLC with the expectation that, using their expertise, EPHLC's financial performance would improve. During their management of EPHLC, financial performance did not improve, and percent beds occupied declined. Given this experience, this was considered an unlikely alternative plan.

2.3. Offer new EPHLC programs so more beds are occupied, EPLC breaks even

Even if new EPHLC programs offered could attract additional residents, 10 beds would need to be added to the current 38 bed capacity at an estimated cost of $10 million (see 2.4 below) for EPHLC to be able to break even. This was considered an unlikely alternative plan

2.4. Increase the EPHLC number of beds so, if occupied, EPHLC breaks even.

EPHLC is not able to fill currently available beds, so adding additional beds will not solve the problem of an anticipated $1.4 million loss in 2020, and similar losses into the future. But to consider the alternative plan, the current EPHLC bed capacity is 38, and the number of beds required to be occupied to break even has been estimated at 48 beds. It has been estimated that construction to add beds would cost about $1 million per bed, or $10 million to add 10 beds. EPH, facing a $7.5 million loss in 2021 and considering significant and difficult expense reductions to remain financially viable, is not in a position to invest $10 million to add beds to EPHLC, especially in light of EPHLC having beds currently available it does not fill. This was considered an unlikely alternative plan.

2.5. Other programs in EPHLC space could generate revenue to cover EPHLC financial losses

The 2020 EPHLC loss is expected to be $1.4 million. We were not able to identify programs or services that could be offered in available EPHLC space that could generate revenues even remotely approaching $1.4 million annually.

2.6. Increase property tax (mill levy) support to cover EPHLC financial losses

Succeeding with mill levy (property tax) elections is the most difficult type of funding election according to the George K Baum election consultant who assisted with the Estes Valley Recreation and Park District (EVRPD) mill levy election for the EVRPD Community Center. An election for a mill levy increase is a Taxpayer Bill of Rights (TABOR) election. In terms of timing, according to Joe McConnell with the Colorado Department of Local Affairs, TABOR elections for Special Districts like EPH can only be held on the first Tuesday of November or during a regularly scheduled Special District election. As a result, the earliest TABOR election could be held in November of 2021, with the next opportunity being May 2022.

The last mail ballot election for EPH Board members cost about $30,000. Legal advice is needed to craft TABOR-compliant ballot language, another expense. Based on experience, the cost of the campaign for a mill levy increase would be at least $15,000 for campaign mailings and other materials.

Mill Levy elections tend to have higher voter turnout, increasing the number of voters needed to approve the property tax increase. The table below shows some recent local mill levy election results.

Mill Levy Election History in the Estes Valley

Organization	Ballot	Year	Month	# Voters Registered	Percent Turnout	Votes For	% Votes For	Votes Against	% Votes Against
Estes Valley Recreation and Park District		2005	Nov	8,467	52%	2,101	47.0	**2,332**	53.0
Estes Valley Recreation and Park District	Larimer County Ballot Issue 4C	2008	Nov	8,280	81.9	**3,516**	53.0	3,180	47.0
Estes Valley Recreation and Park District	Larimer County Ballot Issue 4D	2008	Nov	8,280	80.7	3,109	47.0	**3,570**	53.0
Estes Park School District R3	Larimer County Ballot Issue 3A	2013	Nov			2,206	48.6	**2,329**	51.4
Estes Valley Library District	Larimer County Ballot Issue 5A	2013	Nov			**2,349**	51.3	2,227	48.7
Estes Valley Recreation and Park District	Larimer County Ballot Issue C	2015	Nov	9,307	54.8	**2,630**	51.6	2,467	48.4
Estes Valley Recreation and Park District	Larimer County Ballot Issue D	2015	Nov	9,307	54.8	**2,661**	52.3	2,423	47.7
Estes Park School District R3	Larimer County Ballot Issue 3A	2017	Nov			**2,196**	52.3	2,002	47.7

The results show mill levy elections are closely contested with few votes separating the total of votes for and against, there is relatively high voter turnout, and the number of votes in favor needed to prevail with about 9,800 eligible voters in a mail ballot EPH election would likely be in excess of 2,700.

