Agenda

Estes Park Health Board of Directors' Regular Meeting

Tuesday, December 8, 2020
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/1990880618031577612

	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	5	Information	Public
4	General Board Member Comments	5	Information	Board
5	Consent Agenda Items Acceptance: 5.1 Board Minutes and Reports 5.1.1 Board Special Executive Session Meeting Minutes November 2, 2020 5.1.2 Board Regular Meeting Minutes November 9, 2020 5.1.3 Board Special Executive Session Meeting Minutes November 16, 2020 5.1.4 Board Special Meeting Minutes November 20, 2020 5.1.5 Board Special Executive Session Meeting Minutes November 30, 2020 5.1.6 HHC/Hospice Annual Agency Evaluation Report	2	**Action**	Board
6	Presentations:			
	6.1 Estes Park Health Updates	5	Discussion	Mr. Vern Carda
	6.2 EPH Living Center Alternatives Task Force Update	7	Discussion	Dr. David Batey
	6.3 2021 EPH Budget Approval and Covid-19 Financial Impact	40	**Action**	Mr. Tim Cashman, Board
	6.4 Chief Nursing Officer Quarterly Report	10	Discussion	Ms. Pat Samples
	6.5 Chief of Staff Quarterly Report	10	Discussion	Dr. John Meyer
	6.6 Estes Park Health Foundation Quarterly Report	10	Discussion	Mr. Kevin Mullin
	6.7 Estes Park Health Covid-19 Status Update	5	Discussion	Mr. Gary Hall, Ms. Pat Samples, Dr. John Meyer
7	Strategic Operations and Significant Developments: *Goals, Accomplished, Next Actions, Schedule, Issues*			
	7.1 Executive Summary - Significant Items Not Otherwise Covered	3	Discussion	Senior Leadership Team
8	Medical Staff Credentialing Report	2	**Action**	Board
9	Review Action List Items and Due Dates	1	Discussion	Board
10	Potential Agenda Items for January 26, 2021 Regular Board Meeting	2	Discussion	Board
11	Adjournment	1	**Action**	Dr. David Batey
	Total Regular Session Mins.	110		

Next Regular Board Meeting: Tuesday, January 26, 2021 4:00 - 6:00 pm

ESTES PARK HEALTH
BOARD OF DIRECTORS'
Special Executive Session Board Meeting Minutes – November 2, 2020

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

Other Attendees
Mr. Vern Carda, CEO
Mr. Tim Cashman, CFO
Ms. Pat Samples, CNO
Mr. Gary Hall, COO

Call to Order
The meeting was called to order at 4:08 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.

Dr. Alper motioned to move into Executive Session, pursuant to §§ 24-6-402(4)(e), C.R.S. for the purpose of determining positions relative to matters that may be subject to negotiations; developing strategy for negotiations and Section 24-6-402(4)(f), C.R.S. for the purpose of discussing personnel matters. Mr. Pinkham seconded the motion, which carried unanimously.

With no further discussion to be conducted, Mr. Pinkham motioned to adjourn the Executive Session and concluded the meeting at 6:05 p.m. Dr. Alper seconded the motion, which carried unanimously.

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

ESTES PARK HEALTH
BOARD OF DIRECTORS'
Meeting Minutes – November 9, 2020

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

Other Attendees:
Mr. Vern Carda, CEO
Mr. Tim Cashman, CFO
Ms. Pat Samples, CNO
Mr. Gary Hall, CIO
Dr. John Meyer, CMO (via webinar)
Ms. Lesta Johnson, Quality Director (via webinar)
Mr. Kevin Mullin, Estes Park Health Foundation Executive Director (via webinar)

Community Attendees (via webinar):
Shirley Barrow, Larry Leaming, Phillip Moenning, Michael Keilty, Peggy Lynch, Karen Sackett, David Standerfer, John and Donna Cooper, Joann Ginal, Wendy Rigby and Cindy Leaycraft

1. **Call to Order**
   The Board meeting was called to order at 4:03 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**
   Dr. Batey requested the following changes to the agenda.
   - Move Item 6.2 Phase 2 Mitigation Plan Update to occur first under Presentations
   - Add Evacuation Status and Reintegration Update to occur after Item 6.2 Phase 2 Mitigation Plan Update
   - Move Item 6.1 EPH Living Center Discussion Review to occur after Evacuation Status and Reintegration Update

   Ms. Muno motioned to approve the agenda with the changes noted above. Dr. Alper seconded the motion, which carried unanimously.

3. Public Comments on Items Not on the Agenda

Q. When will the Urgent Care Center reopen?

A. The topic will be addressed in a report provided during this meeting.

4. General Board Comments Not on the Agenda

The Board recognized the challenging times that EPH has experienced with the pandemic and fire evacuation and expressed their deep appreciation for everyone who executed the evacuation and reintegration plan.

5. Consent Agenda Items

Mr. Pinkham motioned to approve consent agenda items 5.1.1, 5.1.2, 5.1.3, 5.1.4, 5.1.5 and 5.1.6 as presented. Ms. Begley seconded the motion, which carried unanimously.

