Agenda

Estes Park Health Board of Directors' Regular Meeting - On Line Only

Monday, May 18, 2020

3:45 - 4:00 pm Public Open House - Cancelled - COVID-19 Social Distancing Implemented

4:00 - 6:00 pm Board Meeting

Estes Park Health, 555 Prospect Avenue, Estes Park CO 80517

Timberline Conference Room / https://attendee.gotowebinar.com/register/4127572554964437003

3:45 - 4:00 pm Public Open House - Informational Conversations with Board Members - CANCELLED

	Regular Session	Mins.	Procedure	Presenter(s)
1	Call to Order/Welcome	1	**Action**	Dr. David Batey
2	Approval of the Agenda	1	**Action**	Board
3	Public Comments on Items Not on the Agenda and Thanking Monty Miller for his Service		Information	Public
4	General Board Member Comments and Thanking Monty Miller for his Service	10	Information	Board
5	Swearing In Elected Board Members, Election of Board Officers	5	**Action**	Board
6	Introduction of Pat Samples, Interim CNO	5	Information	Mr. Vern Carda
7	Consent Agenda Items Acceptance: 7.1 Board Minutes 7.1.1 Special Board Meeting Minutes April 24, 2020 7.1.2 Regular Board Meeting Minutes April 27, 2020 7.1.3 Special Tele Town Hall Meeting Minutes May 13, 2020 7.1.4 Special Board Executive Session Meeting Minutes May 14, 2020 7.2 Audited End of Year 2019 Financials	2	**Action**	Board
8	Presentations:			
	8.1 May 5, 2020 Estes Park Health Board ElectionResults	3	Discussion	Ms. Sarah Sheppard
	8.2 Covid-19 Status Update	15	Discussion	Mr. Gary Hall, Ms. Pat Samples, Dr. John Meyer
	8.3 Covid-19 Financial Impact on Estes Park Health	10	Discussion	Mr. Tim Cashman
	8.4 Urgent Care Center Status Update	5	Discussion	Ms. Barb Valente
	8.5 Alardo Outpatient Clinic	5	Discussion	Mr. Tim Cashman
	8.6 Chief Nursing Officer Report	10	Discussion	Ms. Pat Samples
	8.7 Chief Human Resource Officer Report	10	Discussion	Mr. Randy Brigham
	8.8 Clinical Quality Report	15	Discussion	Ms. Lesta Johnson
	8.9 Colorado End-of-Life Options Act Annual Policy Reivew	10	Discussion	Dr. David Batey and Dr. Amanda Luchsinger
	8.10 Public Health Centered Care Committee	10	Discussion	Dr. Nicholaus Mize and Dr. Scott Chew
9	Operations Significant Developments: *Goals, Accomplished, Next Actions, Schedule, Issues* 9.1 Executive Summary - Significant Items Not Otherwise Covered	3	Discussion	Senior Leadership Team
10	Medical Staff Credentialing Report	2	**Action**	Board
11	Review any Action List Items and Due Dates	1	Discussion	Board
12	Potential Agenda Items for June 29, 2020 Regular Board Meeting	2	Discussion	Board
13	Adjournment	1	**Action**	Dr. David Batey
	Total Regular Session Mins.	126		

Next Regular Board Meeting: Monday, June 29, 2020 4:00 - 6:00 pm

ESTES PARK HEALTH
BOARD OF DIRECTORS'
Special Board Meeting Minutes – April 24, 2020

Board Members in Attendance

- ☒ Dr. David Batey, Chair
- ☒ Ms. Sandy Begley, Vice Chair (via phone)
- ☒ Dr. Monty Miller, Treasurer (via phone)
- ☒ Ms. Diane Muno, Secretary (via phone)
- ☒ Mr. William Pinkham, Member-at-Large (via phone)

Other Attendees

Mr. Vern Carda, CEO
Mr. Tim Cashman, CFO
Ms. Terri Brandt Correia, CNO
Mr. Gary Hall, CIO (via phone)
Mr. Randy Brigham, CHRO (via phone)

1. **Call to Order**
   The Special Board meeting was called to order at 1:21 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. **Approval of the Agenda**
   Dr. Miller motioned to approve the agenda as submitted. Ms. Begley seconded the motion, which carried unanimously.

3. **Public Comments**
   No public comments were submitted.

4. **Open Action Items**
   4.1 Resolution 2020-05: Approval of SBA Loan from Payroll Protection Program as Support for COVID-19 Expenses
   Mr. Cashman stated that the Board Finance Committee is recommending Board approval of the financing of a $4,800,000 loan from the Small Business Administration and the Payroll Protection Program of the 2020 CARES Act, for seventeen (17) months, which will be financed through the Bank of Colorado, for the purposes of adequate funds for the payroll cost over an eight (8) week period. While 75% of the money must be earmarked for payroll needs according to the CARES Act, Estes Park Health will be utilizing 100% of the funds for payroll.

Mr. Cashman stated that the loan is forgivable, which is outlined by the rules set forth by the SBA in response to the implementation of sections 1102 and 1106 of the CARES Act.

Dr. Miller motioned to approve Resolution 2020-05 as presented. Ms. Muno seconded the motion

Discussion topics included:

- Prior to this loan, the hospital has received approximately $5.4M through loans and stimulus packages.
- The Board thanked Mr. Cashman for all his work on obtaining the loans and stimulus packages.
- The loan will close today if approved by the Board.

With no further discussion a verbal vote was called, and the motion carried unanimously.

5. Adjournment

Mr. Pinkham motioned to adjourn the meeting at 1:40 p.m. Dr. Miller seconded the motion, which carried unanimously.

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

ESTES PARK HEALTH
BOARD OF DIRECTORS'
Meeting Minutes – April 27, 2020

Board Members in Attendance:

☒ Dr. David Batey, Chair
☒ Ms. Sandy Begley, Vice Chair (via webinar)
☒ Dr. Monty Miller, Treasurer (via webinar)
☒ Ms. Diane Muno, Secretary (via webinar)
☒ Mr. William Pinkham, Member-at-Large (via webinar)

Other Attendees:

Mr. Vern Carda, CEO
Mr. Tim Cashman, CFO
Ms. Terri Brandt-Correia, CNO (via webinar)
Mr. Gary Hall, CIO (via webinar)
Mr. Randy Brigham, CHRO (via webinar)
Mr. Guy Beasley, EMS Director
Ms. Barbara Valente, Urgent Care Director (via webinar)
Ms. Sarah Bosko, Home Health/Hospice Director (via webinar)
Mr. James Mann, CPA Principal Clifton Larsen Allen, LLP (via webinar)
Ms. Sarah Sheppard, Circuit Rider LLC (via webinar)
Ms. Lisa Taylor, Marketing Director (via webinar)
Ms. Catherine Cornell, Emergency Preparedness Liaison (via webinar)
Ms. Leslie Roberts, Emergency Department Director (via webinar)
Dr. John Meyer, Chief of Staff (via webinar)
Mr. Kevin Mullin, Executive Director, Estes Park Health Foundation (via webinar)
Ms. Peggy Savelsberg, Executive Assistant, Estes Park Health Foundation (via webinar)

Community Attendees (via webinar):

Wendy Rigby, Aaron Alberter, Phil and Tara Moenning, Diane Scruton, Dr. Larry Leaming, Drew Webb, Robert Foster, James and Gail Cozette, Bill Solms, Morgan Svoboda and Sandy Chockla

1. **Call to Order**

   The Board meeting was called to order at 4:10 p.m. by Dr. Batey, Chairman of the Board of Directors; there was a quorum present. Notice of the Board meeting was posted in accordance with the SUNSHINE Law Regulation.

2. Approval of Agenda

Ms. Muno motioned to approve the agenda as submitted. Dr. Miller seconded the motion, which carried unanimously.

3. Public Comments on Items Not on the Agenda and Farewell Comments for Chief Nursing Officer Ms. Terri Brandt Correia

Dr. Larry Leaming thanked Ms. Brandt-Correia for her service and dedication to EPH.

4. General Board Comments and Farewell Comments for Chief Nursing Officer Ms. Terri Brandt Correia

Each Board member thanked Mr. Brandt-Correia for her service and the tremendous impact she made to the organization during her tenure and wished her well in her future endeavors.

5. Consent Agenda Items

Dr. Miller motioned to approve consent agenda items 5.1.1, 5.1.2, 5.1.3 and 5.2.1 as presented. Mr. Pinkham seconded the motion, which carried unanimously.

6. Presentations

6.1 May 5, 2020 Estes Park Health Board Elections Update

Ms. Sarah Sheppard advised the Board that the ballots were mailed out between the required April 13 and April 20 deadline, and all ballots have been delivered as of April 27. There were several last-minute changes to the voter rolls from Arapaho County on April 13 and 14 which resulted in the mail out of the ballots to occur towards the latter side of the deadline. Two (2) additional UOCAVA (Uniformed and Overseas Citizens Absentee Voting Act) ballots have been mailed or emailed to electors with the new list that the County provided. To date, five (5) replacement ballots were either mailed or provided to voters in Estes Park.

The local newspapers printed the election publication notice ahead of the April 15 deadline, and has been very helpful, again with limited human resources due to in-person office closures.

This same notice for the election was posted on the district's website at the top of the elections page: https://eph.org/about-us/board-of-directors/may-2020-board-election/. This notice details the timing for mailing and drop off locations and times through 7pm Election Day, May 5. Ballots can be dropped off or mailed according to the election notice. Mr. Carda and/or Mr. Brigham will deliver the ballot box for counting after the close of the local ballot drop-off at 7pm on Election Day.

6.2 Resolution 2020-05: Approval of SBA Loan from Payroll Protection Program as Support for COVID-19 Expenses

Mr. Cashman stated that the Board approved the financing of the $4,800,000 loan from the Small Business Administration and the Payroll Protection Program of the 2020 CARES Act, for seventeen (17) months for the purposes of funding the payroll costs over an eight (8) week period at their April 24, 2020 Special Board meeting. The loan is forgivable and was closed on Friday, April 24 with the Bank of Colorado.

Prior to this loan, EPH has received approximately $5.8M in various loans and stimulus packages.

6.3 Audited End of Year 2019 Financials

Mr. Mann, Clifton Larsen Allen, advised the Board that the audit went very well and that no material weaknesses or deficiencies were identified.

Highlights of the audit include the following:

- Recommendation to review journal entries more closely and establish improvements around IT controls, which includes performing external penetration testing in 2020.
- Declines in the operating margin, total margin and operating EBIDA occurred, but trended in line to other facilities across the country.
- Days Cash on Hand = 149 days, which is well above the requirement.
- Net Days in Accounts Receivable = 54
- Debt Service Coverage Ratio = 2.2
- Dept to Capitalization = 35%
- Average Age of Plant = 11.6

2019 was eventful for the organization and included a conversion to Epic and Lawson, which utilized a great deal of time and labor. Additionally, the sterilizer went out of service, which caused loss of surgery revenue. However, none of these events are on-going and therefore will not result in additional losses in revenue.

6.4 COVID-19 Preparation and Status Update

Mr. Hall updated the Board on the following items:

- EPH is still open for business
- COVID-19 hotline remains open
- Transfer to the available ICUs
- EPH continues to screen from home
- EPH COVID-19 status
- Surge planning
- Health of healthcare workers

Additional discussion items included the following:

- No additional staff members have tested positive. EPH only tested approximately 5% of employees because the organization has always operated with appropriate PPE and in accordance with all guidelines.
- At this time the organization has ample PPE, but it is monitored closely.
- First responder and healthcare worker essential testing has been implemented.
- Discussions are underway regarding more negative pressure rooms in the ER.
- The clinic has a designated "respiratory hallway."
- Urgent Care will have a COVID-19 screening plan finalized prior to opening.
- Community testing is available with a physician's referral Monday – Friday by appointment only. Information is available at www. eph.org
- Hospital visitors are screened at the front door. If symptomatic, they are sent back to their car with instructions to call the COVID-19 hotline in order to receive instructions on how to access the appropriate entrance to the facility.
- Testing turnaround time is twenty-four (24) to forty-eight (48) hours. If a patient or a healthcare worker is symptomatic, they will be placed at the front of the line for testing.
- The ambulance system is screening every patient and managing resources appropriately. One ambulance has been deemed the COVID-19 transport vehicle.
- There is a high level of concern regarding the senior population and a rebound of the virus.

- The Rocky Mountain National Park does not have any information on when their phased reopening will occur.

6.5 CEO Report

Mr. Carda thanked Ms. Terri Brandt-Correia for her leadership and achievements at EPH. Ms. Pat Samples has accepted the Interim CNO position and started work today. Introductions will be performed at the May Board meeting.

6.6 Community Paramedics Program Update

Mr. Beasley advised the Board that EPH previously applied for the ET3 Community Paramedicine program and was accepted and received the necessary licensing from the State of Colorado. Unfortunately, on April 8, CMS withdrew their participation in the program, which means that EPH will not be able to bill Medicare and Medicaid patients for any Community Paramedicine services provided. Additionally, insurance companies also withdrew from the program once CMS withdrew. Due to the withdrawal of CMS from the program, EPH has halted the program at this time. Currently there are three (3) full-time and one (1) per diem employees that are working in the Urgent Care Clinic. Referrals are also being made to Home Health/Hospice and mental health to help decrease readmits.

Once the service line can be launched, it will be beneficial to the community.

6.7 Urgent Care Center Status Update

Ms. Valente stated that the construction is progressing and that the opening is scheduled for May 26. There has been a slight delay with getting data up and running due to decreased staffing levels because of COVID-19.

The staff is currently working and training in the ER, clinic and front desk at the hospital. A tentative plan for screening patients is being considered but will be based on the current guidelines in place at the time of opening. A virtual tour is being considered.

6.8 Alarado Outpatient Clinic Status Update

- The Rehabilitation Department is scheduled to move on May 22.
- The Specialty Clinic's move is on schedule.
- There is one apartment above the Urgent Care facility that will be available for professional use.

6.9 1Q2020 Financials

The impact of the COVID-19 event has shown a profound impact on the organization.

- Prior to March 19, visits were tracking close to budget; Net Revenues were very close to Budget.
- After March 19, after the Governor's Executive Order to "Cease All Elective Surgeries and Procedures and Preserve Personal Protective Equipment and Ventilators due to the presence of COVID-19";
  - Most patient visits ceased, including clinic visits, ancillary and surgical;
  - Emergency Department experienced a decline;
  - Overall revenues declined by 60% (this is still the case)
- Incident Command was established resulting in the development of the "Operations Committee."

- Staffing remained generally intact, intending to evaluate the situation and sustain the employees thru April.
- Revenues for the 1st quarter are $2.3M under budget and $1.8M under last year.
- Expenses are slightly over budget and 17% higher than last year.
- Total Earnings are $1.5M less than budget due to the decline in business volumes/revenues.
- Days in Accounts receivable have dropped to 53.
- Days Cash on Hand are 132, less than last year. Use of cash will continue to decline due to the COVID-19 pandemic.
- Cash Flow is now negative and projected to become much worse over the year, with a loss of potentially $7M.

Support

As a result of the recent support from the Federal Government, several programs have provided funding in April:

- Advance Payment Program $4.4M - currently scheduled for repayment; possibility of forgiveness.
- Health and Human Services stimulus $702K - forgivable.
- Payroll Protection Program $4.8M (approved; pending) - eligible for forgiveness assuming compliance with stipulations.

Revenues

- Inpatient, Swing and Observation are down by $925k.
- Birth Center is down by $126k.
- Surgery and Anesthesia is down by $713k and $117k, respectfully.
- Emergency Dept is down by $91k.
- Ambulance/EMS is down by $48k.
- Lab, Radiology, Pharm & Rehab is down by $730k.
- Clinic Physicians is down by $100k.
- Cardiology Clinic is down by $121k.

Expenses

- Contract labor is over budget by $281k.
- Supplies are over budget $338k.

6.10 COVID-19 Possible Financial Impacts on Estes Park Health

Mr. Cashman stated that EPH's senior leadership team will continue to monitor the finances throughout the remainder of the year. The organization has a solid business plan in place and will continue to manage its expenses, contracts and staffing models in an effort to minimize the financial impact of COVID-19.

7. Operations Significant Developments

7.1 Executive Summary

Nothing to report.

8. Medical Staff Credentialing Report

Mr. Pinkham motioned to approve the Medical Staff Credentialing report as submitted. Dr. Miller seconded the motion, which carried unanimously.

9. Review any Action Items and Due Dates

None.

10. Potential Agenda Items for May 18, 2020 Regular Board Meeting

- Colorado End-of-Life policy review
- Public Health Centered Care Committee recommendations
- Introduction of Interim CNO Pat Samples

11. Adjournment

Dr. Miller motioned to adjourn the meeting at 6:29 p.m. Mr. Pinkham seconded the motion, which carried unanimously

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

ESTES PARK HEALTH
BOARD OF DIRECTORS'
Special Tele Town Hall Board Meeting Minutes - May 13, 2020

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

Other Attendees
Mr. Vern Carda, CEO
Mr. Tim Cashman, CFO (via webinar)
Ms. Pat Samples, CNO
Mr. Gary Hall, CIO (via webinar)
Dr. John Meyer, COS (via webinar)
Dr. Amanda Luchsinger

Community Attendees (via webinar)
Morgan Svoboda, Karen Sackett, Judith Beechy, Kim Mooney, Robert Drake, Sam DeWitt, Jane Truesdell, Barbara Ayres, Kay Rosenthal, Steve Barlow, Dona Cooper, John Cooper, Jennifer McLellan, James Cozette, Gail Cozette, Aaron Alberter, Sylvia Schneider, Lyle Hileman, Lisa Beard, Pavel Perminov, David Brewer, Sandy Chockla, Audrey TeSelle and Jean McGuire

1. **Call to Order**
   The Special Tele Town Hall Board meeting was called to order at 6:03 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. **Approval of the Agenda**
   Mr. Pinkham motioned to approve the agenda as submitted. Dr. Miller seconded the motion, which carried unanimously.

3. **Public Comments**
   No public comments were submitted.