TABOR elections have ballot language requirements that emphasize the total cost to the potential taxpayers. An effective campaign in favor of a mill levy increase would need to convince about 2,700 property owners in the district that increasing their property tax support for EPH would be a good value. Assuming the expected 2020 EPHLC loss of $1.4 million would be the target to be covered by an increase mill levy, and the current mill levy generates about $2.7 million, property tax support would need to increase by 52% to cover an annual $1.4 million loss. Current residential property tax support for EPH is about $54 per $100,000 of property value. With current District median residential value of about $400,000, 50% of residential property owners would expect to pay at least $108 additional per year to support the EPH subsidy of EPHLC. Property other than residential would pay about 3.6 times more, or at least $389 annually.

The other important issue would be how the EPHLC financial loss would be covered until a mill levy increase election in 2021 or 2022. Our assessment was that with the challenges to accomplishing a mill levy increase coupled with the fact that an election could not be held for a year or two make this an unlikely alternative plan.

2.7. Establish a sales tax to cover EPHLC financial losses

While succeeding in a sales tax election is slightly easier than a mill levy election, both are TABOR elections with the same challenges described in section 2.6 regarding mill levy elections above. As a result, this was also considered an unlikely alternative plan.

3. Possible, But Challenging

3.1. Gradually close EPHLC to minimize resident disruption

This may merit additional discussion. The key considerations would include:
3.1.1. Defining the duration of the gradual close.
3.1.2. Determining if new residents would be accepted.
3.1.3. Determining the threshold number of residents required for needed care and programming.
3.1.4. Determining how operating losses would be covered as resident numbers and revenues decline.
3.1.5. Determining the threshold level of revenues needed for continued viability.

3.2. Create a non-profit independent of EPH that could build and operate a new EPHLC facility

Both Tim Cashman and Vern Carda have had indirect experience with this approach. After forming a non-profit to build and operate a new EPHLC facility, the challenge would be funding construction and operations. To construct a 48-bed nursing home would probably cost in the range of $22 to $25 million. Nursing homes generally operate at a loss, so if the facility were stand-alone, an endowment to generate funds to cover the losses or some external subsidy (mill levy, sales tax) to cover the losses would be needed. Alternatively, the national model that seems to work is a Continuing Care Retirement Community with integrated independent living, assisted living, and nursing care services. In this model, funding from the independent living and assisted living services are used to subsidize the nursing care services. This continuity of care model requires considerable capital to establish.

6. Questions and Answer Session

Q. It is hard to believe that the nursing home is in decline. Could the hospital donate the current space to a nonprofit to operate the facility? How much did the Hospitalists cost to acquire? How much did the surgeon cost to replace the last surgeon that did not have to do surgery because the OR was closed? How much did you pay the Public Relations firm that recommended the rebranding of the Hospital? How much did the actual rebranding cost (the real number of all associated costs)? How much revenue was lost by the hospital when the Operating Room was closed for both the leaking roof and the autoclave being down? How much did it cost the hospital in revenue when Dr. Van Der Werf left the hospital? How much did it cost when Dr. MacElwee left the hospital? How many traveling nurses do you currently have? How much more do they cost than a regular employed nurse? How many requests have you had for new residents since you planned to close PPLC? How many residents are planning to leave since you announced the closing of the LC? How much money does the LC add to the income of the Hospital from referrals for surgeries, tests, x-ray etc.?

A. Due to the one question limit, the first question will be answered, and the remaining questions will be addressed at a later time. Yes, the hospital could donate the current space to a nonprofit if they have a separate tax ID.