6. Presentations

Per Board action, Item 6.1 Phase 2 Mitigation Plan Update was moved to occur first under Presentation.

6.1 Phase 2 Mitigation Plan Update

Full Time Equivalents (FTE) Reduction in Force

Twenty-seven (27) FTEs representing 7.5% of the total EPH workforce has been impacted. Employee reductions occurred in numerous departments including management, urgent care, clinic, and other roles within EPH. The approximate annual amount of labor cost reduced was **$ 1.5 MM**. Finally, i*t is important to note that potential exists for further workforce reduction after January 1, 2021.*

Urgent Care Changes

Currently, Estes Park Urgent Care operates seven (7) days per week 8 hours per day. The days of operation will be adjusted to five (5) days per week, eight (8) hours per day. The Estes Park Urgent Care will operate from 11 am to 7 pm Thursday – Monday. Additionally, staffing of the Estes Park Urgent Care will be adjusted to accommodate these new hours. This reduction will account for $400,000 to $500,000 in yearly savings.

Rural Physicians Group (RPG) Hospitalist Programming Change

RPG currently provides hospitalist coverage for inpatients at Estes Park Health. The coverage is twenty-four (24) hours per day, seven (7) days a week staffed 365 days per year. The hospitalists responsibilities include admitting patients from the emergency department, directly from physician offices, providing consultation services and requesting consultations from other specialist physicians, in addition to, monitoring and discharging patients on a daily basis.

This service represents an important Estes Park Health component serving the hospital, clinic, and emergency department. Designing and implementing an EPH hospitalist employment model vs. utilizing a contracted service will generate anticipated savings of $400,000 to $700,000 annually. Utilizing this model, EPH assumes responsibility for billing both professional and technical fees generated from managing hospital inpatients on a daily basis.

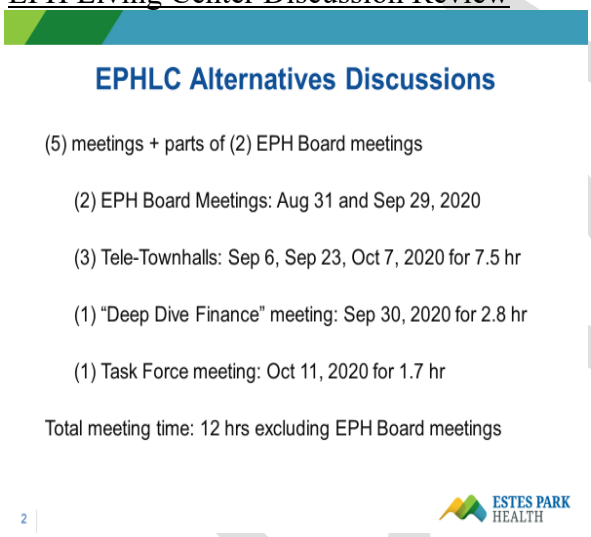
Per Board action, the topic Evacuation Status and Reintegration Update was added to the agenda.

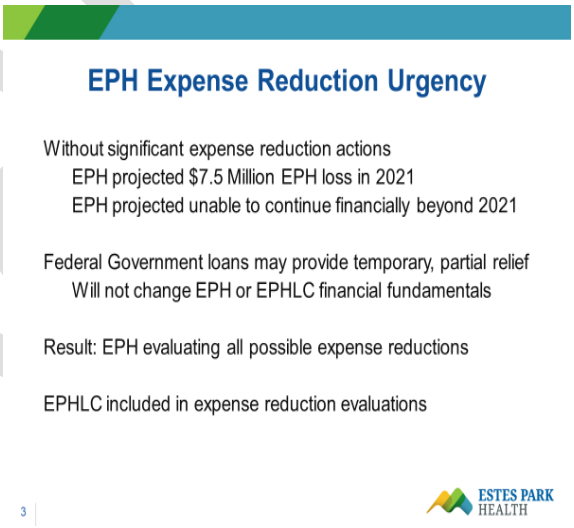
Fire Evacuation Status and Reintegration Update

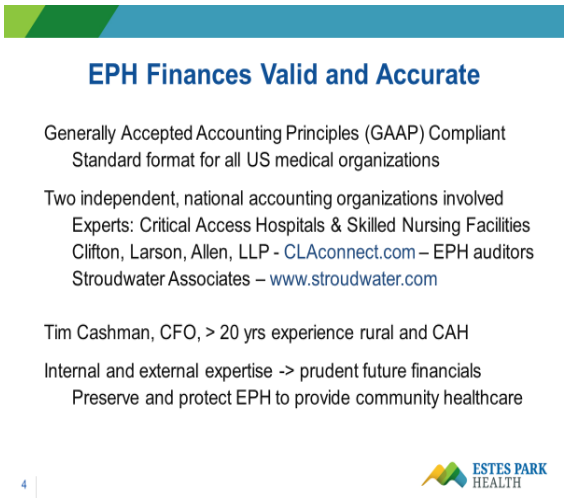
- All patients were evacuated safely. The school district assisted in transporting the Living Center residents.
- The staff evacuated with the Living Center residents and have remained with them.
- No staff members or patients sustained any injuries during the evacuation.
- The hospital's Life Safety inspection took place on October 28.
- The Emergency Department was opened late on October 28, along with the Lab, Pharmacy and Radiology.
- Inpatient and the Physician Clinic had a soft opening on October 30.
- Living Center residents are scheduled to return on November 10.
- Prior to the Living Center evacuation, there were 9 residents that tested positive for Covid. Of those returning, 5 will be isolated, and 3 will be quarantined.
- No admissions to the Living Center can occur until there have been 14 consecutive days without a positive staff or patient test.