4. Colorado End of Life Options Act Policy Discussion

4.1 Colorado End of Life Options Act (CEoLOA)

- CEoLOA authorizes an individual who satisfies the statute's requirements to request aid-in-dying medication, to fill the prescription, and to self-administer the medication. Requirements include:
  - Colorado resident adult
  - Terminal diagnosis prognosis of 6 months or less
  - Mental capacity to make and communicate an informed decision
  - Able to self-administer aid-in-dying medication
  - And satisfy many other requirements
- CEoLOA takes place within the privacy and confidentiality of the doctor-patient relationship
- CEoLOA provides privacy and confidentiality protections for all involved
- Patient and provider choice to participate or not participate is voluntary
- CEoLOA prohibits any adverse organizational consequences of the choice to participate or not participate in CEoLOA activities

4.2 Estes Park Health Colorado End of Life Options Act Policy and Procedure

- Estes Park Health offers patients a full range of end-of-life journey options including services addressing:
  - Colorado Advance Directive
  - Pain Management
  - Palliative Care
  - Hospice
  - Colorado End of Life Options Act
- All EPH medical staff who may have direct involvement in CEoLOA activities (Primary Care and potentially involved specialties) will:
  - Provide information on CEoLOA
  - Provide CEoLOA referrals if requested
  - Some EPH medical staff may facilitated CEoLOA patient needs
- EPH CEoLOA Policy does not permit self-administration of aid-in-dying medication on Estes Park Health premises including:
  - The Emergency Department
  - The Inpatient Hospital
  - The Estes Park Health Living Center (EPHLC)
    - EPHLC is a skilled nursing facility
    - EPHLC is a skilled nursing facility with limited physical plant hindering in patient privacy in self-administration of aid-in-dying medication

4.3 Colorado Department of Public Health and Environment – Medical Aid in Dying

In 2016, Colorado voters approved Proposition 106, "Access to Medical Aid in Dying," which amends Colorado statues to include the Colorado End-of-Line Options Act at Article 48 of Title 25, C.R.S. The Act:

- Allows an eligible terminally ill individual with a prognosis of six moths or less to live to request and self-administer medical aid-in-dying medication in order to voluntarily end his or her life;
- Authorizes a physician to prescribe medical aid-in-dying medication to a terminally ill individual under certain conditions; and
- Creates criminal penalties for tampering with a person's request for medical aid-in-dying medication or knowingly coercing a person with a terminal illness to request the medication.

This Act requires the prescribing physician and the health care professional dispensing aid-in-dying medication to provide the Colorado Department of Public Health and Environment (CDPHE) with information outlined by the Act, and necessary to ensure compliance with the documentation requirements of the Act.

4.4 2017 – 2019 Trends and Totals Data Summary

- In 2019, for those requesting prescriptions
  - Median age 72 (range mid 20's to upper 90's)
  - 62.5% Cancer, 19.2% Neurological, 7.9% Cardiovascular, 5.8% Pulmonary, 4.6% Other
- In 2019, for those who died following prescription
  - 82.6 % died in a residence
  - 83.5% died under hospice care

Colorado End-of-Life Options Act Statistics				
	2017	2018	2019	2017 - 19
Number of patients prescribed Aid-in-Dying medication	72	123	170	365
Number of patients dispensed Aid-in-Dying medication	56	85	129	270
Percent of patients prescribed Aid-in-Dying medication that had the medication dispensed	77.8%	69.1%	75.9%	74.0%

Comments and Questions

- Prohibiting this in the Living Center is not right and should be amended. The hospital is willing to transfer a patient to another facility in order to accommodate the request, but that does not seem appropriate.
  - By the time a patient enters the Living Center they are debilitated and will not qualify under the law because they are no longer able to care for themselves or make sound decisions.
- Would an employee be put at risk if they were present with their own family member during the process?
  - The national hospice policy requires staff to leave the room during the ingestion, so the intention in the EPH policy was to mirror that requirement. The Board will review the policy to ensure that the language is clear regarding when it is appropriate and not appropriate for an employee to remain in the room.
- How many participating providers are available?
  - The State publishes the number of prescribing physicians and pharmacies for prior years, however, due to confidentiality laws, no names are published.
- Has there been any consideration from EPH to change the policy of not allowing the act to occur on the premises?
  - At this time, no change is being made regarding EPH's policy on prohibiting the act to occur on its premises. The law does not state that an individual has the right to perform the act in a specific place.
- Are people utilizing Telehealth for the use of the act?
  - The request must be submitted in writing to a physician first.
- If an individual still has the capacity to understand and can self-administer, why are they not allowed to perform the act at EPH?
  - The individuals in the Living Center do not qualify under the law because they are no longer able to care for themselves or make sound decisions. EPH will help in the referral process for anyone who qualifies under the law.

- What will happen if someone presented to the ER who already ingested the medication?
  - Once the medication is ingested there are no measures that can be taken to reverse the outcome. The ER staff will remain with the patient during the process and make them as comfortable as possible.
- What will happen if someone who is a patient in the facility ingests the medication?
  - Inpatient medication are, by policy, taken from patients upon admission. Home medications, by policy, cannot be brought into the facility.
- Has EPH considered hiring or identifying a patient navigator to route patients to a healthcare provider?
  - EPH does refer to UCH, but our system is too small to require a patient navigator position. The starting point for any patient will be their primary care physician, who will act as the navigator.
- What happens if a physician has a fundamental issue with the law and won't provide a referral?
  - A recent survey of the medical staff found that all were willing to provide referrals.
- What will be done with a patient that presents to the facility with one disease and contracts a terminal disease?
  - EPH has procedures in place to institute hospice care to help the patient pass with comfort, dignity and care. An individual in this scenario most likely will not qualify under the law due to their condition and status.
- Does EPH have homes available on the hospital campus that could be utilized for hospice care?
  - The homes on the campus are currently being utilized for other services.
- Can Board members provide their personal opinions on the law?
  - Dr. Batey – A Board member's responsibility is to make recommendations and decisions based on what is the in the best of the organization and the needs of the community, not based on their personal opinions.
  - Mr. Pinkham – The rights of individuals and dealing with patients in a compassionate way is the basis for decision making. The policy is to provides guidelines for assisting individuals in finding resources.
  - Ms. Muno – It would not be my personal choice; however, Board decisions are made based on all the information received from the community, physicians and hospital. Obtaining input from various avenues allows the Board to reach decisions without relying on our own personal preferences.
  - Ms. Begley – We all have personal choices, but the Board bases their decisions on what is most beneficial to the hospital and the Estes Park community.
  - Dr. Miller – The majority of community voted to allow this act and encouraged the EPH Board to continue its work with providers and administrators to find a solution within the organization.
  - Dr. Alper – I encourage people to think beforehand and take responsibility in making the best decision for themselves. People in the community have several options available and the hospital is here to assist with referrals.

Final Comments:

- Many participants thanked the Board for hosting the forum and providing clear information
- A challenge was placed on the community to pursue obtaining a hospice house.
- The EPH Board is committed to providing service and honoring patient wishes.

5. Adjournment

Mr. Pinkham motioned to adjourn the meeting at 7:18 p.m. Dr. Miller seconded the motion, which carried unanimously.

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

ESTES PARK HEALTH
BOARD OF DIRECTORS'
Special Executive Session Board Meeting Minutes - May 14, 2020

Board Members in Attendance
Dr. David Batey, Chair
Ms. Sandy Begley, Vice Chair (via phone)
Dr. Monty Miller, Treasurer (via phone)
Ms. Diane Muno, Secretary (via phone)
Dr. Steve Alper. Director Elect

Other Attendees
Mr. Vern Carda, CEO
Mr. Tim Cashman, CFO
Ms. Pat Samples, CNO
Mr. Gary Hall, CIO (via phone)
Mr. Randy Brigham, CHRO (via phone)

Call to Order
The meeting was called to order at 2:05 p.m. by Dr. Batey, Chairman of the Board of Directors; there was a quorum present. Notice of the Special Executive Session Board meeting was posted in accordance with the SUNSHINE Law Regulation.

Ms. Muno motioned to move into Executive Session, pursuant to §§ 24-6-402(4)(e), C.R.S., and 24-6-402(4)(f) to discuss matters that may be subject to negotiations, developing strategy for negotiations, instructing negotiators and personnel matters related to all hourly and salaried positions at Estes Park Health. Ms. Begley seconded the motion, which carried unanimously.

With no further discussion to be conducted, Mr. Miller motioned to adjourn the Executive Session and concluded the meeting at 3:55 p.m. Ms. Muno seconded the motion, which carried unanimously.

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

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH

FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED DECEMBER 31, 2019 AND 2018

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
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YEARS ENDED DECEMBER 31, 2019 AND 2018

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT

Board of Directors
Park Hospital District
dba: Estes Park Health
Estes Park, Colorado

Report on the Financial Statements

We have audited the accompanying financial statements of Park Hospital District dba: Estes Park Health (the District), which comprise the statements of net position as of December 31, 2019 and 2018, and the related statements of revenues, expenses, and changes in net position and cash flows, and the statements of financial position and related statements of activities of its discretely presented component unit Estes Park Health Foundation, for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of the financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the District's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Board of Directors
Park Hospital District
dba: Estes Park Health

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Park Hospital District dba: Estes Park Health and of its discretely presented component unit Estes Park Health Foundation as of December 31, 2019 and 2018, and the respective changes in net position and cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 3 through 7 and the budgeted and actual revenues and expenses on page 33 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards,* we have also issued our report dated April 27, 2020, on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the result of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the District's internal control over financial reporting and compliance.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Denver, Colorado
April 27, 2020

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
MANAGEMENT'S DISCUSSION AND ANALYSIS
DECEMBER 31, 2019 AND 2018

INTRODUCTION

This management's discussion and analysis of Park Hospital District dba: Estes Park Health (the District) provides an overview of the District's financial activities for the years ended December 31, 2019 and 2018. It should be read in conjunction with the accompanying financial statements of the District, which begin on page 8.

USING THIS ANNUAL REPORT

The District's financial statements consist of three statements: a statement of net position, a statement of revenues, expenses, and changes in net position, and a statement of cash flows. These statements provide information about the activities of the District, including resources held by the District but restricted for specific purposes by creditors, contributors, grantors or enabling legislation. The District is accounted for as business-type activities and present their financial statements using the economic resources measurement focus and the accrual basis of accounting. The Foundation's financial statements consist of a statement of financial position and a statement of activities. The Foundation information is not included in management's discussion and analysis.

FINANCIAL HIGHLIGHTS

- The District's cash and noncurrent cash and investments decreased in 2019 by $1,460,517, or 7%, compared to a decrease of $417,587, or 2%, in 2018.
- Net position decreased $248,038 in 2019 compared to an increase of $2,548,749 in 2018.
- Net operating revenues decreased by $247,990, or 0.5%, in 2019, compared to an increase of $4,675,537, or 10%, in 2018.
- Operating expenses increased by $2,550,070, or 5%, in 2019, and $5,221,287, or 12%, in 2018.
- Nonoperating revenues (expenses) decreased by $9,240 in 2019 compared to an increase of $348,617 in 2018.

THE STATEMENT OF NET POSITION AND STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

One of the most important questions asked about any organization's finances is, "Is the organization as a whole better or worse off as a result of the year's activities?" The statement of net position and the statement of revenues, expenses, and changes in net position report information about the Districts' resources and its activities in a way that helps answer this question. These statements include all restricted and unrestricted assets and all liabilities using the accrual basis of accounting. Using the accrual basis of accounting means that all of the current year's revenues and expenses are taken into account regardless of when cash is received or paid.

These two statements report the District's net position and changes in it. The District's total net position—the difference between assets and liabilities—is one measure of the District's financial health or financial position. Over time, increases or decreases in the District's net position is an indicator of whether their financial health is improving or deteriorating. Other nonfinancial factors, such as changes in the District's patient base, changes in legislation and regulations, measures of the quantity and quality of services provided to its patients, and local economic factors, should also be considered to assess the overall financial health of the District.

THE STATEMENT OF CASH FLOWS

The final required statement is the statement of cash flows. The statement reports cash receipts, cash payments, and net changes in cash and cash equivalents resulting from operations, noncapital financing activities, capital and related financing activities, and investing activities. It provides answers to such questions as where did cash come from, what was cash used for, and what was the change in cash and cash equivalents during the reporting period.

THE DISTRICT'S NET POSITION

The District's net position is the difference between its assets and liabilities reported in the statements of net position. The District's net position decreased $248,038 (1%) in 2019 and increased $2,548,749 (6%) in 2018 as shown in Table 1.

TABLE 1: ASSETS, LIABILITIES, AND NET POSITION

	2019	2018	2017
ASSETS AND DEFERRED OUTFLOWS			
Cash and Cash Equivalents	$ 18,703,367	$ 13,272,797	$ 10,006,606
Patient and Resident Accounts Receivable, Net	6,455,682	6,470,014	6,294,121
Other Current Assets	6,478,394	5,799,168	5,803,693
Capital Assets, Net	31,746,460	29,628,676	30,009,464
Long-Term Investments	2,014,341	8,905,428	12,589,206
Other Noncurrent Assets	285,184	325,000	337,391
Total Assets	$ 65,683,428	$ 64,401,083	$ 65,040,481
LIABILITIES			
Current Liabilities	$ 5,948,560	$ 4,507,317	$ 6,665,665
Long-Term Liabilities	14,240,513	14,545,000	15,585,000
Total Liabilities	20,189,073	19,052,317	22,250,665
Deferred Inflows - Property Taxes	3,119,724	2,726,097	2,715,896
NET POSITION			
Net Investment in Capital Assets	18,261,460	15,083,676	13,389,544
Restricted Expendable	1,412,536	1,403,206	1,402,013
Unrestricted	22,700,635	26,135,787	25,282,363
Total Net Position	42,374,631	42,622,669	40,073,920
Total Liabilities, Deferred Inflows, and Net Position	$ 65,683,428	$ 64,401,083	$ 65,040,481

THE DISTRICT'S ASSETS AND LIABILITIES

The most noteworthy changes in 2019 to the District's statement of net position are the increases in capital assets and current liabilities, along with decreases in total cash and investments. The statement of net position shows that total cash and investments decreased $1,460,517 between 2018 and 2019. A decline in the operating loss was the primary driver of the decrease in current cash and investments in 2019 along with an increase in capital expenditures. Net capital assets experienced an increase of $2,117,784 between 2018 and 2019 as a result of fixed asset additions in the current year being offset by continued depreciation on the assets that have been placed in service. Current liabilities increased in 2019 primarily as a result of timing of payments being made.

THE DISTRICT'S ASSETS AND LIABILITIES (CONTINUED)

The most noteworthy changes in 2018 to the District's statement of net position are the increases in net patient and resident accounts receivable, along with decreases in total cash and investments, capital assets, current liabilities, and long-term debt. The statement of net position shows that total cash and investments decreased $417,587 between 2017 and 2018. A decline in operating income (loss) was the primary driver of the decrease in current cash and investments in 2018. Net patient and resident accounts receivable increased as a result of an increase in net patient and resident revenues in fiscal year 2018. Net capital assets experienced a decrease of $380,788 between 2017 and 2018 as a result of fixed asset additions in the current year being offset by continued depreciation on the assets that have been placed in service. Current liabilities decreased in 2018 primarily as a result of timing of payments being made. Long-term debt decreased in 2018 as a result of the Districts continuing to make principal payments on the outstanding long-term debt. The District made both the 2018 and the 2019 principal payments on the long-term debt during fiscal year 2018.

OPERATING RESULTS AND CHANGES IN DISTRICT'S NET POSITION

In 2019 the District's net position decreased by $248,038 while in 2018 it increased by $2,548,749. See Table 2 for the operating results and changes in net position.

TABLE 2: OPERATING RESULTS AND CHANGES IN NET POSITION

	2019	2018	2017
OPERATING REVENUES			
Net Patient and Resident Service Revenues	$ 48,337,074	$ 48,444,063	$ 43,578,483
Other Operating Revenues	727,677	868,678	1,058,721
Total Operating Revenues	49,064,751	49,312,741	44,637,204
OPERATING EXPENSES			
Salaries and Employee Benefits	28,516,716	26,722,743	24,946,789
Purchased Services and Professional Fees	11,797,929	10,902,501	8,459,130
Supplies and Other	9,898,447	10,050,079	8,786,721
Depreciation	2,081,218	2,068,917	2,330,313
Total Operating Expenses	52,294,310	49,744,240	44,522,953
OPERATING GAIN (LOSS)	(3,229,559)	(431,499)	114,251
NONOPERATING REVENUES AND EXPENSES			
Property Taxes	2,896,027	2,890,593	2,725,660
Investment Income	334,928	256,522	145,314
Interest Expense	(395,453)	(409,376)	(432,885)
Other Nonoperating Revenues and Expenses, Net	43,924	150,927	101,960
Net Nonoperating Revenues	2,879,426	2,888,666	2,540,049
EXCESS (DEFICIT) OF REVENUES OVER EXPENSES	(350,133)	2,457,167	2,654,300
CAPITAL GRANTS	102,095	91,582	108,196
INCREASE (DECREASE) IN NET POSITION	$ (248,038)	$ 2,548,749	$ 2,762,496

OPERATING GAIN (LOSS)

The first component of the overall change in the District's net position is its operating gain (loss), which is the difference between net patient and resident service revenue and the expenses incurred to perform those services. In 2019, the District reported an operating loss of $3,229,559, which is an increase from the operating loss reporting in 2018. The District's management and staff have worked together to ensure quality patient care while keeping rates to patients competitive with other hospitals, controlling expenses, and maintaining a strong financial position through investments, tax revenues, and grants and contributions.

Net patient and resident service revenue of $48.3 million in 2019 which is consistent with 2018 net patient and resident service revenue. Salaries and employee benefits increased in 2019 by $1,793,973 or 6.3%. This was driven by salary increases and staff and physician turnover. Purchased services and professional fees increased in 2019 by $895,428 as a result of additional programs, physician contract labor needs, and recruiting challenges.

The provision for bad debt in 2019 increased from 2018 by 58%. The increase in the provision for bad debt was primarily driven by a decrease in charity care provided in 2019 and a receivables cleanup effort in anticipation of the conversion to the Epic electronic medical record system. It is important to note that the allowance for self-pay accounts receivable, inclusive of bad debt reserve, was $1,784,000 and $1,474,000 for 2019 and 2018, respectively.