Q. Isn't the identified loss of $1.4M attributed to the freeze on accepting new patients?
A. The number of licensed beds in the LC is 52. The breakeven point is 48 beds and current capacity is 38 beds. There is currently no freeze on admissions, and they are being considered on a case by case basis. The LC is not accepting any long-term admissions at this time until a determination is made on whether the LC remains open or closes.
Q. Is EPH adding more services and programs if the LC closes?
A. EPH does not have any plans, nor have we identified any programs, that will go into the LC space should it be closed. EPH has used a systemic process to look at the organizational expenses in an effort to reduce costs. Other programs and services are being evaluated in addition to the LC. On the revenue side, it will take approximately 12-18 months before EPH sees any impact from any revenue enhancements.
Q. Could UCH buy EPH but not the LC and then allow the taxing district to run the LC with the property tax revenue?
A. The Board has not considered this option. The LC has been subsidized by EPH for many years and the property tax revenue dollars would not be able to cover the losses without the subsidy from EPH. Research would need to be conducted to determine if the property tax revenue could be utilized for only the LC residents and not inclusive of EPH. Additionally, UCH is also experiencing soft volumes and layoffs so it is unlikely they would consider purchasing EPH at this time.
Q. Can EPH provide a detailed Profit and Loss statement for just the LC?
A. Yes, EPH's CFO will provide the information.
Q. Have you considered transitioning to other, more sustainable long-term care programs like PACE or other home and community-based services such as Innovage? PACE enables you to get nursing home reimbursement for providing home and community-based services. If Medicaid is 60% that means 60% are eligible for PACE. Some long-term care insurance also pays for PACE.
A. The recommendation will be researched.
Q. UCH is very interested in buying critical access hospitals at this time and they have a great interest in EPH. There is a good administrator in the LC now, so what is the hurry in closing? Can you provide him a budget and take out the cost shift items like dietary, EVS and allow a year to see if it can be turned around?
A. EPH has a good relationship with UCH and currently there are no talks of selling or having UCH acquire the hospital. The cost shifting topic will be discussed in depth at the September 30 Finance Study Session meeting. EPH must make necessary arrangements to reduce expenses by $7.5M by early next year, otherwise it will be detrimental to the facility.
Q. Why do we need to increase the number of LC beds? Has advertising been considered to increase admissions?
A. Current capacity is due to geography and residents wanting their own room. The space requirements for lifts, staffing, bathrooms etc. has the care requirements for the residents outgrowing the geography of the space. Typically advertising campaigns for nursing homes do not result in generating increased admissions.
Q. The Board and the senior team state that EPH will not be able to return to pre-pandemic level, but isn't this based on opinion vs. fact?
A. The forecast is based on opinions of experts and colleagues that work in the industry and the trend that is being reported around the country. EPH has been subsidizing the LC for years and its economic size and the pandemic has caused the need to investigate a potential closure. To be financially viable, the LC would need to be around the 80-bed mark.
Q. Has the $1.4M loss been verified and is it only attributed to the LC? How does the loss relate to other service lines? Will we as a community be provided clear financial information as it relates to all hospital departments, including the LC?

A. Hospitals are unique enterprises with the various departments that encompass it, with each having their own revenue cycles and business models. A Finance Study Session will be conducted on September 30 in order to take an in-depth look at the financials. EPH is facing a deficit of $7.5M and if that deficit is not resolved by July / August of 2021 it could be detrimental to the facility. EPH is not focusing primarily on the LC. All other service lines, contracts, departments and staffing are being examined. If the LC is closed, that would only constitute a small portion of the $7.5M in savings that is needed.

Q. How is the hospital going to achieve the $7.5M besides potentially closing the LC?

A. EPH has identified roughly $4M in expense reductions on the hospital side. The clinic is still being examined, but there could potentially be $500k in expense reductions. The entire organization is engaged in the process to help solve the issue. These are very difficult decisions, but if implemented, EPH should be able to get very close to the $7.5M needed in expense reductions.

Q. Are there other mountain communities like Estes Park that are facing the same issues as we are?

A. Yes, many facilities on the western slope and eastern plains are experiencing the same financial issues as EPH. Many do not have tax subsidies and the critical access hospital is subsidizing them, such as EPH has been doing for the LC.

Q. We need to take care of the elderly in our community. Consider advertising in order to obtain more admissions. Can the Board brainstorm with the senior leadership and LC director/staff to determine if there are any additional expense reductions that can be identified?

A. The Board, senior leadership, LC personnel and the staff at EPH have been and are currently involved in brainstorming expense reduction ideas.

Q. Why is EPH focusing on the LC when the alternative appears to be refocusing from an inpatient setting to the home setting?

A. EPH needs to look at immediate expense reductions. EPH has a great Home Health Hospice program and more work can be done to integrate that into a home-based type program.

Q. Could the LC beds be repurposed?

A. Swing beds in a critical access hospital allow for acute care and then a change to subacute care while utilizing the same bed.

Q. Can the census data and revenue and expenditures data be provided for 2015 – 2019?

A. The data can be provided by the CFO.

Q. Has EPH considered through attrition having non-private rooms?

A. The recommendation will be researched for consideration.

Q. What is the first course of action you would pursue if you had to save the LC?

A. Increasing the census, improving the aesthetics and environment and look at staffing challenges.

7. Adjournment

The meeting was adjourned at 8:12 p.m.

David M. Batey, Chair
Estes Park Health Board of Directors