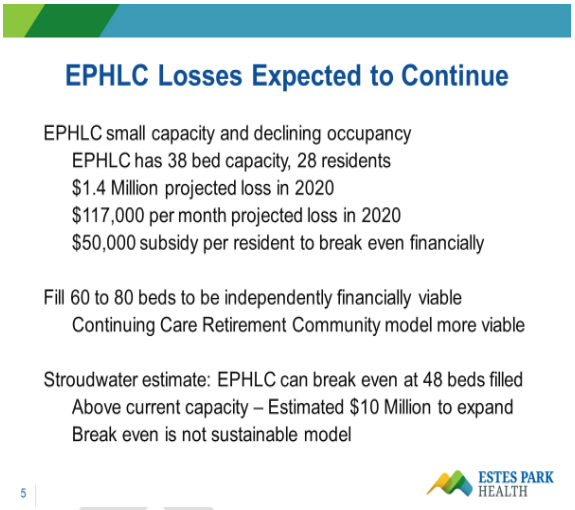
Per Board action, Item 6.2 EPH Living Center Discussion Review was moved to the third item on the agenda.

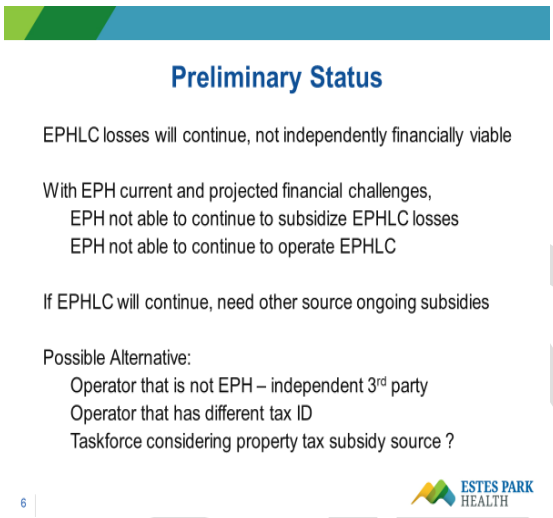
6.2 EPH Living Center Discussion Review











6.3 Q3 Chief Operating Officer Update

The Fires of 2020: Estes Park has been fortunate through the extreme fire challenges of 2020. While we are not "out of the woods" until the weather assists with extinguishing, we've been ready to evacuate if/when necessary for several weeks. Our Incident Command is still meeting with appropriate regularity and we get constant updates from Larimer County and the park in regard to fire status.

Pharmacy: Unfortunately, our beloved pharmacy director (Matt Makelky) left for a great position at UCHealth oncology pharmacy. Interviewing process ongoing for replacement; two experienced pharmacists are managing the department in the meantime. We added two more Pyxis medication workstations for anesthesia and moved others around to create broader, easier coverage for better patient care.

Environmental Services (EVS): In several months of management of this, we've reworked and streamlined staff as necessary and resolved some of the communication and workflow challenges.

Laboratory: Diasorin analyzer was added to give us COVID testing in less than two hours. We continue to work toward ever more integration of analyzers with our Epic EHR, to build our staff to the highest level of skill and certification, and to use the Epic tools to provide the safest integrated

processes for our lab work. We've hired several techs who have deep experience in the blood bank processes and other Epic-integrated tools.

Rehab Services: Director Nancy Karr and the Rehab team continue to enjoy growing volume at their new location at the Urgent Care Center. While not back to "normal" yet, it's moving in the right direction, and we hope the recent surge does not result in further restrictions on our outpatient business.

Backfill of Rehab Area and Specialty Clinic: We have moved chemo/infusion, coumadin clinic, and respiratory therapy away from the inpatient areas and to the front of house (vacated rehab area) for patient convenience and comfort and optimal safety. We completed a multi-stage, multi-month process of cascading moves to "breathe space" into our physician clinic, taking advantage of the partially vacated Specialty Clinic area.

Diagnostic Imaging: Colorado Imaging Associates is now providing onsite coverage twice a month to help close the service gap caused by the retirement of our longtime occasional onsite radiologist.

Dietary: The Dietary team has adjusted cafeteria rules to manage proper social distancing and is following all protocol to ensure a healthy kitchen and safe dining environments.

Marketing: We're continuing to address the immediate marketing needs from this office.

Safety/Emergency Preparedness: Continuing to provide oversight of the Safety Management plan of EPH, which covers Life Safety (fire and other items), Security, Radiologic Safety, Hazardous Waste Safety, and Emergency Preparedness. Action on all fronts continues to ensure we're as safe as can be.