Net patient and resident service revenue of $48.4 million in 2018 represented a 10% increase over 2017. The District had an increase in outpatient procedures, which contributed to the increase in net patient and resident service revenues. Salaries and employee benefits increased in 2018 by $1,775,954 or 6.6%. This was driven by salary increases and turnover in physician staffing. Purchased services and professional fees increased in 2018 by $2,443,371 as a result of additional programs and staffing recruiting challenges. Supplies and other expenses increased in 2018 by $1,263,358 or 12.6%, as a result of increased patient volumes and an increase in pain management, wound care, and chemotherapy costs.

The provision for bad debt in 2018 decreased from 2017 by 60%. The decrease in the provision for bad debt was primarily driven by an increase in charity care provided in 2018. It is important to note that the allowance for self-pay accounts receivable, inclusive of bad debt reserve, was $1,474,000 and $1,474,000 for 2018 and 2017, respectively.

The District has policies established regarding the request of an initial deposit or payment for elective services, predicated on the expectation that bad debts and long-term accounts receivable will decline, thereby receiving cash flow and lower allowances. Further, the District has a financial assistance policy in place with a basis from the federal poverty guidelines. Discounts are offered for prompt payment of self-pay receivables.

NONOPERATING REVENUES AND EXPENSES

Nonoperating revenues and expenses consist primarily of property tax revenue, investment income, and interest expense. Property tax revenues from the county increased 0.2% in 2019 and 6% in 2018. Revenues from investments increased by 23% for 2019 and 77% for 2018, due to the changing economic climate. Interest expense decreased 4% in 2019 and 6% in 2018 as a result of principal payments continuing to be made on outstanding long-term debt.

THE DISTRICT'S CASH FLOWS

The changes in the District's cash flows are consistent with changes in operating income and losses and nonoperating revenues and expenses, as discussed earlier.

CAPITAL ASSETS, NET

The District's capital assets, net of accumulated depreciation, increased from $29,628,676 in 2018 to $31,746,460 in 2019, as detailed in Note 6 to the financial statements. During 2019 and 2018, the District added capital assets of $4,199,002 and $1,707,108, respectively. Of the 2019 capital asset additions, $2,857,882 was related to the new electronic health record and accounting system implementation. This project was capitalized in the last part of fiscal year 2019.

LONG-TERM DEBT

At December 31, 2019 and 2018, the District had long-term debt (including current portion) of $13,485,000 and $14,545,000, respectively. The District did not issue any new debt during 2019. During 2018, the District did pay its capital lease obligation in full.

OTHER ECONOMIC FACTORS

The District operates in rural Colorado in Larimer County. This area is a resort destination, which generally relies on tourism. As a result, the community can be impacted by national economic and environmental trends.

CONTACTING THE DISTRICT'S FINANCIAL MANAGEMENT

This financial report is designed to provide our patients, suppliers, taxpayers, investors, and creditors with a general overview of the District's finances and to show the District's accountability for the money they receive. Questions about this report and requests for additional financial information should be directed to the District's executive office by telephoning 970-577-4470.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
STATEMENTS OF NET POSITION
DECEMBER 31, 2019 AND 2018

	2019	2018
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 18,703,367	$ 13,272,797
Restricted Cash Under Debt Agreement	1,412,536	1,403,206
Receivables:		
Patient and Resident, Net of Estimated Uncollectibles of Approximately $1,784,000 in 2019 and $1,474,000 in 2018, Respectively	6,455,682	6,470,014
Property Taxes and Other	3,288,957	2,870,617
Supplies	1,096,406	1,111,852
Prepaid Expenses	680,495	413,493
Total Current Assets	31,637,443	25,541,979
LONG-TERM INVESTMENTS	2,014,341	8,905,428
CAPITAL ASSETS		
Capital Assets Not Being Depreciated	1,331,948	1,174,761
Depreciable Capital Assets, Net of Accumulated Depreciation	30,414,512	28,453,915
Total Capital Assets, Net	31,746,460	29,628,676
LONG-TERM PREPAID LEASE	285,184	325,000
Total Assets	$ 65,683,428	$ 64,401,083

See accompanying Notes to Financial Statements.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
STATEMENTS OF NET POSITION (CONTINUED)
DECEMBER 31, 2019 AND 2018

LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	2019	2018
CURRENT LIABILITIES		
Accounts Payable	$ 2,250,218	$ 1,215,050
Estimated Third-Party Payor Settlements	829,000	869,000
Accrued Expenses:		
Salaries, Wages, and Related Liabilities	1,683,574	1,351,015
Compensated Absences	1,102,158	991,689
Other	83,610	80,563
Total Current Liabilities	5,948,560	4,507,317
LONG-TERM LIABILITIES		
Long-Term Debt	13,485,000	14,545,000
Long-Term Portion of Accounts Payable	755,513	-
Total Long-Term Liabilities	14,240,513	14,545,000
Total Liabilities	20,189,073	19,052,317
DEFERRED INFLOWS OF RESOURCES - PROPERTY TAXES	3,119,724	2,726,097
NET POSITION		
Net Investment in Capital Assets	18,261,460	15,083,676
Restricted, Expendable	1,412,536	1,403,206
Unrestricted	22,700,635	26,135,787
Total Net Position	42,374,631	42,622,669
Total Liabilities, Deferred Inflows of Resources, and Net Position	$ 65,683,428	$ 64,401,083

See accompanying Notes to Financial Statements.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
ESTES PARK HEALTH FOUNDATION
DISCRETELY PRESENTED COMPONENT UNIT
STATEMENTS OF FINANCIAL POSITION
DECEMBER 31, 2019 AND 2018

	2019	2018
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 528,911	$ 540,260
Promises to Give, Short-Term	8,002	100
Other Receivables	5,230	8,612
Prepaid Expenses	1,236	1,293
Total Current Assets	543,379	550,265
OTHER ASSETS		
Investments	3,385,094	2,610,067
Charitable Remainder Unitrust Receivable	81,131	70,396
Net Promises to Give, Long-Term	9,727	5,325
Total Other Assets	3,475,952	2,685,788
Total Assets	$ 4,019,331	$ 3,236,053
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable	$ 68	$ 298
Accrued Expenses	23,077	46,203
Total Current Liabilities	23,145	46,501
NET ASSETS		
Net Assets without Donor Restrictions	1,041,584	631,415
Net Assets with Donor Restrictions	2,954,602	2,558,137
Total Net Assets	3,996,186	3,189,552
Total Liabilities and Net Assets	$ 4,019,331	$ 3,236,053

See accompanying Notes to Financial Statements.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
OPERATING REVENUE		
Net Patient and Resident Service Revenue, Net of Provision for Bad Debts of Approximately $1,130,000 in 2019 and $715,000 in 2018, Respectively	$ 48,337,074	$ 48,444,063
Other Revenue	727,677	868,678
Total Operating Revenue	49,064,751	49,312,741
OPERATING EXPENSES		
Salaries and Wages	22,868,648	20,941,930
Employee Benefits	5,648,068	5,780,813
Professional Fees and Purchased Services	11,797,929	10,902,501
Supplies	5,964,403	5,715,814
Utilities	583,846	550,420
Leases and Rentals	401,423	318,845
Insurance	305,411	292,015
Repairs and Maintenance	150,314	252,549
Depreciation	2,081,218	2,068,917
Other	2,493,050	2,920,436
Total Operating Expenses	52,294,310	49,744,240
OPERATING LOSS	(3,229,559)	(431,499)
NONOPERATING REVENUES (EXPENSES)		
Property Tax Revenues	2,896,027	2,890,593
Interest Expense	(395,453)	(409,376)
Investment Income	334,928	256,522
Gain (Loss) on Disposal of Capital Assets	8,500	(9,979)
Noncapital Grants and Contributions	23,021	165,241
Other	12,403	(4,335)
Total Nonoperating Revenues, Net	2,879,426	2,888,666
EXCESS (DEFICIT) OF REVENUES OVER EXPENSES BEFORE CAPITAL CONTRIBUTIONS	(350,133)	2,457,167
Capital Contributions	102,095	91,582
INCREASE (DECREASE) IN NET POSITION	(248,038)	2,548,749
Net Position - Beginning of Year	42,622,669	40,073,920
NET POSITION - END OF YEAR	$ 42,374,631	$ 42,622,669

See accompanying Notes to Financial Statements.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
ESTES PARK HEALTH FOUNDATION
DISCRETELY PRESENTED COMPONENT UNIT
STATEMENTS OF ACTIVITIES
YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
REVENUES, GAINS, AND OTHER SUPPORT WITHOUT RESTRICTIONS		
Contributions	$ 134,371	$ 200,008
Investment Income (Loss), Net	263,595	(44,427)
Net Assets Released from Restriction	420,800	199,414
Total Revenues, Gains, and Other Support without Restrictions	818,766	354,995
EXPENSES		
Grants and Contributions to Estes Park Medical Center:		
Capital Assets	61,240	273,180
Salaries and Benefits	260,212	222,763
Advertising and Marketing	32,876	14,609
Office Expenses	10,146	17,168
Professional Fees	28,306	17,886
Contracted Services	5,072	18,148
Insurance	2,511	2,437
Travel and Meetings	8,234	2,767
Total Expenses	408,597	568,958
INCREASE (DECREASE) IN NET ASSETS WITHOUT DONOR RESTRICTIONS	410,169	(213,963)
NET ASSETS WITH DONOR RESTRICTIONS		
Contributions	457,704	158,481
Restricted Investment Income (Loss)	359,561	(79,328)
Net Assets Released from Restriction	(420,800)	(199,414)
Increase (Decrease) in Net Assets with Donor Restrictions	396,465	(120,261)
CHANGE IN NET ASSETS	806,634	(334,224)
Net Assets - Beginning of Year	3,189,552	3,523,776
NET ASSETS - END OF YEAR	$ 3,996,186	$ 3,189,552

See accompanying Notes to Financial Statements.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from and on Behalf of Patients and Residents	$ 48,311,406	$ 48,209,170
Payments to Suppliers and Contractors	(21,375,786)	(21,380,216)
Payments for Employee Salaries and Benefits	(28,070,641)	(27,062,979)
Other Receipts and Payments	712,187	882,099
Net Cash Provided (Used) by Operating Activities	(422,834)	648,074
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Property Taxes Supporting Operations	2,886,804	2,895,136
Noncapital Grants and Contributions	23,021	165,241
Net Cash Provided by Noncapital Financing Activities	2,909,825	3,060,377
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchase and Construction of Capital Assets	(2,940,651)	(1,776,918)
Proceeds from Disposal of Capital Assets	8,500	9,000
Principal Payments on Long-Term Debt	(1,060,000)	(2,074,920)
Interest Paid on Long-Term Debt	(395,453)	(620,052)
Capital Contributions	102,095	91,582
Net Cash Used by Capital and Related Financing Activities	(4,285,509)	(4,371,308)
CASH FLOWS FROM INVESTING ACTIVITIES		
Sales of Investments	6,891,087	3,649,586
Investment Income and Other	347,331	252,187
Net Cash Provided by Investing Activities	7,238,418	3,901,773
NET INCREASE IN CASH AND CASH EQUIVALENTS	5,439,900	3,238,916
Cash and Cash Equivalents - Beginning of Year	14,676,003	11,437,087
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 20,115,903	$ 14,676,003

See accompanying Notes to Financial Statements.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
STATEMENTS OF CASH FLOWS (CONTINUED)
YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
RECONCILIATION OF CASH AND CASH EQUIVALENTS TO THE STATEMENTS OF NET POSITION		
Cash and Cash Equivalents	$ 18,703,367	$ 13,272,797
Restricted Cash Under Debt Agreement	1,412,536	1,403,206
Total Cash and Cash Equivalents	$ 20,115,903	$ 14,676,003
RECONCILIATION OF OPERATING LOSS TO NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES		
Operating Loss	$ (3,229,559)	$ (431,499)
Adjustments to Reconcile Operating Loss to Net Cash Provided (Used) by Operating Activities		
Depreciation	2,081,218	2,068,917
Provision for Bad Debts	1,130,251	714,907
(Increase) Decrease in Assets:		
Patient and Resident Receivables	(1,115,919)	(890,800)
Other Receivables	(15,490)	13,421
Supplies	15,446	(68,636)
Prepaid Expenses	(267,002)	84,706
Long-Term Prepaid Lease	39,816	-
Increase (Decrease) in Liabilities:		
Accounts Payable	532,330	(443,706)
Estimated Third-Party Payor Settlements	(40,000)	(59,000)
Accrued Salaries, Compensated Absences, and Other	446,075	(340,236)
Net Cash Provided (Used) by Operating Activities	$ (422,834)	$ 648,074
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Capital Assets Included in Accounts Payable	$ 1,258,351	$ -

See accompanying Notes to Financial Statements.

NOTE 1 NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Nature of Organization and Reporting Entities

The financial statements of Park Hospital District dba: Estes Park Health (the District) have been prepared in accordance with accounting principles generally accepted in the United States of America. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The significant accounting and reporting policies and practices used by the District are described below.

The District operates a 23-bed acute care facility (the Hospital); the Prospect Park Nursing Facility (the Nursing Facility), a 52-bed skilled nursing facility; and the Physician Clinic (the Clinic) located in Estes Park, Colorado. The District is organized as a political subdivision of the state of Colorado and has been recognized by the IRS as exempt from federal income taxes under Internal Revenue Code (IRC) Section 501(a). The District is governed by a board of directors consisting of five members elected by residents of Park Hospital District. The District is not a component unit of another governmental entity.

For financial reporting purposes, the District is reported separately from the Estes Park Health Foundation (the Foundation). The Foundation is a 501(c)(3) organization whose sole purpose is to support the District and is reported as a discretely presented component unit of the District. Estes Park Health Foundation conducts fundraising campaigns on behalf of the District. The Foundation's individual financial statements can be obtained from management of the Foundation.

During fiscal year 2018 the Park Hospital District updated its trade name which it does business under from Estes Park Medical Center to Estes Park Health. The financial statements have been updated for this change.

Standards of Accounting and Financial Reporting

The accompanying financial statements have been presented in conformity with accounting principles generally accepted in the United States of America in accordance with the American Institute of Certified Public Accountants' audit and accounting guide, health care entities, and other pronouncements applicable to health care organizations and guidance from the GASB, where applicable.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

NOTE 1 NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Net Position

The net position of the District is classified in three components. *Net investment in capital assets* consist of capital assets net of accumulated depreciation and reduced by any outstanding balances of borrowings used to finance the purchase or construction of those assets. *Restricted expendable net position* is noncapital net position that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the District. Restricted net assets are reduced by any liabilities payable from restricted assets. *Unrestricted net position* is the remaining net assets that do not meet the definition of invested in capital assets net of related debt or restricted.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less, excluding internally designated or restricted cash and investments. For the purposes of the statement of cash flows, the District considers all cash and investments with an original maturity of three months or less as cash and cash equivalents.

Patient and Resident Accounts Receivable, Net

The District reports patient and resident accounts receivable for services rendered at net realizable amounts from third-party payors, patients, residents and others. The District provides an allowance for bad debts based upon a review of outstanding receivables, historical collection information, and existing economic conditions. As a service to the patient and residents, the District bills third-party payors directly and bills the patient or resident when the patient or resident's liability is determined. Patient and residents are not required to provide collateral for services rendered. Patient and resident accounts receivable are ordinarily due in full when billed. Delinquent receivables are written off based on individual credit evaluation and specific circumstances of the patient, resident or third-party payor. In addition, an allowance is estimated for other accounts based on historical experience of the District. At December 31, 2019 and 2018, the allowance for uncollectible accounts was approximately $1,784,000 and $1,474,000, respectively.

Property Tax Receivable and Revenue

Property tax receivable is recognized on the lien date, which is January 1 of the tax year in Colorado. The property tax receivable represents taxes certified by the board of directors to be collected in the next fiscal year. However, by statute, the tax asking becomes effective on the first day of the following year. Although the property tax receivables has been recorded, the related revenue is considered a deferred inflow of resources – unavailable revenue and will not be recognized as revenue until the year for which it has been levied.

Lien date	-	January 1
Levy date	-	January 1, succeeding year
Due dates	-	February 28 and June 15, succeeding year

NOTE 1 NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Supplies

Supply inventories are stated at the lower of cost, determined using the first-in, first-out basis, or net realizable value.

Noncurrent Cash and Investments

Noncurrent cash and investments includes long-term investments, internally designated investments which are set asides by the board of directors for future capital improvements, over which the board retains control and may at its discretion subsequently use for other purposes, and cash and investments restricted by donors. Investments are measured at fair value.

Investment income includes dividend and interest income, realized gains and losses on investments carried at other than fair value and the net change for the year in the fair value of investments carried at fair value.

Capital Assets, Net

Capital asset acquisitions in excess of $5,000 are capitalized at cost at the date of acquisition or fair value at the date of donation, if acquired by gift. Depreciation is computed using the straight-line method over the estimated useful life of each asset. Assets under capital lease obligations and leasehold improvements are depreciated over the shorter of the lease term or their respective estimated useful lives. The following estimated useful lives are being used by the District:

	Years
Land Improvements	8 to 40
Buildings and Leasehold Improvements	5 to 40
Equipment	2 to 25

Gifts of long-lived assets such as land, buildings, or equipment are reported as additions to unrestricted net position, and are excluded from excess (deficit) of revenue over expenses before capital contributions. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted net positon.

Compensated Absences

The District's policies permit most employees to accumulate paid time-off benefits. Expense and the related liability are recognized as benefits when earned. Compensated absence liabilities are computed using the regular pay rates in effect at the statement of net position date.

NOTE 1 NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Estimated Health Claims Payable

The District provides for self-funded insurance reserves for estimated incurred but not reported claims for its employee health plan. These reserves, which are included in salaries, wages, and related liabilities on the statements of net position, are estimated based upon historical submission and payment data, cost trends, utilization history, and other relevant factors. Adjustments to reserves are reflected in the operating results in the period in which the change in estimate is identified.

Deferred Inflows of Resources

Although certain revenues are measurable, they are not available. Available means collected within the current period or expected to be collected soon enough thereafter to be used to pay liabilities of the current period. Deferred inflows of resources represents the amount of assets that have been recognized, but the related revenue has not been recognized since the assets are not collected within the current period or expected to be collected soon enough thereafter to be used to pay liabilities of the current period. Deferred inflows of resources consist of unavailable property taxes. The property taxes will be recognized as revenue in the year for which the taxes have been levied and become available.

Net Patient and Resident Service Revenue

Net patient and resident service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered and include estimated retroactive revenue adjustments and a provision for uncollectible accounts. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the services are rendered and such estimated amounts are revised in future periods as adjustments become known.

Charity Care

The District provides care without charge or at amounts less than its established rates to patients meeting certain criteria under its charity care policy. Because the District does not pursue collection of amounts determined to qualify as charity care, these amounts are not reported as net patient and resident service revenue. Charges excluded from revenue under the District's charity care policy were approximately $813,000 and $1,114,000 for 2019 and 2018, respectively.

Grants and Contributions

From time to time, the District receives grants and contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenues. Amounts restricted to capital acquisitions are reported after excess (deficit) of revenues over expenses before capital contributions.

NOTE 1 NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Operating Revenues and Expenses

The District's statements of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, the District's principal activity. Nonexchange revenues, including taxes, interest expense, grants, and contributions received for purposes other than capital asset acquisition, are reported as nonoperating revenues. Operating expenses are all expenses incurred to provide health care services.

Income Taxes

The District is organized as a political subdivision of the state of Colorado and has been recognized by the IRS as exempt from federal income taxes under IRC Section 501(a). The Foundation is exempt from income taxes under Section 501(c)(3) of the IRC and a similar provision for state law. However, the Foundation is subject to federal income tax on any unrelated business taxable income.

Advertising Costs

The District expenses advertising costs as incurred.

Fair Value Measurements

To the extent available, the District's investments are recorded at fair value. GASB Statement No. 72 – *Fair Value Measurement and Application,* defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. This statement establishes a hierarchy of valuation inputs based on the extent to which inputs are observable in the marketplace. Inputs are used in applying the various valuation techniques and take in to account the assumptions that market participants use to make valuation decisions. Inputs may include price information, credit data, interest and yield curve data, and other factors specific to the financial instrument. Observable inputs reflect market data obtained from independent sources.

In contrast, unobservable inputs reflect an entity's assumptions about how market participants would value the financial instrument. Valuation techniques should maximize the use of observable inputs to the extent available. A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

In contrast, unobservable inputs reflect an entity's assumptions about how market participants would value the financial instrument. Valuation techniques should maximize the use of observable inputs to the extent available. A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

NOTE 1 NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Fair Value Measurements (Continued)

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used for financial instruments measured at fair value on a recurring basis:

Level 1 – Inputs that utilize quoted prices (unadjusted) in active markets for identical assets or liabilities that the District has the ability to access.

Level 2 – Inputs that include quoted prices for similar assets and liabilities in active markets and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instrument. Fair values for these instruments are estimated using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows.

Level 3 – Inputs that are unobservable inputs for the asset or liability, which are typically based on an entity's own assumptions, as there is little, if any, related market activity.

NOTE 2 TAX, SPENDING, AND DEBT LIMITATIONS

Colorado voters passed an amendment to the state constitution, Article X, Section 20, which has several limitations including revenue raising, spending abilities, and other specific requirements of state and local governments.

The District's financial activity provides the basis for calculation of limitations adjusted for allowable increases tied to inflation and local growth.

The amendment excludes enterprises from its provisions. Enterprises are defined as government-owned businesses authorized to issue revenue bonds and receive less than 10% of their annual revenue in grants from all state and local governments combined. The District is of the opinion that its operations qualify for this exclusion.

Fiscal year spending and revenue limits are determined based on the prior year's spending, adjusted for inflation and local growth. Revenue in excess of the limit must be refunded unless the voters approve retention of such revenue.

NOTE 3 NET PATIENT AND RESIDENT SERVICE REVENUE

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. These payment arrangements include the following:

Hospital and Clinic

Medicare

The District has elected the Critical Access Hospital (CAH) designation. As a Critical Access Hospital, inpatient acute care services rendered to Medicare program beneficiaries are paid on a cost-reimbursed basis and inpatient nonacute services and outpatient services are reimbursed on a cost basis. The District is reimbursed for certain services at tentative rates with final settlement determined after submission of annual cost reports by the District and audits thereof by the Medicare fiscal intermediary. The Hospital's Medicare cost reports have been audited by the Medicare fiscal intermediary through December 31, 2017. Clinical services are paid on a cost basis or fixed fee schedule.

Medicaid

Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Through October 31, 2016, inpatient nonacute services, certain outpatient services, and defined capital costs related to Medicaid beneficiaries were paid based on a cost-reimbursement methodology. The District is reimbursed for cost-reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicaid fiscal intermediary. The District's Medicaid cost reports have settled through the year ended October 31, 2016. On November 1, 2016, the Medicaid program began reimbursing inpatient nonacute services and certain outpatient services using a prospective payment methodology.

In 2012, the state of Colorado adopted a provider fee program, approved by the Centers for Medicare and Medicaid Services (CMS), under which all hospitals in the state were assessed a fee. The inpatient fee is based on a rate for managed care and nonmanaged care days for the reporting period and the outpatient fee is based on a percentage of total outpatient charges. The state of Colorado uses the fees to supplement state budget funds for the Medicaid program, which brings matching federal funds into the program, enabling the state of Colorado to fund Medicaid payments to hospitals at a higher rate than would otherwise be possible. Beginning with the state fiscal year ended June 30, 2011, funding received in excess of costs to provide these services to Medicaid and uninsured patients may be refunded. As of December 31, 2019 and 2018, the District has recorded a reserve of $350,000, for the estimated portion of funding received in excess of costs. It is reasonably possible that this estimate could materially change in the near term.

NOTE 3 NET PATIENT AND RESIDENT SERVICE REVENUE (CONTINUED)

Hospital and Clinic (Continued)

Other

The District has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

Uninsured

The District provides healthcare services to patients who have not purchased commercial healthcare insurance coverage and do not qualify as beneficiaries of the Medicare and Medicaid programs. Based upon financial information obtained, some of these patients qualify for discounts from charges under the District's charity care policy.

Nursing Facility

Medicare

The Nursing Facility participates in the Medicare program. This federal program is administered by the Centers for Medicare and Medicaid Services (CMS). The Nursing Facility is paid under the Medicare Prospective Payment System (PPS) for residents who are Medicare Part A eligible and meet the coverage guidelines for skilled nursing facility services (SNFs). The PPS is a per diem price-based system. Annual cost reports are required to be submitted to the designated Medicare Administrative Contractor; however, they do not contain a cost settlement. CMS recently finalized the Patient Driven Payment Model (PDPM) to replace the existing Medicare reimbursement system effective October 1, 2019. Under PDPM, therapy minutes are removed as the primary basis for payment and instead uses the underlying complexity and clinical needs of a patient as a basis for reimbursement. In addition, PDPM introduces variable adjustment factors that change reimbursement rates during the resident's length of stay.

Medicaid

The Nursing Facility participates in the Medicaid program administered by the Colorado Department of Health Care Financing and Policy. The Medicaid rates are established prospectively: based on the facility's annual cost report; subject to limitations for the health care related services; administration is based on a price; and the capital component is based on the fair rental allowance system. The direct health care related services component is adjusted quarterly, based on the facility's resident acuity.

NOTE 3 NET PATIENT AND RESIDENT SERVICE REVENUE (CONTINUED)

Concentrations of gross revenue by major payor accounted for the following percentages of the District's patient and resident revenues for the years ended December 31, 2019 and 2018:

	2019	2018
Medicare	43 %	48 %
Medicaid	12	14
Other Third Party	43	35
Self Pay	2	3
Total	100 %	100 %

Laws and regulations governing the Medicare, Medicaid and other programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Net patient and resident service revenue increased approximately $617,000 and $241,000 for the years ended December 31, 2019 and 2018, respectively, due to change in the allowances previously estimated that are no longer necessary as a result of final settlements and years that are no longer likely subject to audits, review, and investigations.

The following is a reconciliation of gross patient and resident service revenue to net patient and resident service revenue for the years ended December 31, 2019 and 2018:

	2019	2018
Gross Patient and Resident Service Revenue	$ 91,195,541	$ 90,001,176
Less Charity Care	(812,791)	(1,114,125)
Total Patient and Resident Service Revenue	90,382,750	88,887,051
Contractual Adjustments		
Medicare	(23,610,172)	(22,727,395)
Medicaid	(7,661,893)	(8,351,409)
Blue Cross Blue Shield	(986,647)	(904,092)
Other	(8,656,713)	(7,745,185)
Provision for Bad Debts	(1,130,251)	(714,907)
Total Contractual Adjustments and Provision for Bad Debts	(42,045,676)	(40,442,988)
Net Patient and Resident Service Revenue	$ 48,337,074	$ 48,444,063

NOTE 4 PATIENT AND RESIDENT ACCOUNTS RECEIVABLE, NET

The District grants credit without collateral to their patients and residents, most of who are area residents and are insured under third-party payor agreements. Concentrations of patient and resident accounts receivable at December 31, 2019 and 2018 consisted of the following:

	2019	2018
Medicare	29 %	39 %
Medicaid	8	9
Other Third Party	45	34
Self Pay	18	18
Total	100 %	100 %

NOTE 5 DEPOSITS AND INVESTMENTS

Deposits

The Colorado Public Deposit Protection Act (PDPA) requires that all units of local government deposit cash in eligible public depositories. Eligibility is determined by state regulators. Amounts on deposit in excess of federal insurance levels must be collateralized. The eligible collateral is determined by PDPA. PDPA allows the institution to create a single collateral pool for all public funds. The pool is to be maintained by another institution or held in trust for all the uninsured public deposits as a group. The market value of the collateral must be at least equal to the aggregate uninsured deposits.

The State Regulatory Commissioners for bank and financial services are required by statute to monitor the naming of eligible depositories and reporting of uninsured deposits and assets maintained in collateral pools.

The District may legally invest in direct obligations of and other obligations guaranteed as to principal by the U.S. Treasury and U.S. agencies and instrumentalities and in-bank repurchase agreements. It may also invest to a limited extent in corporate bonds.

Investments

At December 31, 2019 and 2018, the District had the following investments and maturities:

			December 31, 2019			
Type	Fair Value	Rating	Less than 1	1-5	6-10	More than 10
Certificates of Deposit	$ 757,615	NA	$ 757,615	$ -	$ -	$ -
Government Securities	1,004,877	AA+	1,004,877	-	-	-
Corporate Bonds	251,849	AA-	251,849	-	-	-
Total Investments	$ 2,014,341		$ 2,014,341	$ -	$ -	$ -

			December 31, 2018			
Type	Fair Value	Rating	Less than 1	1-5	6-10	More than 10
Certificates of Deposit	$ 1,753,568	NA	$ 1,505,339	$ 248,229	$ -	$ -
Government Securities	2,394,401	AA+	2,394,401	-	-	-
Corporate Bonds	4,757,459	A+ - AA+	4,508,283	249,176	-	-
Total Investments	$ 8,905,428		$ 8,408,023	$ 497,405	$ -	$ -

NOTE 5 DEPOSITS AND INVESTMENTS (CONTINUED)

Fair Value Measurements

The District uses fair value measurements to record fair value adjustments to certain assets and liabilities and to determine fair value disclosures. For additional information on how the District measures fair value refer to Note 1 – Nature of Operations and Summary of Significant Accounting Policies. The following table presents the fair value hierarchy for the balances of the assets and liabilities of the District measured at fair value on a recurring basis as of December 31, 2019 and 2018:

	December 31, 2019			
Investment Type	Level 1	Level 2	Level 3	Total
Government Securities	$ 1,004,877	$ -	$ -	$ 1,004,877
Corporate Bonds	-	251,849	-	251,849
Total	$ 1,004,877	$ 251,849	$ -	$ 1,256,726

	December 31, 2018			
Investment Type	Level 1	Level 2	Level 3	Total
Government Securities	$ 2,394,401	$ -	$ -	$ 2,394,401
Corporate Bonds	-	4,757,459	-	4,757,459
Total	$ 2,394,401	$ 4,757,459	$ -	$ 7,151,860

Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. The District's investment policy does not contain a provision that limits investment maturities as a means of managing its exposure to fair value losses arising from increasing interest rates.

Credit Risk

State Statutes limit the investments in bonds, debentures or notes of any corporation to be rated "A" or higher by nationally recognized statistical rating organizations at the time of purchase. As of December 31, 2019 and 2018, the District believes it was compliant with State Statutes with regard to credit risk. The District has no investment policy that would further limit its investment options.

Custodial Credit Risk

Custodial credit risk is the risk that in the event of the failure of the counterparty, the District will not be able to recover the value of its investment or collateral securities that are in the possession of an outside party. All of the underlying securities for the District's investments in repurchase agreements at December 31, 2019 and 2018 are held by the counterparties in other than the District's name. The District's investment policy does not address how the securities' underlying repurchase agreements are to be held.

NOTE 5 DEPOSITS AND INVESTMENTS (CONTINUED)

Summary of Carrying Values

The carrying values of deposits and investments shown are included in the statements of net position as follows:

	2019	2018
Carrying Value:		
Deposits	$ 20,115,903	$ 14,676,003
Investments	2,014,341	8,905,428
Total Deposits and Investments	$ 22,130,244	$ 23,581,431

	2019	2018
Included in the Following Statements of Net Position Captions:		
Cash and Cash Equivalents	$ 18,703,367	$ 13,272,797
Restricted Cash Under Debt Agreement	1,412,536	1,403,206
Noncurrent Cash and Investments:		
Long-Term Investments	2,014,341	8,905,428
Total Deposits and Investments	$ 22,130,244	$ 23,581,431

Investment Income

Investment income consisted of the following for the years ended December 31, 2019 and 2018:

	2019	2018
Interest Income	$ 362,010	$ 299,386
Unrealized Losses	(27,082)	(42,864)
Total	$ 334,928	$ 256,522

NOTE 6 CAPITAL ASSETS, NET

Capital asset activity for the year ended December 31, 2019 was as follows:

	2019				
	Beginning Balance	Additions	Disposals and Retirements	Transfers	Ending Balance
Land	$ 513,973	$ -	$ -	$ -	$ 513,973
Land Improvements	881,009	-	-	-	881,009
Buildings and Leasehold Improvements	39,958,325	260,220	-	-	40,218,545
Equipment	9,434,095	923,713	(80,094)	2,857,882	13,135,596
Construction in Progress	661,187	3,015,069	-	(2,857,882)	818,374
Total	51,448,589	4,199,002	(80,094)	-	55,567,497
Less Accumulated Depreciation:					
Land Improvements	658,743	35,906	-	-	694,649
Buildings and Leasehold Improvements	14,380,399	1,251,219	-	-	15,631,618
Equipment	6,780,771	794,093	(80,094)	-	7,494,770
Total	21,819,913	2,081,218	(80,094)	-	23,821,037
Capital Assets, Net	$ 29,628,676	$ 2,117,784	$ -	$ -	$ 31,746,460

NOTE 6 CAPITAL ASSETS, NET (CONTINUED)

Capital asset activity for the year ended December 31, 2018 was as follows:

	2018				
	Beginning Balance	Additions	Disposals and Retirements	Transfers	Ending Balance
Land	$ 513,973	$ -	$ -	$ -	$ 513,973
Land Improvements	888,759	-	(7,750)	-	881,009
Buildings and Leasehold Improvements	40,049,633	111,516	(916,659)	713,835	39,958,325
Equipment	9,988,895	369,388	(924,188)		9,434,095
Construction in Progress	148,818	1,226,204	-	(713,835)	661,187
Total	51,590,078	1,707,108	(1,848,597)	-	51,448,589
Less Accumulated Depreciation:					
Land Improvements	629,115	37,378	(7,750)	-	658,743
Buildings and Leasehold Improvements	14,095,557	1,201,501	(916,659)	-	14,380,399
Equipment	6,855,942	830,038	(905,209)	-	6,780,771
Total	21,580,614	2,068,917	(1,829,618)	-	21,819,913
Capital Assets, Net	$ 30,009,464	$ (361,809)	$ (18,979)	$ -	$ 29,628,676

Construction in progress at December 31, 2019 consists of costs the related to leasehold improvements for the Urgent Care Clinic and various other projects. The Urgent Care Clinic leasehold improvements are expected to be completed in May 2020 at an estimated cost of $2.5 million. This project the being funded through a note payable as identified in Note 11. The various other projects are expected to be completed throughout the first half of fiscal year 2020 at an estimated total cost of approximately $875,000. These various projects are being funded through operations.

NOTE 7 LINE OF CREDIT

The District has entered into a line of credit agreement with a financial institution that provides for the available borrowings of $3,000,000. The agreement matures on July 30 and currently is renewed through July 30, 2020. Borrowings under the line of credit bear interest at the Prime Rate as published by the Wall Street Journal less 0.75 percentage points. The minimum interest rate is 3.5% and the line of credit is secured by all accounts the District holds with the financial institution, to the extent permitted by applicable law. There was no amount outstanding as of December 31, 2019 and 2018.

NOTE 8 LONG-TERM DEBT

The following is a summary of long-term debt transactions for the District for the years ended December 31, 2019 and 2018:

	2019				
	Beginning Balance	Additions	Reductions	Ending Balance	Amounts Due Within One Year
Promissory Notes, Series 2016	$ 14,545,000	$ -	$ (1,060,000)	$ 13,485,000	$ -

	2018				
	Beginning Balance	Additions	Reductions	Ending Balance	Amounts Due Within One Year
Promissory Notes, Series 2016	$ 16,605,000	$ -	$ (2,060,000)	$ 14,545,000	$ -
Capital Lease Obligations	14,920	-	(14,920)	-	-
Total Long-Term Debt	$ 16,619,920	$ -	$ (2,074,920)	$ 14,545,000	$ -

During 2016, the District refinanced its Limited Tax-Revenue Bonds Series 2006 (the Bonds) with Promissory Notes, Series 2016 (the Notes). The District used the proceeds from the Notes of $17,625,000 and deposits restricted under the 2006 bond indenture to complete the refinancing. The Notes bear interest of 1.85% and 2.90% with the interest being payable semiannually on each January 1 and July 1 and principal being due in varying annual installments through December 31, 2031.The Notes are secured by the District's pledged revenues. As of December 31, 2019 and 2018, the District had made the principal payment due on January 1 of the subsequent year, thus there is no current portion of long-term debt shown in the financial statements.