Urgent Care IT/Facilities/EVS: Continued tuning of parking situations, HVAC controls, network management, housekeeping.

Facilities: We are scheduled in early November to complete our long-term surgical services air-handler HVAC work. This final step in a three-year project helps us completely separate the airflow of the OR suite from any other parts of the building. The operating rooms were given their own air handlers and controls some years ago, and this completes the project. We also are working to contract with a water specialist to provide expert guidance in the best long-term management of our OR sterile processing work, and to assist us with other aspects of water testing and management.

6.4 Q3 Financial Report Including Covid-19 Impact

ESTES PARK HEALTH

2020 September and YTD Overview

- The month of September and the Quarter reflect positive results. Volumes and Revenues recovered better than expected. For the Quarter (July, August & September), Net revenues were 94% of Budget. YTD Net Revenues are $5.8M under budget or 14%. (Expectations for the Quarter were 80% of Budget)
- Expenses are 6% over budget for the month. YTD Expenses are 2% under budget, notably in Wages and Benefits. However, Supplies and Pharmacy continue to increase, due to the cost of acquisition.
- Income from Operations is a loss of ($316K) for the month and ($6.4M) for the YTD, thru September.
- Net Earnings for the month is a loss of ($45K) and ($3.4M) for the YTD.

ESTES PARK HEALTH

YTD Review of Comments

2020 1st Quarter Overview

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

- Before 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%.
- Incident Command was established resulting the development of the "Operations Committee".
- Staffing remained generally intact, intending to evaluate the situation and sustain the employees thru April.

2020 2nd Quarter Overview

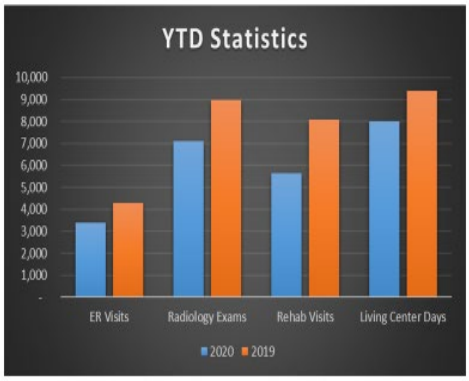
- For the month, Operating Revenues are 10% down from Budget and 19% down from last year. Year to date shows 17% less than Budget. Year-to-date Operating Revenues are 17% under Budget and 9% under last year. Due to the Covid-19 pandemic the hospital had anticipated a 20% drop for the month. Year to date, expectations indicated an 80% recovery.
- Expenses for the year are 3% under budget. Currently, the only area above budgeted Expense is Supplies. The 10% rollback of wages for the highest earners was initiated June 1, resulting in a 13% drop in Salary expense. For the month, Expenses are 7% under budget.
- Earnings for the month are a net $1.2M, under budget by 18%. However, Year-To-Date earnings are a loss of $4.8M compared to a budgeted loss of $214K, obviously due to the impact of COVID-19.
- Stimulus funds received to date are a total of $14.5M. Expectations for retainage include $10.1M, with the remainder of $4.4M currently held as a "loan" and identified for repayment.
- Balance Sheet is holding up, principally due to the Stimulus funds.
  - AR Days are 46
  - Days Cash on Hand are 234

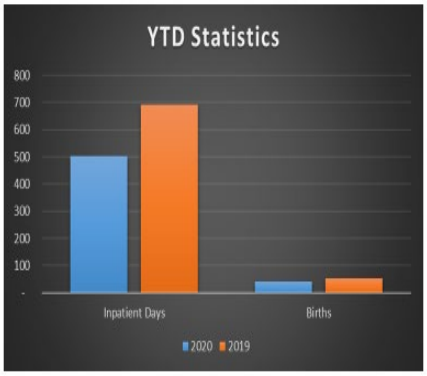
2020 3rd Quarter YTD

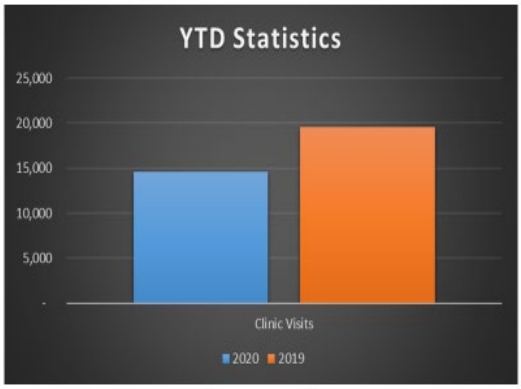
- Gross Revenues for the month were very close to budget and 16% under budget for the YTD. Areas of growth include Inpatient Days, Surgery, Lab, Pharmacy, Rehab and Home Health services. Areas of decline include Birth Center, Urgent Care, Emergency Department and the Physician Clinic.
- Net Patient Revenues, for the month are 2% higher than budget and 14% under budget for the YTD. The difference is due to the intricacies of Contractual adjustments and the timing of Medicare rate changes.
- Expenses - principal areas of variance are in Supplies and Purchased Services. Some of this is due to timing of invoices and payables, as well as COVID related supply requirements.
- Wages and Benefits are under budget due to staffing adjustments and Phase I mitigation efforts, including 10% withhold of Salaries for Leadership and the overall freeze on employee PTO accruals.
- AR Days are 43.1, Days Cash on Hand are 245 and the Debt Coverage Ratio is -.70

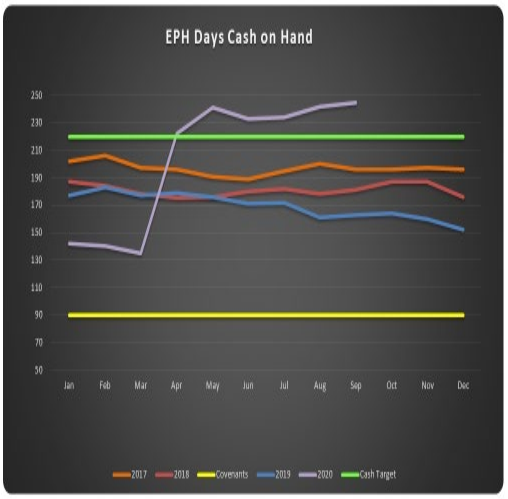
Summary of Profit and Loss

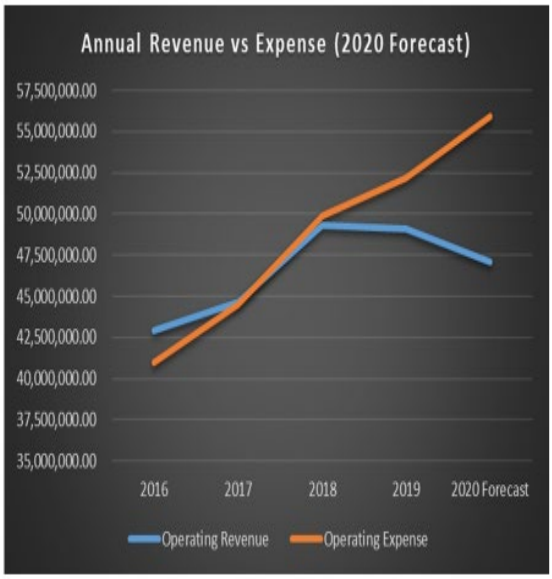
	Actual 2020 YTD	Budget 2020 YTD	Variance $	Prior Year 2019	Prior Year % Var
Patient Revenue	63,961	75,904	(11,943)	69,633	-8%
Total Revenue Deductions	(28,515)	(34,916)	6,401	(32,813)	13%
Total Operating Revenue	35,798	41,606	(5,808)	37,420	-4%
Total Operating Expenses	42,240	42,919	678	39,150	-8%
Operating Income (Loss)	(6,443)	(1,313)	(5,130)	(1,731)	-272%
Non-Operating Income	2,496	2,707	(211)	2,359	6%
Gift to Purchase Capital Assets	524	200	324	102	
Increase (Decrease) in Net Assets	(3,423)	1,594	(5,018)	730	-569%
EBIDA	(792)	4,238		2,549	

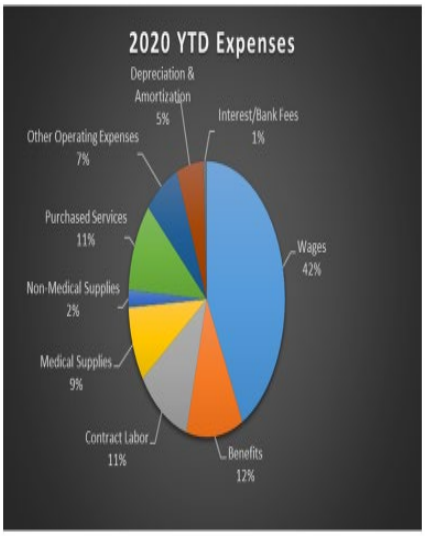

YTD Statistics
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
ER Visits
Radiology Exams
Rehab Visits
Living Center Days
2020
2019


YTD Statistics
800
700
600
500
400
300
200
100
-
Inpatient Days
Births
2020
2019


YTD Statistics
25,000
20,000
15,000
10,000
5,000
-
Clinic Visits
2020
2019


EPH Days Cash on Hand
250
230
210
190
170
150
130
110
90
70
50
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2017
2018
Covenants
2019
2020
Cash Target


Annual Revenue vs Expense (2020 Forecast)
57,500,000.00
55,000,000.00
52,500,000.00
50,000,000.00
47,500,000.00
45,000,000.00
42,500,000.00
40,000,000.00
37,500,000.00
35,000,000.00
2016
2017
2018
2019
2020 Forecast
Operating Revenue
Operating Expense


2020 YTD Expenses
Depreciation & Amortization 5%
Interest/Bank Fees 1%
Other Operating Expenses 7%
Purchased Services 11%
Wages 42%
Non-Medical Supplies 2%
Medical Supplies 9%
Contract Labor 11%
Benefits 12%