Restrictive Covenants

Under the terms of the Promissory Notes, Series 2016 agreement, the District is required to maintain certain deposits with the lender. Such deposits are included in restricted cash under debt agreement on the statements of net position. The Promissory Notes agreement also requires that the District satisfy certain measures of financial performance including maintaining a debt-service coverage ratio of at least 1.25, have 90 days of cash on hand, and places restrictions on incurrence of additional debt. Management believes the District is in compliance with restrictive covenants at December 31, 2019.

NOTE 8 LONG-TERM DEBT (CONTINUED)

Scheduled principal and interest payments on bank loans are as follows:

	Promissory Notes, Series 2016	
Year Ending December 31,	Principal	Interest
2020	$ -	$ 327,417
2021	1,085,000	349,304
2022	1,105,000	328,767
2023	1,125,000	307,854
2024	1,140,000	282,219
2025 - 2029	6,250,000	880,523
2030 - 2031	2,780,000	82,663
Total	$ 13,485,000	$ 2,558,747

Capital Lease Obligations

The District was obligated under lease agreements for equipment that was accounted for as a capital lease obligations. The capital lease obligations required varying monthly payments at an interest rate of 3% through January 2018 and were secured by the leased equipment. The capital lease obligations were paid in full during fiscal year 2018.

NOTE 9 PENSION PLAN

The District has a money purchase pension plan (the Plan) covering all employees of the District immediately upon hire. The Plan was established by and can be amended by the authority of the District's board of directors. Employee contributions to the Plan vest immediately. Employer contributions to the Plan are currently set at 6.25% of eligible employee compensation. The employer contributions vest based on the following schedule: 25% based on less than a year of employment, 50% at one year of employment, 75% at two years of employment, and 100% at three or more years of employment. Distributions can be made by the participant from their vested account balance upon the participant reaching the age of 62 or terminating employment with the District. Total pension expense for the years ended December 31, 2019, 2018, and2017 was $1,480,807, $1,349,522, and $1,259,799, respectively.

NOTE 10 COMMITMENTS AND CONTINGENCIES

Risk Management

The District is exposed to various risks of loss from torts; theft of, damage to and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters other than employee health and workers' compensation claims. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

NOTE 10 COMMITMENTS AND CONTINGENCIES (CONTINUED)

Litigation

In the normal course of business, the District is, from time to time, subject to allegations that may or do result in litigation. The District evaluates such allegations by conducting investigations to determine the validity of each potential claim. Based upon the advice of legal counsel, management records an estimate of the amount of ultimate expected losses, which are not covered by insurance, if any. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

Malpractice Claims

The District pays fixed premiums for annual medical malpractice insurance coverage under a claims-made policy. The medical malpractice insurance coverage is subject to a $1 million per claim limit and an annual aggregate limit of $3 million. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term, but reported subsequently, would be uninsured. The District is not aware of any unasserted claims, unreported incidents, or claims outstanding, which are expected to exceed malpractice insurance coverage limits as of December 31, 2019. Further, the District is subject to the provisions of the Colorado Government Immunity Act, which provides a limitation on the liability of the District. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Employee Health Insurance

Substantially all of the District's employees and their dependents are eligible to participate in the District's employee health insurance plan. The District is partially self-insured for health claims of participating employees and dependents up to an annual aggregate amount of $75,000 per claim. Commercial stop-loss insurance coverage is purchased for claims in excess of the aggregate annual amount. A provision is accrued for self-insured employee health claims including both claims reported and claims incurred but not yet reported. The accrual is estimated based on consideration of prior claims experience, recently settled claims, frequency of claims, and other economic and social factors. It is reasonably possible that the District's estimate will change by a material amount in the near term.

Activity in the District's accrued employee health claims liability during 2019 and 2018 is summarized as follows:

	2019	2018
Balance - Beginning of Year	$ 319,000	$ 475,000
Current Year Claims Incurred and Changes in Estimate for Claims Incurred in Prior Years	3,410,908	3,607,957
Claims and Expenses Paid	(3,429,908)	(3,763,957)
Balance - End of Year	$ 300,000	$ 319,000

NOTE 10 COMMITMENTS AND CONTINGENCIES (CONTINUED)

Operating Leases

During fiscal year 2019 the District entered into a lease for the Urgent Care Clinic space. The lease starts in fiscal year 2020 and expires in fiscal year 2030 with an option to extend for an additional ten year period. A summary of future minimum operating lease payments are as follows:

Year Ending December 31,	Amount
2020	$ 239,956
2021	417,831
2022	426,188
2023	434,711
2024	443,406
Thereafter	2,523,333
Total	$ 4,485,424

Compliance

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Recently, federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously, billed and collected revenues from patient services. The District operates a Compliance Committee which reviews the operations of the District. The District records allowances where the government has shown a pattern of adjusting periodic reports submitted by the District, including Medicare cost reports or tax reporting, or where internal reviews indicate the possibility of future adjustments. Management believes that the District is in substantial compliance with current laws and regulations.

Other

In the normal course of business, there could be various outstanding contingent liabilities such as, but not limited to, the following:

- Lawsuits alleging negligence of care
- Environmental pollution
- Violation of a regulatory body's rules and regulations
- Violation of federal and/or state laws

No other contingent liabilities such as, but not limited to those described above, are reflected in the accompanying financial statements. No such liabilities have been asserted and, therefore, no estimate of loss, if any, is determinable.

NOTE 11 SUBSEQUENT EVENTS

Subsequent to year-end, the World Health Organization declared the spread of Coronavirus Disease (COVID-19) a worldwide pandemic. The COVID-19 pandemic is having significant effects on global markets, supply chains, businesses, and communities. Specific to the District, COVID-19 may impact various parts of its 2020 operations and financial results including but not limited to additional costs for emergency preparedness, disease control and containment, potential shortages of healthcare personnel, or loss of revenue due to reductions in certain revenue streams. Management believes the District is taking appropriate actions to mitigate the negative impact. However, the full impact of COVID-19 is unknown and cannot be reasonably estimated as of December 31, 2019.

In April 2020, the District received payments under the Medicare Accelerated and Advanced Payment Program (the Program) of approximately $4,400,000 to help with cash flow during the COVID-19 pandemic. Under the Progam these funds will start to be repaid 120 days after the funding is received and are to be repaid in full within a one year from the receipt of the accelerated payments. The District also received $702,000 under the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act) which is treated as a grant.

On March 30, 2020, the District entered into a promissory note payable with a financial institution for $2,500,000 to fund the construction costs related to the Urgent Care Clinic buildout. Starting April 30, 2021, monthly payments of $22,361 are due on the promissory note payable and they continue through March 30, 2031. Interest accrues at the Bank of Colorado Estes Park 12-month Public Funds Certificate of Deposit Rate plus 1% (1.1% as of the loan issuance date). The promissory note payable is secured by a certificate of deposit account held by the financial institution.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
BUDGETED AND ACTUAL REVENUES AND EXPENSES
YEAR ENDED DECEMBER 31, 2019
(SEE INDEPENDENT AUDITORS' REPORT)

	Actual	Budgeted	Favorable (Unfavorable) Variance
OPERATING REVENUES			
Net Patient and Resident Service Revenue	$ 48,337,074	$ 50,327,968	$ (1,990,894)
Other Revenue	727,677	875,430	(147,753)
Total Operating Revenues	49,064,751	51,203,398	(2,138,647)
OPERATING EXPENSES			
Salaries, Wages, and Employee Benefits	28,516,716	28,886,598	369,882
Other	23,777,594	22,261,824	(1,515,770)
Total Operating Expenses	52,294,310	51,148,422	(1,145,888)
OPERATING INCOME (LOSS)	(3,229,559)	54,976	(3,284,535)
NONOPERATING REVENUES (EXPENSES)	2,879,426	2,506,823	372,603
EXCESS (DEFICIT) OF REVENUES OVER EXPENSES	$ (350,133)	$ 2,561,799	$ (2,911,932)

NOTE TO SCHEDULE

Annual budgets are adopted as required by Colorado statutes. Formal budgetary integration is employed as a management control device during the year. Budgets are adopted on a basis that is consistent with accounting principles generally accepted in the United States of America.

Appropriations are adopted by resolution in total.

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Directors
Park Hospital District
dba: Estes Park Health
Estes Park, Colorado

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Park Hospital District dba: Estes Park Health (the District), which comprise the statement of net position as of December 31, 2019, and the related statement of revenues, expenses, and changes in net position, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated April 27, 2020.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the District's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Board of Directors
Park Hospital District
dba: Estes Park Health

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the result of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Denver, Colorado
April 27, 2020

ESTES PARK (PARK) HOSPITAL DISTRICT
May 5, 2020 Election Memo

To: Board of Directors, Park Hospital District

From: Sarah E. E. Shepherd, Designated Election Official

Date: May 13, 2020

Subject: May 5, 2020 Election Status and Filing

Dear Board:

Please find attached the Unofficial Abstract of Election Results. The candidates who received the highest number of votes on Election Day were: Diane Muno, William Pinkham, and Stephen Alper.

One (1) additional UOCAVA (Uniformed and Overseas Citizens Absentee Voting Act) ballot was received after election day and before the end of the day on May 13. Therefore, one additional vote was registered for the following candidates: Monty G. Miller (826), Aaron Alberter (673), and Stephen Alper (943). This change will be noted on the form for the Canvass Board to certify, but does not change the outcome of the election.

Oaths of office are requested to be administered and signed at this Board meeting or prior to June 4, so we can complete the filing of the full election results with the County Clerk's office, Division of Local Government and County Court office. All information and documents will submitted according to the Election Calendar.

I'm happy to answer questions as to the results during the board meeting. The counting and election overall was very positive, which a strong turnout.

Challenges that arose during the process were mostly related to work-from-home closures of offices, limited staffing such as newspapers and County officials working remotely, and many people having a lot on their . Everyone did their best to provide information and meet their obligations during what we hope is a unique election.

Thanks to the Board, candidates and electors for voting and carrying forward a very positive turn out, despite the unusual Covid-19 circumstances.

Thanks again to Vern, Randy and Sherrie and front door nursing staff for their efforts in issuing replacement ballots, confirming the drop off address with local voters, delivering the final ballot box contents to the election offices for counting. Thanks to the local post office for their cooperation, local newspapers, other officials and organizations for helping to disseminate voting information and logistics.

Once the final Oaths and filing has been completed, we will deliver the files to the hospital for retention. Thank you very much from all of us at Circuit Rider of Colorado for the opportunity to serve the Board, District and community.

Circuit Rider of Colorado, LLC
Mailing: P. O. Box 359 – Littleton, CO 80160 * Telephone: 303-482-1002 – Email: sees@ccrider.us

JUDGES UNOFFICIAL ABSTRACT OF VOTES FOR PARK HOSPITAL DISTRICT

For the regular election held for Park Hospital District on May 5, 2020.
Ballots counted for the following candidates (numeric only):

CANDIDATES FOR THREE 3-YEAR TERM	VOTES COUNTED
Monty G. Miller	825
Aaron Alberter	672
Stephen Alper	943
John Meissner	586
William (Bill) C. Pinkham	967
Diane L. Muno	1101
James (Jim) M. Murphy	552

Dated this 5th day of May, 2020.

Election Judge

Election Judge

Election Judge

Election Judge

Election Judge

Election Judge

Election Judge

PROCEDURAL INSTRUCTIONS: Use for either polling place or mail ballot election. Post immediately upon completion of the count and within 48-hours of the closing the polls in a conspicuous place that may be seen outside the building. C.R.S. 1-13.5-615

JUDGES' CERTIFICATE OF ELECTION RETURNS and STATEMENT OF BALLOTS MAIL BALLOT ELECTION

§1-13.5-613, C.R.S.

JUDGES' CERTIFICATE OF RETURNS:

IT IS HEREBY CERTIFIED by the undersigned, who conducted the election held in the Park Hospital District, in Larimer County, Colorado, on the 5th day of May, 2020, that after qualifying by swearing and subscribing to their Oaths of Office, they opened the polls at 7:00 a.m., and that they kept the polls open continuously until the hour of 7:00 p.m. on said date, after which they counted the ballots cast for Directors of said District and for any ballot issues and ballot questions duly submitted.

That the votes cast for Director of the District for a 3-year term were as follows (numeric and spelled out):

Candidate for Director	Total Votes Cast
Monty G. Miller	825 Eight hundred twenty-five
Aaron Alberter	672 Six hundred seventy-two
Stephen Alper	943 Nine hundred forty-three
John Meissner	586 Five hundred eighty-six
William (Bill) C. Pinkham	967 Nine hundred sixty-seven
Diane L. Muno	1101 one thousand one hundred one
James (Jim) M. Murphy	552 Five hundred fifty-two

*JUDGES' CERTIFICATE OF ELECTION RETURNS and STATEMENT OF BALLOTS, cont'd. MAIL BALLOT ELECTION

STATEMENT OF BALLOTS:

It is hereby identified and specified that (Numeric & Spelled Out):

TOTAL Number of Ballots Issued to Voters: 9735 Nine thousand seven hundred thirty-five

Total Number of Ballots Returned:

- Official Ballots: 2105 Two thousand one hundred five
- Unofficial Ballots: 0 Zero
- Substitute Ballots: 0 Zero
- Total Voted Challenged Ballots: 0 Zero
- **Total Returned/Cast Mail Ballots:** 2105 Two thousand one hundred five

Delivered to Voter, Not Cast:

- Returned, Undeliverable: 294 Two hundred ninety-four
- Spoiled: 28 Twenty-eight
- Rejected: 14 Fourteen
- Defective: 0 Zero
- Not Returned: 7894 Seven thousand Eight-four
- **Total, delivered and not cast:** 7336 Seven thousand Three-six

Not Delivered to Voter, Not Cast (Unused):

- **Total, unused:** 835 Eight hundred thirty-five
- **Total Mail Ballots Printed:** 10597 Ten thousand five hundred ninety-seven

Certified this 5th day of May, 2020.

Election Judge, Election Judge, Election Judge, Election Judge, Election Judge, Election Judge, Election Judge

*Instructions: Attach to Canvass Board's Official Abstract of Votes Cast.

ESTES PARK HEALTH

EPH COVID-19 Pandemic Update

May 18, 2020

OPEN FOR BUSINESS: Estes Park Health has been relentlessly planning for COVID-19 patients since the inception of the crisis. It's important for our community to know that, **despite all the challenges, we are open for business.** Our lab is open, our radiology suite is open, our rehab services are available, our wound clinic and coumadin clinic and infusion clinic, and more, are open and ready to help our community.

COVID HOTLINE REMAINS OPEN: If you have general questions about COVID-19, or want to ask what to do about potential exposure or symptoms, or other questions for EPH – call us, 24/7, at our COVID hotline at 970-577-4400. We're here to help.

TRANSFER TO THE AVAILABLE ICUs: There are Front Range ICU beds available for COVID-19 cases. What these means to EPH is that our strategy can continue to be identify, stabilize, protect – and transfer when appropriate to those Front Range facilities who are most capable of providing ICU service. As of May 14, Larimer Count shows four COVID-19 cases in Estes Park.

READY FOR A SURGE: Despite our plan to transfer COVID-19 patients to the Front Range while beds are available, we have created an environment that maximizes our ability to keep patients here IF there are no Front Range ICU rooms remaining. We have created six negative-pressure rooms for patient care, and we are working to transform three more Emergency Department rooms to negative pressure. We have also analyzed the whole building for additional options, made a variety of other changes to support the situation if it progresses, and we regularly walk through the processes to ensure we're ready at a moment's notice to get in gear if we do have a case or cases.

IMPACT OF RMNP OPENING MAY 27: Last week's press release indicated the RMNP will open on May 27, after Memorial Day, through a phased approach. They will be short of staff due to housing rules affected by COVID restrictions. Other businesses will continue to open in phased fashion. Our expectation is that there will be a major surge of people in town. We are working closely with the Town and other authorities to recommend that safety is the #1 consideration and that rules and regulations for social distancing, masking, and other protective measures are well-enforced.

CONTINUE TO SCREEN FROM HOME: One of the best safety measures you can take for all, if you are concerned that you may have COVID-19 symptoms, or that you might have been exposed, is to be screened over the phone (meaning "asked the key questions about symptoms and exposure to COVID-19"), from the safety of the home.

HEALTH OF HEALTHCARE WORKERS: Our greatest concern is always our patients' well-being. But our greatest internal concern is the health of our doctors, nurses, lab techs, pharmacists, surgery staff, radiology staff, and all the others who occupy the frontline at EPH and are therefore potentially subject to the greatest risk of exposure. All of the actions above, in addition to their other value and purpose, are also targeted to support the health of our healthcare workers and best equip us for the challenging times ahead.