2020 Forecast

- Due to the impact of the Evacuation and closure of the Hospital in late October, the Forecast has changed.
- Initially, Revenues recovered better than expected. Expectations were a 65% recovery for the 2nd Quarter; and 80% for the 3rd and 4th Quarters. As a result of the loss of one week of Revenues, the net change (gross minus contractuals) was a loss of $1.4M
- A significant rise in the COVID-19 Virus may impact 4th Quarter recovery and long-term business.
- Expenses, through the 3rd Quarter, are showing a decline due to actions by Management. Further action will be necessary as the year progresses and the Stimulus funds are used.
- The Stimulus Funds are still held in reserve as there is still no definitive confirmation of any forgiveness. The PPP funds application for forgiveness is scheduled for submission by November 13, 2020. The Forecast reflects the recognition of those funds by End of Year.
- Forecasted Net Earnings, with the PPP Stimulus funds indicate a continued Net Loss.

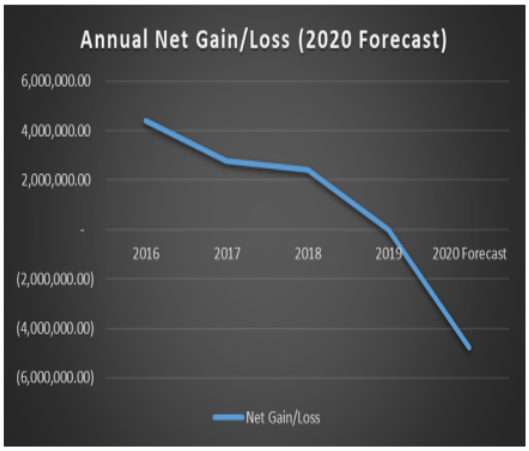
2020 Forecast
Assumptions

- Inpatient Revenues are based on 9 months Actuals, October loss and Nov & Dec Recovery at 80%
- Outpatient Revenues are based on 9 months Actuals, October loss and Nov & Dec Recovery at 90%
- Wages Forecast is based on YTD mitigation efforts and staffing adjustments
- Benefits are also based in trends, mitigation and adjustments
- Supplies forecast based in YTD trends and increasing costs of COVID supplies
- Contract labor is considered, given the turnover in Surgery, Nursing and the Living Center
- Payroll Protection Program (PPP) is anticipated to be forgiven by end of the year.

ESTES PARK HEALTH
Statement of Revenues and Expenses (Unaudited)
Forecast 2020

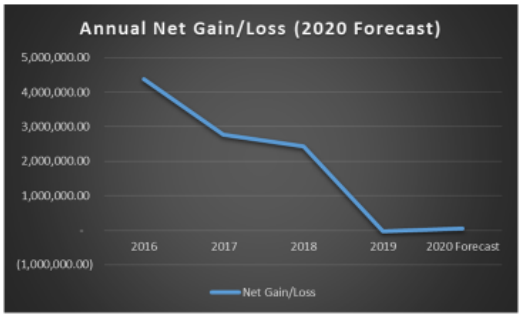
	FORECAST FY 2020					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	FY 2020 Forecast	Budget 2020
TOTAL OPERATING REVENUE	10,864	9,605	15,328	10,275	46,073	53,666
TOTAL OPERATING EXPENSE	(14,805)	(13,815)	(14,081)	(13,685)	(56,386)	(57,159)
OPERATING INCOME (LOSS)	**(3,941)**	**(4,210)**	**1,247**	**(3,410)**	**(10,313)**	**(3,493)**
NON-OPERATING	793	879	823	832	3,328	3,576
Gift to Purchase Capital Assets		133	391	-	524	300
Stimulus Funds			-	-	4,800	-
Total Margin	*-29.0%*	*-35.5%*	*16.1%*	*-25.1%*	*-8.6%*	*0.7%*
NET GAIN (LOSS)	**(3,147)**	**(3,198)**	**2,462**	**(2,578)**	**(1,662)**	**383**
REVISED EBIDA	**(2,366)**	**(2,244)**	**3,358**	**(1,680)**	**1,868**	**3,921**

Annual Net Gain/Loss (Without Stimulus)



ESTES PARK HEALTH

Annual Net Gain/Loss (With Stimulus)



6.5 Introduction of 2021 EPH Budget
Budget Message

(Pursuant to 29-1-103(1)(e), C.R.S.)
PARK HOSPITAL DISTRICT (d/b/a Estes Park Health)

(INSTRUCTIONS: Pursuant to section 29-1-103(1)(e), C.R.S., the budget must include the Budget Message. Fill in blank spaces and check any items that are applicable.)

The attached 2021 Budget for PARK HOSPITAL DISTRICT includes these important features*

1. Increase average charge for hospital services by approximately 0%
2. Decrease in volume for some departments
3. Continue service of a new Urgent Care Center, opened May 27, 2020
4. Contractual and Uncompensated care adjustments of 43% reflect the Medicare Cost Report considerations, Medicaid changes and market impact of self-pay receivables.
5. Maintain overall salary expense consistent with market value and maintaining compensation levels for merit by 0.0%.
6. Decrease operating and non-operating expenses.
7. Acquire, only when necessary, new capital equipment including x-ray equipment, lab equipment, IT equipment, and various other smaller items.
8. Mill levy of 7.505 yields budgeted tax revenues of $3,118,849.