ESTES PARK HEALTH

555 Prospect Ave. | P.O. Box 2740 | Estes Park, CO 80517

Forecasted Impact of COVID-19

	FORECAST FY 2020						
REVENUE	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**FY 2020 Forecast**	**Budget 2020**	**Variance**	**% Variance**
TOTAL OPERATING REVENUE	8,397,397	11,933,959	10,084,092	41,395,123	53,750,778	(12,355,655)	-23.0%
TOTAL OPERATING EXPENSE	13,344,859	13,924,859	13,924,859	55,999,191	57,079,435	(1,080,244)	-1.9%
OPERATING INCOME (LOSS)	**(4,947,462)**	**(1,990,900)**	**(3,840,767)**	**(14,604,068)**	**(3,328,657)**	**(11,275,411)**	**-338.7%**
Operating Margin	*-58.9%*	*-16.7%*	*-38.1%*	*-35.3%*			
Non-Operating Revenue	871,128	871,128	871,128	3,419,367	3,484,512	(65,145)	-1.9%
Non-Operating Expense	(16,780)	(16,780)	(16,780)	(62,925)	(72,840)	9,915	-13.6%
NON-OPERATING	854,348	854,348	854,348	3,356,442	3,411,672	(55,230)	
EXCESS REVENUES (EXPENSES)	(4,093,114)	(1,136,552)	(2,986,419)	(11,247,626)	83,015	(11,330,641)	
Gift to Purchase Capital Assets	400,000	-	-	400,000	300,000	100,000	33.3%
INCREASE (DECREASE) IN NET ASSETS	**(3,693,114)**	**(1,136,552)**	**(2,986,419)**	**(10,847,626)**	**383,015**	(11,230,641)	
Total Margin	*-44.0%*	*-9.5%*	*-29.6%*		*0.7%*		
EBIDA	**(2,797,760)**	**(241,198)**	**(2,091,065)**	**(7,380,863)**	**3,964,431**		

ASSUMPTIONS

Estes Park Health			
Assumptions - Forecast thru the COVID-19 Event			
May-20			
	May/June	**3rd Qtr**	**FY 2020**
Revenues	March '20 saw a 31% decline in Revenues, across the board. Accordingly 3rd Qtr results showed an 11% loss of Revenues. Notably in Medsurg, Emergency Dept, Surgery, Radiology, Lab and Rehab.	As time progresses thru the summer, and if luck holds up, expectations could yield a **potential recovery of 70%** by end of September.	By end of year, expectation (and hope) could allow for a **continued 80%** of average by end of the year.
	Expectations for April are approx 45% decline in Revenues		
	With the potential of a change in "Stay at Home" restrictions, EPH could potentially see a gradual increase in patient visits, currently estimated about 5% per week. Resulting in potentially up to **50% of average** (defined as budget) by end of June.		
Expenses	Through May, expenses are expected to remain normal, as was the promise to the staff. Funds are received from the PPP to cover payroll for an 8 week period. Other spending is closely monitored.	For July thru September, with Revenues anticipated at 70% of normal, the hospital will try to keep expenses at 80%. However forecasting budgeted expense.	The same for year end, if Revenues are 80% recovery, so should Expenses.
	For May and June, expectations are to reduce Salary costs by up to 10%, including several initiatives.		
	Contract Labor, other than Pediatric Call, is expected to be eliminated.		
Earnings	The second quarter is reporting a net loss of $3.8M.	Third Quarter forecasts a Net Loss of $1.5M	Fourth Quarter forecasts a net loss of $3.6M and a FY 2020 Loss of $12M
Earnings w/ Stimulus applied	As Stimulus funds		Year end expectations for net loss are between $5M and 7M.
Cash Flow	Loss of Cash thru March is $2M	Thru September Cash is expected to decrease by $5M. This does not include any Stimulus, APP or PPP funds.	End of year is expecting Days Cash on Hand to be aroun 125.
Impact of Stimulus Funds	Thru May 12, total funds received from Medicare and other Stimulus programs is $9.5M. However, as of this report, $4.4M must be repaid over 5 months beginning in August. There are efforts underway to request these funds be forgivable. Pending.	With an added infusion of $14M in cash, availability should not be a problem. However, much depends on the possibility of having to repay $4.4M.	Assuming a repayment of the $4.4M, and the Revenue and Expense projections are close, cash as end of the year will likely show a net loss of $4M, thus reducing Days Cash on Hand to somewhere near 120 days.
	The hospital was successful in obtaining a forgivable loan from the CARES Act and the Payroll Protection Program of $4.8M. This is specifically for covering Payroll costs for 8 weeks.		

ESTES PARK HEALTH

Human Resources Board Report
May 18, 2020

Engagement scores from 2/2020

Employee (75%)	2018	2019
Overall engagement	3.99	4.04

Physician (EPH 85%)	2018	2019
Overall engagement	3.78	4.17

Urgent Care Staffing

- Positions filled; special New Employee Orientation sessions conducted

COVID-19 related items

- Employee support
  - Modified PTO/ESL plan to allow access to accrued hours more easily
  - Exposure shelter availability at YMCA
  - Childcare resources at YMCA
  - Virtual stress management sessions with local EAP provider
- Expense reduction and monitoring
  - Reduce/Eliminate contract labor
  - Re-assess of all current posted openings

Living Center Administrator

- Matt Gordon – previous interim administrator, begins 5/26/2020

Item 8.8

ESTES PARK HEALTH

QUALITY BOARD REPORT

MAY 18, 2020

Patient Safety

- The Living Center continues to monitor falls
- Inpatient Medication Management
- Covid-19 training
- EPH Weekly News Safety Corner:
- Medication Scanning, Hand Hygiene
- Good Catch Award:
- 1Q20 Lab and HHC staff

ESTES PARK HEALTH

Performance Improvement

NRC

CAHPS surveys for Inpatients and Home Health Care

- Implementation complete
- Data now available

Real Time Feedback for Emergency Department and all Outpatient Services including Physician's Clinic

- Good feedback received with increase in comments compared to Press Ganey.
- Leaders learning to use the tool.

ESTES PARK HEALTH

Performance Improvement cont

Colorado Health Care Policy and Financing (HCPF) plan for Hospital Transformation Program

Program has been put on hold due to Covid-19 priorities

Six Measures have been identified and approved by SLT

ESTES PARK HEALTH

DNV Survey and Plan of Correction

- Survey went well overall
- 1 NC-1 nonconformity requiring submission of evidence of correction.
- 9 NC-2 condition level tags to be reviewed at the next survey March 2021
- ISO Stage 1 Audit Report expected for ISO certification in 2021

ESTES PARK HEALTH

ESTES PARK HEALTH

Questions?

Park Hospital Board of Directors –QUALITY REPORT May 18, 2020

Data/ Analytics:

Estes Park Health's 2019 Excellence Dashboard is attached for review.

Regulatory data of the organization's mortality rate is outlined. Note: these rates are "all cause"; inpatient deaths and discharges include medical, surgical, pediatric, and OB patients as well as newborns. This inpatient rate does not include observation and swing bed patients. Quality does provide a mortality report to the Quality Management Council twice a year.

- IP Mortality rate
    - For 1Q20: 46.0 (4)/1000 patient discharges
    - All 4 mortalities 2020 year to date were comfort care/DNR. Review did not identify any clinical opportunities.
- ED mortality rate
    - For 1Q20 0.0/1000 ED discharges

Patient Safety:

The Patient Safety Committee reviews all safety events monthly and identifies further actionable follow up when needed. For 1Q20 79 safety events and associated follow up were reviewed with an evaluation for trends by type, unit and harm level. Staff take less than 7 minutes on average to submit an event. A monthly "Good Catch" award is also identified on a routine basis (1Q20 recognized HHC staff) and monthly Safety Corner articles published in the employee EPH Weekly News. The Safety Corner article provides safety event feedback to staff.

Performance Improvement:

The Quality Department continues to work with 1 PCS Work Group on Moderation Sedation which should be complete by May 1, 2020.

EPH has changed patient satisfaction survey vendors in collaboration with the Epic implementation. The conversion was delayed in part due to an NRC cryptovirus attack in January 2020 as well as issues with file development (UCH) and NRC implementation. Real Time Feedback for outpatient areas were surveyed back to January 1st at the request of leadership with over 1900 responses as of May 4th providing a very robust data set for evaluation. Additionally, there appears to significantly more patient comments available (450) with great value for department directors Approximately 6% of the comments are flagged for review. NRC CAHPS data is now available for Home Health, Hospice and Inpatients. CAHPS reporting is challenged by small survey size.

Colorado's Medicaid Hospital Transformation Program (HTP) has been put on hold until further notice due to the COVID-19 outbreak. Six measures have been identified for the program.

Colorado's Hospital 2020 Quality Improvement Project (HQIP) is still scheduled for reporting. Submission timeline is open from May 1st-June 30th for 2019 data and process reporting. The measures are categorized under Perinatal and Maternal care, Patient Safety, and Patient Experience. Additional new self-reported measures have been put on hold until 2021 due to COVID-19 (Sepsis, Antibiotic

Stewardship, Handoffs/Care Transitions). Measure scoring will be completed late summer with facility notification in October. Calculated facility payments are attached to provider payments.

Accreditation:

DNV-GL surveyors were on-site March 3-4, 2020. The survey went very well with positive feedback from surveyors overall. Prior nonconformities for facilities and grievances were resolved but one for restraints was continued. A total of 9 issues were tagged but none were NC-1 condition level. Facilities will have one nonconformity requiring submission of evidence of correction with the remainder being reviewed at the next survey in March 2021. The survey also provided an ISO Stage 1 Audit Report with 3 main areas for improvement prior to ISO certification in 2021. An expansion of the internal audit program needs to be developed based on 2020 DNV survey findings.

Risk Management:

1Q20 noted grievances were investigated and on time follow up conducted. Additionally, 18 complaints (billing). A number of these were related to an Epic ED charge level issue that was identified and subsequently corrected.

One root cause analysis was conducted in February 2020. Follow-up action items have all been completed.

2019 EPH Excellence Dashboard

There is limited data in several dashboard metrics due to two principal reasons: the conversion to Epic and Department Directors struggle to get comparable data and COVID-19. The majority of departments will continue with their 2019 quality metrics, but several have identified new opportunities to assess including surgical services, physician clinic and diagnostic imaging.

Park Hospital Board of Directors –QUALITY REPORT May 18, 2020

Estes Park Health 2019 Excellence Dashboard								
MEASURE (Items in red: New & in development for 2019)	Preferred Direction	2018	Benchmark OR Goal	1Q19	2Q19	3Q19	4Q19	Notes
Highest Quality								
Laboratory Services								
Blood Utilization Review	↑	80%	90%	94%	88%	90%	90%	
Wrong orders where patients have to be credited	↓	28	0	1	0	0	0	
Emergency & Trauma Services								
Cardiac Aircat Door in Door out - median in minutes	↓	46	≤ 60min	n/a	60	41		not available
Stroke Door to result time CT - percent within 45min	↑	79%	≥90%	86%	83%	75%		not available
ED Door to Doc time <30min - % met	↑	95%	≥95%	95%	94%	95%		not available
Inpatient Med-Surg Unit								
Fall rate w/injury/1000 patient days	↓	0.7	0	0	0	0	0	
Pressure ulcer incidents/1000 patient days	↓	5.1	0	0	0	0	0	
Patients who reported that staff "Always" explained about medicines before giving it to them	↑	66%	≥67%	49%	56%	60%	n/a	CAHPS Top Box Score by response received date .PI project underway.
Living Center								
Antipsych Med(L) %	↓	22%	≤14%	27%	27%	30%	26%	
Excess Weight Loss(L) %	↓	12%	≤8%	8%	7%	8%	7%	
Infection control								
Overall Hospital Acquired Infection rate %	↓		0%					
Catheter-associated Urinary Tract Infection Rates /1000 urinary catheter days (CAUTI cases)	↓		0	0	0	0	33	1 CAUTI for 30 cath days
Living Center Acquired Urinary Tract Infections/1000 Resident Days	↓		0			3.7	5.7	
Utilization Review								
IP Average Length of Stay (LOS) - measured in days	↓	2.5	<4	2.6	2.7	1.9	2.3	
% Observation Length of Stay >48 hr	↓	13%	<10%	16%	6%	14%		
30 d all cause re-admission rates %	↓	5%	≤10%	4%	6%	0%		
Facilities Management/Safety								
Campus slips, trips & falls	↓	13	0	5	4	1	1	Count of employees & Visitors
Patient Satisfaction								
Quietness of hospital environment (IP)	↑	63%	≥64%	41%	58%	71%	n/a	HCAHPS Top Box (received date) . (state avg=64%) for inpatient
Cleanliness of hospital environment (IP)	↑	83%	≥77%	57%	75%	81%	n/a	HCAHPS Top Box (received date) . (state avg =77%) for inpatient
Birth Center								
Breast feeding initiation rates	↑	97%	90%	96%	100%	96%	96.0%	
Primary Cesarean section rate of term nulliparous (first baby) singleton (single fetus) in the vertex (head down)	↓	14%	≤23.9%	17%	0%	17%	13.3%	
Pharmacy								
Anticoagulation Education by Pharmacy Staff % (inpatient)	↑	87%	100%	95%	95%	92%	n/a	
INR (measure of clotting ability - to prevent blood clots) at Goal %	↑	57%	80%	48%	62%	62%	62.0%	
Medication safety??								
Surgical Services/OR								
Surgical Site Infection	↓	0.3%	0%	0%	0%	0.3%	0.0%	
Prophylactic Antibiotic received within 1 hour prior to surgical incision %	↑	96%	100%	98%	89%	92%	n/a	
EMS (Ambulance Services)								
Total Calls	↑	2120		410	523	794	479	
% of calls beyond on-duty resources	↓	4.0%	0%	4%	3%	7.6%	1.46%	
% of transfers	↓	25%		26%	24%	25%	28%	
Physician Clinic								
% of Diabetics with HbA1c>9	↓	50%	26%	55%	53%	48%		not available
% of Patients with BMI in "healthy range" (NQF Measure)	↑	57%	50%	61%	62%	61%		not available

Park Hospital Board of Directors –QUALITY REPORT May 18, 2020

% of Diabetics with LDL Cholesterol <100	↑	25%	53%	20%	21%	21%		not available
% of hypertensive patients with BP <140/90	↑	72%	73%	72%	72%	75%		not available
Diagnostic Imaging Services								
Overuse of ordering double/combination CT scans (Abdomen & Chest)	↓	6%	<3%	5%	3%	2%	6.0%	National average - 0.45%
Inappropriate Utilization of Imaging resources	↓	2%	<1%	7%	4%	3%		
Critical Result Reporting time (in min)	↓	14	<30min	15	10	10	10	Tracking only
Stat orders (unwarranted)	↓	90%	<5%	92%				Will be resumed after EPIC go live

ESTES PARK HEALTH

Quality Department Plan 2020

Approvals:

Patient Care and Safety: 2/11/2020

Quality Management Committee: 2/18/2020

Park Hospital District Board:

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ESTES PARK HEALTH MISSION & VALUES

"We exist to make a positive difference in the health and wellbeing of all we serve". The Mission is supported by the five values of:

- Safety
- Excellence
- Respect
- Integrity
- Stewardship

QUALITY DEPARTMENT VISION

The Quality Department Vision is that all members of the organization adopt Safety and Quality as their personal mission and come together as a team to place patients and other customers first. Operating with proven approaches such as High Reliability Principles all employees are focused on providing quality and value in everything they do.

OUR PURPOSE – QUALITY DEPARTMENT

Our Purpose is to build a Quality Management System that supports Estes Park Health in consistently delivering excellent patient outcomes. We achieve this by using the suite of Quality Management methodologies in a planned, systematic, organization-wide approach to monitoring, analysis and improvement of organizational performance; and delivery of value to our patients and our community.

LONG-TERM GOAL FROM 2019 QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT/ PATIENT SAFETY (QAPIPS) PLAN

The goal of the 2019-2020 QAPIPS plan is to support the mission of EPH by providing the highest level of Quality Services to all customers. This overarching goal will remain in place for 5 years and Strategic Goals for the Quality Department will be developed as "Short Term" goals to meet this overarching Quality Plan Goal.

ESTES PARK HEALTH

STRATEGIC PRIORITIES, STRATEGY AND TACTICS

STRATEGIC GOAL/PRIORITY #1 **Enable the highest Quality and Value to all Customers (internal and external)**		
Rationale: The Quality Department's long term goal is to support the mission of Estes Park Health by providing the highest level of Quality Services to all Customers. The Donabedian Quality Triad of "Structure, Process, Outcomes" provides the Strategic Framework to achieve this goal. Senior Leadership's commitment to Quality a strategic approach, underpinning the work of the individual and the organization is vital for attaining this goal. Significant progress was made utilizing this approach) and ongoing work toward this 5 year long-term goal remains the #1 Strategic Goal in 2020 as well.		
STRATEGY	**TACTICS**	**TIMEFRAME**
Hardwire the 2019 Quality work executed utilizing Strategic Framework (Quality Triad – Structure, Process, Outcomes)	1. Continue to support teams, refine processes, develop data analysis and reporting capabilities, apply the suite of quality methodologies where needed to hardwire proven approaches to improvement. 2. Provide just in time training on PDSA when needed. Utilize Root Cause Analysis and Event Debriefs to identify real time process opportunities. 3. Continue Quality/PI/PS presentations at new employee orientation and review of safety event reporting system. 4. Support Quality Management Committee, Patient Care and Safety Committee, Quality Subcommittee of the Board and quarterly Park Hospital District Board reports. 5. Support department quality/regulatory updates at QMC and quality measure run charts. 6. Support Antibiotic Stewardship Program as appropriate. ABS will report function, activities, intervention implementations, and education efforts through Infection Prevention reporting to Patient Care and Safety Committee. 7. To engage LTC in EPH Quality structure and reporting.	Throughout 2020
Hardwire DNV Accreditation and prepare for ISO	1. Lead teams and provide support for Corrective Action Plans as needed. 2. Continue staff education about ISO 9001:2015 Quality Management System in order to ensure any changes made with regard to Quality alignment with required ISO standards. 3. Validate commitment to DNV accreditation and ISO journey with new CEO and SLT. 4. Initiate internal audit program and continue ECRI risk assessments for a variety of processes/areas. 5. Provide random sample checks on prior survey tags and convene survey prep work group. 6. Support mock accreditation/conditions of participation walk through of Urgent Care Center. 7. Representatives to attend DNV symposium yearly.	**CAP** – next survey March 2020 **ISO** – throughout 2020
Epic Implementation Project	1. Continue to work with Epic/UCH to ensure Estes Park Health has the reporting capabilities from the EPIC system needed to support the delivery of Quality across the entire organization and meet external reporting requirements. 2. Support random chart checks on restraint orders/documentations, pain assessments and care plan individualization.	**Monitoring** – Post Implementation

Adopt the philosophy of TQM as important for the organization to succeed in fulfilling its' mission	1. Obtain ongoing commitment to Quality – culture growth/change; engage new CEO in discussions to understand their vision for organization's \quality program. 2. Lay the ground-work for TQM 3. Educate on relationship with ISO 4. Adopt key principles prior to formal TQM implementation work 5. Provide structure to Senior Leadership to facilitate system-wide TQM Commitment 6. Determine a timeframe for adoption of TQM (after the final work for initiatives such as EPIC, ISO etc. have been implemented – 5 year goal) 7. Continue to provide all opportunities to develop the Culture of Quality throughout the organization.	**Commitment** to TQM – 2021 **Education** – First Quarter 2021 **Adoption** – Ongoing through 2021 PRN

STRATEGIC GOAL/PRIORITY #2

Support the Growth and Development of Strategic Service Lines by accelerating adoption of all quality methodologies and all components of the Strategic Framework in these areas.

Rationale: Focus Quality Resources on the Key Service Lines with the highest potential to bring customers and increase market share to maintain the organization as sustainable, vibrant and financially stable in the increasingly competitive and resource limited world of healthcare; as well as keeping the organization strong, independent and community owned. Execute full implementation of the Strategic Framework for Quality (Structure, Process and Outcomes) in these areas before the rest of the organization.

STRATEGY	TACTICS	TIMEFRAME
Support Urgent Care – develop Quality functions simultaneously, while utilizing Risk Management methodologies to mitigate challenges	1. Ensure Urgent Care has all Quality Methodology in place to support effective processes, and data and information/reporting as necessary. Support Community Paramedic Program under the facility Quality umbrella. Assist with development of quality metrics and reporting to Quality Management Committee. Add Urgent Care representative to Patient Care and Safety Committee. 2. Utilize Risk Management Methodology to support Urgent Care implementation – provide methodology for team to evaluate and mitigate risk effectively. UCC added to facilities life safety rounding to assess risk areas.	January 2020 – ongoing throughout life of the project
Support Strategic Service Line Development – develop all applications of quality appropriate for each Medical Staff Council	1. Utilize the Strategic Framework methodology to ensure all quality methodologies are in place to support the Medical Staff Councils: Perioperative Council, Birth Center Council, Emergency Services Council, Med Surg Leadership Council and Outpatient Medicine Council. 2. Facilitate Council reporting at Quality Management Committee.	January 2020 – ongoing as scheduled

STRATEGIC GOAL/PRIORITY #3 **Raise individual and community awareness of the High Quality healthcare and Value provided at Estes Park Health**		
Rationale: To demonstrate, though a variety of communication modalities, the Quality of Care and Value provided at Estes Park Health in support of the organization's strategic goal to remain sustainable, vibrant, independent, and financially stable in the increasingly competitive and resource limited world of healthcare.		
STRATEGY	**TACTICS**	**TIMEFRAME**
Provide Quality Information on the Website	1. Maintain data displayed on the website – quarterly updates 2. Showcase key service line Quality 3. Showcase Access to Care improvement activities	**Website** – TBD with Epic implementation 2Q2020 **Physician Quality** – 2Q2020 – after EPIC implementation **Service Line Quality** – Refer to department quality indicators for 2020 **Access to Care Improvement** – NRC Real Time Feedback February 2020
Focus on real-time solutions to complaints, thereby minimizing the number of grievances and improving opportunities for service recovery.	1. Utilize Huddle to identify any customer/patient satisfaction issues 2. Resolve grievances quickly with personal contact as appropriate 3. Utilize Service Recovery methodologies	**Huddle** – 3Q2020 **Complaints/Grievance/Service Recovery** – ongoing

VALUE CREATED WITH THIS STRATEGY

The Strategic Priorities of the Quality Department presented in this document create Value for the organization in the following ways:

Strategic Priority #1 – Enable the highest Quality and Value to all customers (internal and external)

- Measurable, proven methodology to assure and ensure Quality within the organization that is stainable over time and leadership change
- Developing a workforce focused on Quality
- Implementing an internationally recognized Quality Management System, proven to improve quality management (ISO 9001:2015)
- A leadership and management approach to long-term success through customer satisfaction

Strategic Priority #2 – Support the Growth and Development of Strategic Service Lines.

- Service line personnel are able to utilize the full range of quality methodologies to deliver high quality outcomes and value to their customers
- Effective processes and improvement methodology
- Additional support from the Quality Department to empower service lines to embed quality principles in all their work, utilize data for decision making and drive quality outcomes
- Employ quality and project management expertise to accelerate process improvement and provide more value to the customer
- Conduct risk assessments to identify areas of focus

Strategic Priority #3 - Raise individual and community awareness of the high quality healthcare and value provided at Estes Park Health

- Inform the community of the organization's efforts to provide the highest quality of care, providing a positive focal point for discussion of hospital activities including community educational programs and leadership presentations to local service groups
- Improved speed of resolutions and complaints – to real time, where opportunities for service recovery are more fruitful
- Identify value and high quality care provided at the organization
- Provide information about quality rather than a void

CORE CAPABILITIES AND NEEDS FOR SUCCESS

There is a range of Core Capabilities needed to ensure success of this plan. These are listed below in no particular order:

- Team member commitment to the Mission, Vision, Values and Goals and everyday execution of them with full Quality department staffing including Director and Quality Analyst
- Flexibility and Teamwork
- Willingness to learn and grow skill sets
- Ability to maintain the Quality Philosophy (TQM) in all we do
- Ability to flex and work in any area of the Quality Department functions
- Project Management skills
- Process analysis and redesign methodology sills
- Data analysis, metrics and reporting skills
- Change Management Skills
- Ability to alter plans, build a new approach quickly when needed
- Ability to Motivate and Encourage
- Ability to implement and sustain process, practice and culture change

Tele - Town Hall:

Estes Park Health Policy on Colorado End of Life Options Act

Wednesday May 13, 2020 6:00 pm

Webinar link https://attendee.gotowebinar.com/register/7006930724808599054
United States: +1 (415) 655-0052
Access Code: 821-599-023
Audio PIN: Shown after joining the webinar

Agenda

1. Tele - Town Hall Procedures
2. Privacy & Confidentiality
3. Introduce Estes Park Health (EPH) Attendees
4. Brief Overview of Colorado End of Life Options Act (CEoLOA)
5. Estes Park Health and CEoLOA
6. Colorado’s 3-Year CEoLOA experience
7. Comments and Questions and Answers

1. Tele – Town Hall Procedures

- Gary Hall will manage comments and questions
- Use “Chat” or “Raise Hand” for comments or questions
- Do not wait to comment or to ask questions, submit immediately
- Chat or Raise Hand will generally be addressed in order received
- Gary Hall may combine similar questions

2. Privacy & Confidentiality

- CEoLOA: Doctor-patient relationship privacy & confidentiality
- CEoLOA: Protections for patients, healthcare providers, and others
- Please omit references to any information that could break privacy or confidentiality

3. Estes Park Health Attendees

- Board of Directors: Sandy Begley, Monty Miller, Diane Muno, Bill Pinkham, David Batey, Director-Elect Steve Alper

- CEO Vern Carda, Chief Nursing Officer Pat Samples,
- Chief of Staff Dr. John Meyer,
- EPH Living Center Medical Director Dr. Amanda Luchsinger

4. Brief Overview of CEoLOA

- CEoLOA authorizes an individual who satisfies the statute's requirements to request aid-in-dying medication, to fill the prescription, and to self-administer the medication.
- Requirements:
    - Colorado resident adult
    - Terminal diagnosis prognosis of 6 months or less
    - Mental capacity to make & communicate an informed decision
    - Able to self-administer aid-in-dying medication
    - And satisfy many other requirements

4. Brief Overview of CEoLOA

- CEoLOA takes place within the privacy and confidentiality of the doctor-patient relationship
- CEoLOA provides privacy & confidentiality protections for all involved
- Patient and Provider choice to participate or not participate is voluntary
- CEoLOA prohibits any adverse organizational consequences of the choice to participate or not participate in CEoLOA activities

5. EPH and CEoLOA

- Estes Park Health offers patients a full range of End-Of-Life Journey options including services addressing
    - Colorado Advance Directive
    - Pain Management
    - Palliative Care
    - Hospice
    - Colorado End of Life Options Act
    - And others

5. EPH and CEoLOA

- All EPH medical staff who may have direct involvement in CEoLOA activities (Primary Care and potentially involved specialties) will:

  - Provide information on CEoLOA

  - Provide CEoLOA referrals if requested

  - Some EPH medical staff who may have direct involvement in CEoLOA activities are willing to act as an attending or consulting physician for patients pursuing CEoLOA actions

5. EPH and CEoLOA

- EPH CEoLOA Policy does not permit self-administration of aid-in-dying medication on Estes Park Health premises including:
- The Emergency Department
- The Inpatient Hospital
- The Estes Park Health Living Center (EPHLC)
    - EPHLC is a skilled nursing facility
    - EPHLC is a group home without privacy of a private residence

5. EPH and CEoLOA

- According to the EPH Living Center (EPHLC) Medical Director:
- There are 28 patients currently in EPHLC
- None of the 28 would qualify for CEoLOA based on requirements
- CEoLOA requires (among others)
  - Mental capacity to make an informed decision
  - Ability to self-administer the aid-in-dying medication
- All 28 patients or those responsible for them have accepted EPH CEoLOA Policy prohibition on taking aid-in-dying medication in EPHLC

6. Colorado 3-Year CEoLOA Experience

- In 2019, for those requesting prescriptions
  - Median age 72 (range mid 20's to upper 90's)
  - 62.5% Cancer, 19.2% Neurological, 7.9% Cardiovacular, 5.8% Pulmonary, 4.6% Other

- In 2019, for those who died following prescription
  - 82.6 % died in a residence
  - 83.5% died under hospice care

6. Colorado 3-Year CEoLOA Experience

Colorado End-Of-Life Options Act Statistics				
	2017	2018	2019	2017-19
Number of patients Prescribed Aid-in Dying Mediction	72	123	170	365
Number of Patients Dispensed Aid-in-Dying Medication	56	85	129	270
Percent of Patients Prescribed Aid-in-Dying Medication that had the medication dispensed	77.8%	69.1%	75.9%	74.0%

6. Colorado 3-Year CEoLOA Experience

CO, WA, OR End-Of-Life Prescriptions Statistics			
	2017	2018	2019
Colorado State Population (3 yrs experience)	5,612,000	5,691,000	5,759,000
Number of patients Prescribed Aid-in Dying Mediction	72	123	170
Rate Aid-in-Dying Medication Prescriptions per 100k	1.28	2.16	2.95
Washington State Population (11 yrs experience)	7,423,000	7,524,000	7,615,000
Number of patients Prescribed Aid-in Dying Mediction	212	267	July 2020
Rate Aid-in-Dying Medication Prescriptions per 100k	2.86	3.55	
Oregon State Population (22 yrs experience)	4,144,000	4,182,000	4,218,000
Number of patients Prescribed Aid-in Dying Mediction	218	249	290
Rate Aid-in-Dying Medication Prescriptions per 100k	5.26	5.95	6.88
	Generally 3 to 7 per 100k population		

7. Comments and Questions

- Use “Chat” or “Raise Hand” options
- Gary Hall will give you access to the Town Hall
- Another opportunity for public comment on EPH CEoLOA Policy at EPH Board meeting Monday 18-May 4:00 pm

ESTES PARK HEALTH

POLICY and PROCEDURE

Department: Administration

Creation Date: 26-Jan-2019
Review Date:
Revise Date:

Policy Title: Colorado End of Life Options Act
(Patient's request for medical aid in dying)

PURPOSE:

The Colorado End of Life Options Act (C.R.S § 25-48-101, et seq.) authorizes medical aid in dying and allows a terminally ill adult with a prognosis of six months or less, who has mental capacity, has made an informed decision, is a resident of Colorado, and has satisfied other requirements, to request and obtain a prescription for medical aid in dying medication for the purpose of shortening a prolonged dying process through self-administration of the aid-in-dying medication to end his or her own life in a peaceful manner.

The purpose of this policy is to describe the position of Estes Park Health regarding the End of Life Options Act, including participation of physicians employed or under contract, to describe the requirements and procedures for compliance with The Colorado End-of-Life Options Act, and to provide guidelines for responding to patient requests for information about aid-in-dying medications in accordance with federal and state laws.

The requirements outlined in this policy do not preclude or replace other existing policies, including but not limited to Colorado End-of-Life Options Act, Hospice; Medically Inappropriate Treatment (Futility); Spiritual Care of Patients; Hospice Scope of Service; Healthcare Ethics Committee; Patient Rights Ethical Issues, Nursing; Patient Rights and Responsibilities; Do Not Resuscitate; Advanced Directives; Treatment of Pain, Nursing; Informed Patient Consent; referenced herein.

POLICY:

1. The Colorado End-of-Life Options Act (herein after the "Act") allows adult (18 years or older) terminally ill patients, with capacity to make health care decisions, seeking to mitigate suffering and shorten a prolonged dying process, to request aid-in-dying medications from an attending physician. These terminally ill patients must be Colorado residents (as defined herein) who will, within reasonable medical judgment, die within 6 months. Patients requesting an aid-in-dying medication must satisfy all requirements of the Act in order to obtain the prescription for that medication. Such a request must be initiated by the patient and cannot be made through utilization of an

Advance Health Care Directive, Physician Orders for Life-Sustaining Treatment or other document. It cannot be requested by the patient's surrogate.

2. Estes Park Health respects the privacy of the Health Care Provider-Patient relationship and expects that any discussion of, or participation in the Act will be kept private and confidential.
3. Estes Park Health neither encourages nor discourages participation in the Act. Only those providers who are willing and desire to participate should do so. Any participation or refusal to participate in the Act by Estes Park Health physicians, employees, or patients is entirely voluntary, and Estes Park Health will not penalize an individual for participating in, or refusing to participate in the Act. An Estes Park Health physician, staff, or employee that elects not to engage in activities authorized by the Act is not required to take any action in support of a patient's request for a prescription for an aid-in-dying medication, including but not limited to, referral to another provider who participates in such activities.
4. Estes Park Health is more than an Acute Care Hospital. Estes Park Health includes services delivered outside of the Acute Care Hospital: Long-term Residential Care in the Estes Park Health Living Center, and Home Health and Hospice.
5. Estes Park Health permits the ingestion or self-administration of an aid-in-dying medication outside of Estes Park Health premises, including within a patient's home. Estes Park Health premises include the Acute Care Hospital (Emergency Department, Inpatient Hospital), and the Estes Park Living Center.
6. Estes Park Health does not permit ingestion or self-administration of an aid-in-dying medication on any Estes Park Health premises including the Acute Care Hospital (Emergency Department, Inpatient Hospital), and the Estes Park Living Center.
7. If an Estes Park Health patient in the Acute Care Hospital or the Estes Park Living Center wishes to ingest or self-administer an aid-in-dying medication, Estes Park Health will cooperate with the patient in transfer to another facility of the patient's choice. The transfer will promote continuity of care. Upon request, Estes Park Health will transfer a copy of the patient's medical record to the new health care provider/facility.

PROCEDURE:

1. Written notice of this policy will be included in the admissions paperwork filled out by every Estes Park Health patient. This policy will also be communicated by other means intended to provide advance notification of this policy, including posting on the Estes Park Health website.
2. When a patient makes an inquiry about or requests access to activities under the Act, initially, the patient will be given a copy of this policy and then will be referred to an organization or individual that is well versed in the requirements of the Act. The organization or individual will assist the patient in understanding of the Act, inform them about the process and provide educational material related to the patient's end-of-life options. This activity will augment, but not substitute for, the obligations of the attending and consulting physicians' roles described herein. If the patient's current physician chooses not to participate in the Act, which is his or her right under the Act, the organization or individual will make an effort to identify a physician who will participate in the Act with the patient.
3. Estes Park Health will notify employed and contracted physicians and other health care providers of this policy. All other Estes Park Health employees and contractors will also be notified of this policy.
4. If a patient brings medical aid-in-dying medication into the Estes Park Health Acute Care Hospital setting and the patient's possession of such medication becomes known to any Estes Park Health personnel, the personnel shall inform the attending physician of the fact, and the attending physician shall at the next convenient opportunity inform the patient that the Patient may not ingest or self-administer aid-in-dying medication in the Acute Care Hospital. The physician will request that the patient relinquish such medication, which will be kept securely, and will be returned to patient upon patient's request at some point during the process of discharging or transferring the patient out of the Acute Care Hospital.
5. In the absence of a legal Do Not Resuscitate order, or a CPR directive in a Living Will document, standard acute poisoning protocols will be used to respond to an individual who ingests or self-administers an aid-in-dying medication on any Estes Park Health premises including the Acute Care Hospital and the Estes Park Living Center. Standard acute poisoning protocols will also be used to respond to an individual who arrives at Estes Park Health premises having ingested or self-administered an aid-in-dying medication.
6. Estes Park Health physicians and other health care providers may, if they choose, and as applicable and as defined in the Act and herein:
    a. Perform the duties of an attending physician.
    b. Perform the duties of a consulting physician.
    c. Perform the duties of a mental health specialist.

d. Prescribe medications under this Act.
e. Participate in patient or provider support related to the Act.

7. Other than Physicians, who may choose to be present, Estes Park Health employees will not be present during the actual ingestion or self-administration of an aid-in-dying medication.
8. Estes Park Health may provide oversight and may review records to the extent necessary to ensure all requirements of the law have been followed and the correct documentation completed and submitted to the Colorado Department of Public Health and Environment.

9. **Right to request medical aid-in-dying medication**:
    a. An adult resident of Colorado may make a request, in accordance with sections 25-48-104 and 25-48-112, to receive a prescription for medical aid-in-dying medication if:
    b. The individual's attending physician has diagnosed the individual with a terminal illness with a prognosis of six months or less;
    c. The individual's attending physician has determined the individual has mental capacity; and
    d. The individual has voluntarily expressed the wish to receive a prescription for medical aid-in-dying medication
    e. The right to request medical aid-in dying medication does not exist because of age or disability.