The services to be provided/delivered during the budget year are the following:

Inpatient, Observation, Swing Bed, Outpatient, Clinic, Emergency Dept, Urgent Care Center, Therapies, Surgery, Nursing Home, Home Health, Hospice, Ambulance, and other services as provided in 2021.

" "important features" are not defined in statute; however, important features of the budget would

include starting/ending a service; increases or decreases in levels of services, increases/decreases to revenues (taxes/rates) and/or expenditures; acquisition of new equipment; start or end of capital project; etc.

Draft Budget 2021

Executive Summary

The 2021 Budget is developed with consideration of ongoing national and local trends, specifically the COVIC-19 Pandemic impact and the recent Fire Evacuation in late October. The dramatic impact to the 2019 Revenues during the months of March, April and May and ongoing decrease in volumes have greatly influenced the financials for Estes Park Health.

Assumptions

Inpatient Revenues	0% Rate Incr. Volumes are assumed at 80% of 2019 levels.
Outpatient Revenues	There is no anticipated rate increase and volumes. Most service lines assumed at 80% of 2019 levels.
Surgery	Anticipating recovery of lost procedures, due to 2019 loss of Sterilizer. Aggressive marketing and focus. General Surgery and Orthopedics anticipated to return to 5-year average. Baseline trends from 2017 & 2018 were utilized.
Urgent Care Center	Budgeted at an average of 10 visits/ day. Volumes based on seasonality and expectations of decline in local tourist visits.
Emergency Department	Budgeting a 7% loss of volumes due to industry trend of reduced visits. The impact of the new Urgent Care Center is also considered.
EMS/Ambulance	Planning start-up of Community Paramedic On-Call, in coordination with the Urgent Care Center. Budgeted Revenues and Expenses are consistent with prior years trends.
Birth Center	Expected decrease in volumes, as local trends have indicated.
Clinic	New providers in Clinic should recover visit volumes; more comfort using the new Epic program; and the General Surgeon program will have Clinic availability. There is no rate increase,
Revenue Deductions	Work continues with Medicare Cost Report with favorable results, helping to decrease the Contractual write-offs. Additional lengthy work with Admissions staff to educate patients upon registration/admission on pricing and financial responsibility. Results indicate favorable response and decreased bad debts. Budget continues to show decrease % Adjustments.
Salaries	Merit increases are budgeted to re-start as of June 1, 2021. Thus, allowing for a full 12 months of no increases, dating back to June 1, 2020. Budgets at the departmental level are considering the ongoing recruitment challenges for Clinical staffing.
Benefits	Health Insurance is currently estimated at a slight decrease. No other changes in cost are anticipated.

Contract Labor	Continued Contract Labor costs for RN and Aides in Surgery and the Living Center. This is expected to continue until Recruiting fills open positions.
Supplies	Anticipated increase of only 1%, lower volumes, better contracts. This is lower than prior years.
Depreciation	Includes capitalization of Assets; Property and Equipment, including the Epic/Lawson purchase in 2019 and the Urgent Care improvement.
Tax Subsidy	Property Tax is scheduled for $3.lM and the additional vehicle tax subsidy is $250K

FTE and Staffing

Staffing and FTE's are anticipated to decline by 2.0 FTE's compared to 2020 Actuals and by 20.3 for Budget 2020. Most Departments are making staffing adjustments as a result of reduced patient visits.

Capital Budget

Given the current financial projections, the only capital items that will be considered are those that provide critical services