10. **Request Process – Witness requirements.**
    a. In order to receive a prescription for medical aid-in-dying medication pursuant to the Colorado End of Life Options Act, an individual who satisfies the requirements in Section 25-48-103 must make two oral requests, separated by at least fifteen day, and a valid written request to his or her attending physician
    b. To be valid, a written request for medical aid-in-dying medication must be:
        i. Substantially in the same form as set forth in Section 25-48-112;
        ii. Signed and dated by the individual seeking the medical aid-in-dying medication;
        iii. Witnessed by at least two individuals who, in the presence of the individual, attest to the best of their knowledge and belief that the individual is:
        iv. Mentally capable;
        v. Acting voluntarily; and
        vi. Not being coerced to sign the request.
        vii. Of the two witnesses to the written request, at least one must not be:

viii. Related to the individual by blood, marriage, civil union, or adoption;
ix. An individual who, at the time the request is signed, is entitled, under a will or by operation of law, to any portion of the individual's estate upon his or her death; or
x. An owner, operator, or employee of a health care facility where the individual is receiving medical treatment or is a resident.
xi. Neither the individual's attending physician nor a person authorized as the individual's Qualified Power of Attorney or Durable Medical Power of Attorney shall serve as a witness to the written request.

11. **Right to rescind request – Requirements to offer opportunity to rescind**
    a. At any time, an individual may rescind his or her request for medical aid-in-dying medication without regard to the individual's mental state.
    b. An attending physician shall not write a prescription for medical aid-in-dying medication under the Colorado End of Life Options Act unless the attending physician offers the qualified individual an opportunity to rescind the request for the medical aid-in-dying medication.

12. **Attending physician responsibilities**: The attending physician shall:
    a. Make the initial determination about whether an individual requesting medical aid-in-dying medication has a terminal illness, has a prognosis of six months or less, is mentally capable, is making an informed decision, and has made the request voluntarily;
    b. Request that individual demonstrate Colorado residency by providing documentation as described in section 25-48-102(14);
    c. Provide care that confirms to established medical standards and accepted medical guidelines;
    d. Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis and for a determination of whether the individual is mentally capable, is making an informed decision, and acting voluntarily;
    e. Provide full, individual-centered disclosures to ensure that the individual is making an informed decision by discussing with the individual:
        i. His or her medical diagnosis and prognosis of six months or less;
        ii. The feasible alternatives or additional treatment opportunities, including comfort care, palliative care, hospice care, and pain control;
        iii. The potential risks associated with taking the medical aid-in-dying medication to be prescribed;
        iv. The probable result of taking the medical aid-in-dying medication to be prescribed; and

v. The possibility that the individual can obtain the medical aid-in-dying medication but choose not to use it;

f. Refer the individual to a licensed mental health professional pursuant to section 25-48-108 if the attending physician believes that the individual may not be mentally capable of making an informed decision;

g. Confirm that the individual's request does not arise from coercion or undue influence by another person by discussion with the individual, outside the presence of other persons, whether the individual is feeling coerced or unduly influenced by another person;

h. Counsel the individual about the importance of:

i. Having another person present when the individual self-administers the medical aid-in-dying medication prescribed pursuant to the Act.

ii. Not taking the medical aid-in-dying medication in a public place.

iii. Safe-keeping and proper disposal of unused medical aid-in-dying medication in accordance with section 25-48-120; and

iv. Notifying his or her next of kin the request for medical aid-in-dying medication;

i. Inform the individual that he or she may rescind the request for medical aid-in-dying medication at any time and in any manner;

j. Verify, immediately prior to writing the prescription for medical aid-in-dying medication, that the individual is making an informed decision;

k. Ensure that all appropriate steps are carried out in accordance with this the Act before writing a prescription for medical aid-in-dying medication; and

l. Either:

i. Dispense medical aid-in-dying medication directly to the qualified individual , including ancillary medications intended to minimize the individual's discomfort, if the attending physician has a current Drug Enforcement Administration certificate and complies with any applicable administrative role; or

ii. Deliver the written prescription personally, by mail, or through authorized electronic transmission in the manner permitted under Article 42.5 of Title 12 C.R.S. to a licensed pharmacist, who shall dispense the medical aid-in-dying medication to the qualified individual, the attending physician, or an individual expressly designated by the qualified individual.

13. **Consulting physician responsibilities**: Before an individual who is requesting medical aid-in-dying medication may receive a prescription for the medical aid-in-dying medication, a consulting physician must:

a. Examine the patient and his or her relevant medical records.

b. Confirm in writing the attending physician:
c. That the individual has a terminal illness;
d. The individual has a prognosis or six months or less;
e. That the individual is making an informed decision; and
f. That the individual is mentally capable, or provide documentation that the consulting physician has referred the individual for further evaluation in accordance with Section 25-48-108.

14. **Confirmation that individual is mentally capable – referral to mental health professional.**
    a. An attending physician shall not prescribe medical aid-in-dying under the Colorado End of Life Options Act for an individual with a terminal illness until the individual is determined to be mentally capable and making an informed decision, and those determinations are confirmed in accordance with this section
    b. If the attending physician or the consulting physician believes that the individual may not be mentally capable of making an informed decision, the attending physician or the consulting physician shall refer the individual to a licensed mental health professional for a determination of whether the individual is mentally capable and making an informed decision
    c. A licensed mental health professional who evaluates an individual under this section shall communicate, in writing, to the attending or consulting physician who requested the evaluation, his or her conclusions about whether the individual is mentally capable and making informed decisions. If the licensed mental health professional determines that the individual is not mentally capable of making informed decisions, the person shall not be deemed a qualified individual under the Act and the attending physician shall not prescribe medical aid-in-dying medication to the individual.

15. **Medical record documentation requirements – reporting requirements – department compliance reviews – rules.**
    a. The attending physician shall document in the individual's medical record, the following information:
    b. Dates of all oral requests;
    c. A valid written request;
    d. The attending physician's diagnosis and prognosis, determination of mental capacity and that the individual is making a voluntary request and an informed decision;

e. The consulting physician's confirmation of diagnosis and prognosis, mental capacity, and that the individual is making an informed decision;
f. If applicable, written confirmation of mental capacity from a licensed mental health professional;
g. A notation of notification of the right to rescind a request made pursuant to the Act
h. A notation by the attending physician that all requirements under the Act have been satisfied; indicating steps taken to carry out the request, including a notation of the medical aid-in-dying medications prescribed and when.
i. The Department of Public Health and Environment requires any health care provider, upon dispensing a medical aid-in-dying medication pursuant to this Act, to file a copy of a dispensing record with the department.

16. **Death certificate**.
    a. Unless otherwise prohibited by law, the attending physician or the Hospice Medical Director shall sign the Death Certificate of a qualified individual who obtained and self-administered aid-in-dying medication.
    b. When a death has occurred in accordance with the Act, the cause of death shall be listed as the underlying terminal illness and the death does not constitute ground for post-mortem inquiry under Section 30-10-606(1), C.R.S.

17. **Safe disposal of unused medical aid-in-dying medications**: A person who has custody or control of medical aid-in-dying medication dispensed under this Act that the terminally ill individual decides not to use or that remains unused after the terminally ill individual's death shall dispose of the unused medical aid-in-dying medication either by:
    a. Returning the unused medical aid-in-dying medication to the attending physician who prescribed the medical aid-in-dying medication, who shall dispose of the unused medical aid-in-dying medication in the manner required by law; or
    b. Lawful means in accordance with Section 25-15-328, C.R.S or any other State of Federally approved medication take-back program authorized under the Federal "Secure and Responsible Drug Disposal Act of 2010", PUB.L.111-271, and regulations adopted pursuant to the Federal Act.

DEFINITIONS:

1. **"Adult"** means an individual who is eighteen years of age or older.
2. **"Attending Physician"** means a physician who has primary responsibility for the care of a terminally ill individual and the treatment of the patient's terminal disease.
3. **"Consulting Physician"** means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a terminally ill individual's terminal illness.
4. **"Health Care Provider" or "Provider"** means a person who is licensed, certified, registered, or otherwise authorized or permitted by law to administer health care or dispense medication in the ordinary course of business or practice of a profession. The term includes a health care facility, including a long-term care facility as defined in Section 25-3-103.7(1)(f.3) and a continuing care retirement community as described in Section 25.5-6-203 (1)©(I), C.R.S.
5. **"Informed decision"** means a decision the is:
    a. Made by an individual to obtain a prescription for medical aid-in-dying medication that the qualified individual may decide to self-administer to end his or her life in a peaceful manner;
    b. Based on an understanding and acknowledgement of the relevant facts; and
    c. Made after the attending physician fully informs the individual of:
        i. His or her medical diagnosis and prognosis of six months or less;
        ii. The potential risks associated with taking the medical aid-in-dying medication to be prescribed;
        iii. The probable result of taking the Medical aid-in-dying medication to be prescribed;
        iv. The choices available to an individual that demonstrate his or her self-determination and intent to end his or her life in a peaceful manner, including the ability to choose whether to
            1) Request medical aid in dying;
            2) Obtain a prescription for medical aid-in-dying medication to end his or her life;
            3) Fill the prescription and possess medical aid-in-dying medication to end his or her life; and
            4) Ultimately self-administer the medical aid-in-dying medication to bring about a peaceful death; and
            5) All feasible alternatives or additional treatment opportunities, including comfort care, palliative care, hospice care3, and pain control.
6. **"Licensed Mental Health Professional"** means a psychiatrist licensed under article 36 or Title 12 C.R.S., or a psychologist licensed under Part 3 of Article 43 or Title 12 C.R.S.
7. **"Medical Aid in Dying"** means the medical practice of a physician prescribing medical aid-in-dying medication to a qualified individual that the individual may choose to self-administer to bring about a peaceful death.

8. **"Medical aid-in-dying medication"** means medication prescribed by a physician pursuant to the Colorado End-of-Life Options Act to provide medical aid in dying to a qualified individual.
9. **"Medically Confirmed"** means that a consulting physician who has examined the terminally ill individual and the individual's relevant medical records has confirmed the medical opinion of the attending physician.
10. **"Mental Capacity" or "Mentally Capable"** means that in the opinion of an individual's attending physician, consulting physician, psychiatrist or psychologist, the individual has the ability to make and communicate an informed decision to health care providers.
11. **"Physician"** means a doctor of medicine or osteopathy licensed to practice medicine by the Colorado Medical Board.
12. **"Prognosis of Six Months or Less"** means a prognosis resulting from a terminal illness that the illness will, within reasonable medical judgment, result in death within six months and which has been medically confirmed.
13. **"Qualified Individual"** means a terminally ill adult with a prognosis of six months or less, who has mental capacity, has made an informed decision, is a resident of the state, and has satisfied the requirements of the Colorado End-of-Life Options Act in order to obtain a prescription for medical aid-in-dying medication to end his or her life in a peaceful manner.
14. **"Resident"** means an individual who is able to demonstrate residency in Colorado by providing any of the following documentation to his or her attending physician:
    a. A Colorado driver's license or identification card issued pursuant to Article 2 of Title 42 C.R.S.;
    b. A Colorado voter registration card or other documentation showing the individual is registered to vote in Colorado;
    c. Evidence that the individual owns or leases property in Colorado; or
    d. A Colorado income tax return for the most recent tax year.
15. **"Self-Administer"** means a qualified individual's affirmative, conscious, and physical act of administering the medical aid-in-dying medication to himself or herself to bring about his or her own death.
16. **"Terminal Illness"** means an incurable and irreversible illness that will, within reasonable medical judgment, result in death.

REFERENCES:

1. Colorado End-of-Life Options Act (C.R.S § 25-48-101, et seq).
2. HOSPITAL Administrative Policies:
    a. Colorado End-of-Life Options Act, Hospice
    b. Medically Inappropriate Treatment (Futility)
    c. Spiritual Care of Patients
    d. Hospice Scope of Service
    e. Healthcare Ethics Committee
    f. Patient Rights Ethical Issues, Nursing
    g. Patient Rights and Responsibilities

h. Do Not Resuscitate
i. Advanced Directives
j. Treatment of Pain, Nursing
k. Informed Patient Consent

Item 8.10

ESTES PARK HEALTH

EPH's Public Healthcare Model Crisis Standards of Care & COVID-19

Nicholaus Mize, DO

May 18, 2020

Internal Use Only

What is Patient Centered Care versus Public Centered Care?

Patient Centered Care:

When all resources are available, every individual is cared for to the extent of his/her autonomy based on his/her personal verbal or written directives. If the patient does not have the capacity to communicate or has no predefined directives, then the decisions of care should come from the patient's MDPOA.

Public Centered Care:

When the number of patients seeking care outnumber the care resources available: human, medications, available medical interventions (ventilators, chest tubes, beds, etc.). Public Centered Care provides the greatest care with maximal benefit available to the public as a whole.

Development of EPH's Plan

- **Sources of Information**
  - Colorado Crisis Standards of Care (CSC) from Colorado's GEEERC (Governor's Expert Emergency Epidemic Response Committee)
  - University of Pittsburgh Executive Summary: As Guides for Public Health Centered Care
- **Similarities between the Guides:**
  1. In the initial evaluation of Tier 1 of patients for resource allocation, both are based on the same SOFA (Sequential Organ Failure Assessment) scoring system. See next slide for further definition of SOFA.)

     SOFA scoring is based solely on parameters that detail how ill a patient is and how likely to recover. (SOFA scores have been used historically for patient's admitted to the ICU to evaluate the extent of their illness on a day to day basis)
  2. The next step of evaluation of Tier 1 patients, based on determining resource allocation between individuals with equal SOFA scores:
     - Allocation to individuals with less underlying comorbidities prior to infection, and/or individuals who do not have a life limiting condition that limits their life expectancy to less than 1 year (examples: Congestive Heart Failure, Pulmonary Diseases (COPD), Moderate to Advanced Dementia)

Differences between the Guidelines

Tier 1:

- In terms of Comorbidities, the CSC uses a Modified Charlson Comorbidity Index Score. While Univ of Pittsburgh uses a simple list of: major comorbidities and severely life limiting comorbidities (this is an easier application in an emergent situation for the Triage Team)

Tier 2:

- Listed in the CSC: Priority is given to Pediatrics, HealthCare Workers and First Responders if there is a tie breaker from the initial Tier 1 Categories.
- This is not a part of a Tier in The Executive Summary, however, in the Summary it is listed as a considerable tiebreaker for Tier 1 as Heightened Priority should be given to those who have not lived through some of the Stages of Life, and to those Individuals who are central to the Public Health Response

Tier 3:

- The CSC has a Tier 3: this includes tie breakers as Pregnancy, Sole Caregiver to a dependent family member, and Life years saved (which is basically similar to Life Stages in the Executive Summary)

Differences between the Guidelines

Tier 4:

- In terms of Comorbidities, the CSC uses a Modified Charlson Comorbidity Index Score. While Univ of Pittsburgh uses a simple list of: Major Comorbidities and Severely Life Limiting Comorbidities (this is an easier application in an emergent situation for the Triage Team)
- There is a Tier 4 in the CSC which is the same in the Executive Summary: If there is a situation where tiebreakers have not been met for the allocation of resources, then there is random selection for resources (aka Lottery)

continued

Sequential Organ Failure Assessment (SOFA)

SOFA score	1	2	3	4
Respiration[a]				
PaO_2/FIO_2 (mm Hg)	<400	<300	<220	<100
SaO_2/FIO_2	221-301	142-220	67-141	<67
Coagulation				
Platelets $\times 10^3/mm^3$	<150	<100	<50	<20
Liver				
Bilirubin (mg/dL)	1.2-1.9	2.0-5.9	6.0-11.9	>12.0
Cardiovascular[b]				
Hypotension	MAP <70	Dopamine ≤5 or dobutamine (any)	Dopamine >5 or norepinephrine ≤0.1	Dopamine >15 or norepinephrine >0.1
CNS				
Glasgow Coma Score	13-14	10-12	6-9	<6
Renal				
Creatinine (mg/dL) or urine output (mL/d)	1.2-1.9	2.0-3.4	3.5-4.9 or <500	>5.0 or <200

EPH's Plan

- **EPH has adopted the University of Pittsburgh Executive Summary as its guide for the transition from Patient Centered to Public Health Centered Care**
  - The Executive Summary is easily followed and is supported by the DNV
- **EPH's Public Health Centered Care Triage Team will consist of:**
  1. An ethics or palliative care expert
  2. An attending physician familiar with critical care
  3. A representative of the nursing staff or in case of scarcity in this regard a representative of the administration

Note: As a smaller institution, identifying 3 individuals from the institution not directly involved in the initial care of specific patients can be difficult.

When is the Public Health Centered Triage Team activated?

Minimum Operating Capacity (MOC):

- The MOC is initially predetermined by the Triage Team and is based on available Human Resources, medication resources, and medical intervention resources.
- The MOC is fluid and may be altered if these resources change, but in general it is important to have the MOC defined in advance for any crisis.

After MOC has been met, and triage has begun:

- Daily reassessments of patients, patient load, and allocation of resources must be looked at by the Triage Team
- Calculations of SOFA must be recalculated, and reallocation of resources for care with the maximal benefit as a goal.

When is the Public Health Centered Triage Team activated?

As soon as resources are available, the Public Health Centered Team will transition back to Patient Centered Care Team.

The End

ESTES PARK HEALTH

Item 10

Park Hospital District Board
Timberline Conference Room
May 18, 2020

CREDENTIALING RECOMMENDATIONS

Credentials Committee approval: April 29, 2020
Present: Drs. Zehr (Chair), Florence, Meyer, Vern Carda and Andrea Thomas
Via Cisco WebEx: David Batey and Monty Miller

Medical Executive Committee approval: May 6, 2020

Appointments

Brown, Aaron, M.D.	Courtesy, General Surgery
Katz, David, M.D.	Courtesy, Cardiology
Keller, Patricia, NP	APP, Nurse Practitioner
Morton-McCarthy, Kyana, M.D.	Courtesy, Sleep Medicine
Thomas-Fox, Jennifer, NP	APP, Nurse Practitioner

Reappointments

Lampey, Astrid, M.D.	Courtesy, Family Medicine
Pouliot, Matthew, D.O.	Courtesy, Pain Medicine

FPPE

Lee, Joseph, M.D.	Active, Internal Medicine

Resignations (FYI only)

Bair, Sarah, M.D.	Courtesy, Dermatology
Bisby, Amanda, NP	APP, Nurse Practitioner
Dumont, Frank, M.D.	Courtesy, Internal Medicine
Shedd, Ryan, CRNA, NSPM	APP, Anesthesia/Pain Management
Werth, Jason, CRNA, NSPM	APP, Anesthesia/Pain Management