ESTES PARK HEALTH DRAFT OPERATING BUDGET 2021

	APPROVED 2020 BUDGET	2020 PROJECTED	2021 BUDGET	DRAFT 2021 to PROJ 2020
PATIENT REVENUE				
Inpatient Revenue	19,914,657	13,363,899	14,889,709	$ 1,525,809
Outpatient Revenue	77,940,794	68,879,939	69,240,613	360,674
TOTAL PATIENT REVENUE	97,855,451	82,243,838	$ 84,130,321	1,886,483
Less: Contractual Adjustments	(44,034,955)	(35,513,723)	(35,334,735)	178,988
Less: Bad Debt	(978,557)	(1,137,947)	(1,261,955)	(124,008)
	(45,013,512)	(36,651,670)	(36,596,690)	54,980
	-46.0%	*-44.6%*	*-43.5%*	
NET PATIENT REVENUE	**52,841,939**	**45,592,169**	**47,533,632**	**1,941,463**
		55.4%	*56.5%*	
Other	824,185	479,646	469,650	(9,996)
TOTAL OPERATING REVENUE	$ **53,666,124**	$ **46,071,815**	$ **48,003,282**	$ **1,931,467**
EXPENSES				
Wages	25,117,554	23,350,005	23,781,526	431,520
Benefits	6,796,957	6,642,844	6,843,467	200,623
Contract Labor	6,356,716	6,456,473	5,280,980	(1,175,493)
Medical Supplies	4,495,035	5,019,776	4,954,306	(65,470)
Non-Medical Supplies	1,004,416	1,164,771	985,451	(179,320)
Purchased Services	5,952,299	6,150,156	5,358,455	(791,701)
Other Operating Expenses	3,898,755	4,072,917	5,210,035	1,137,118
Depreciation/ Amortization	3,126,228	3,111,958	3,147,933	35,975
Interest/Bank Fees	411,192	417,091	375,381	(41,710)
TOTAL OPERATING EXPENSES	**$57,159,152**	**$56,385,991**	**$55,937,534**	**(448,457)**
OPERATING INCOME (LOSS)	**(3,493,028)**	**(10,314,176)**	**(7,934,252)**	**2,379,924**
Non-Operating Revenue	3,636,419	3,386,791	3,393,500	6,709
Non-Operating Expenses	(60,150)	(59,007)	(74,900)	(15,893)
Total Non-Operating	**3,576,269**	**3,327,784**	**3,318,600**	(9,184)
EXCESS REVENUES/EXPENSES	**83,241**	**(6,986,392)**	**(4,615,652)**	2,370,740
				-
Gifts to Purchase Capital Assets	300,000	523,770	300,000	(223,770)
Stimulus Funds		4,800,000		
INCREASE (DECREASE) IN NET ASSETS	$ **383,241**	$ **(1,662,621)**	***(4315,652)***	$ **(2,653,031)**
EBITDA	$ **3,920,661**	$ **1,866,428**	$ **(792,338)**	
Total Margin % INCREASE (DECREASE)	*0.71%*	*-3.61%*	*-8.99%*	

6.6 EPH Employed Provider Recruiting Plan – Second Reading and Final Approval

Purpose: To provide a framework for a thorough, inclusive and organized process for effectively recruiting a new employed practitioner to Estes Park Health.

Initial Steps:

i. Define the need, in particular what is the purpose of bringing in a new provider and what are the expectations of this provider
ii. Obtain BOD approval (we are a closed medical staff)
iii. Define the minimum necessary qualifications as well as the preferred qualifications
iv. Establish search committee: Director of Practice Management, Department Director (if also working in Hospital Department), Clinic Medical Director, Department Medical Director (if working in Hospital Department), provider in the same specialty, consider a front-line staff member
v. Decide on appropriate advertising: Trade journals, professional organizations, use of a recruiting firm, combination of methods

Selecting Candidates:

vi. Review submitted CV's and any other submitted documents (Resume, cover letter, etc.), review any other sources of information about candidate
vii. Chose candidates for phone interviews

Phone Interviews:

viii. Group conference call: all members of the search committee present
ix. Plan at least 1 hour, make sure everyone has water.
x. Recap impressions and decide whether to proceed with on-site interviews.

On-Site Interviews:

xi. Schedule in advance to allow clinic schedules to be adjusted as needed
xii. Expect a 2-day process, plan lodging, dining and transportation in advance
xiii. Facility tour
xiv. Individual interviews: Director of Practice Management (if working in clinic include Clinic Nurse Manager), Department Director if working in hospital department, Clinic Medical Director if working in clinic, Department Medical Director if working in hospital department, CEO, COS
xv. Group Interviews: Department Directors, Providers, Senior Leadership, consider BOD, consider front line employees
xvi. Real Estate Tour: pre-arrange with local realtor
xvii. Social event

Decision:

xviii. Written and/or verbal evaluations, pay particular attention if any member is opposed, find out details and explore
xix. Final recommendation from search committee to CEO
xx. Letter of intent
xxi. Signed Contract

On-Boarding (Please see the New Practitioner Onboarding Checklist for details of all items to be completed prior to start date)

xxii. Licensure: time frame dependent on Colorado Board of Medical Examiners

xxiii. Hospital Credentials: Allow 90-120 days from receipt of a completed application
xxiv. Malpractice Insurance: time frame dependent on COPIC
xxv. Apply for UCH EPIC profile: Allow 45 days until provider is active
xxvi. Select a start date
xxvii. Complete mandatory UCH EPIC training
xxviii. Schedule New Practitioner Orientation, must be complete prior to seeing patients.

Dr. Alper motioned to approve the Employed Provider Recruiting Plan as presented. Mr. Pinkham seconded the motion, which carried unanimously.

6.7 Estes Park Health Covid-19 Status Update

KEEPING EVERYONE SAFE AT EPH: We continue to focus on maximum safety at EPH. All staff, patients, and visitors must wear masks at all times, and we check temperatures and screen for symptoms and contact with potential infected parties at the entry doors for all employees, patients, and visitors. We test all inpatients and most surgery patients. We only allow one visitor/caregiver per patient (unless it's a child, where we'll allow both parents) for the inpatient unit, the surgery suite, the emergency department, and the physician clinic.

COVID TESTING AT EPH: Our current swabbing process includes a Telehealth visit for personalized care and follow-up, along with a scheduled specimen collection date and time. On October 26, we begin offering increased availability of Covid-19 testing for our community. In a collaborative effort between the hospital, the physician clinic, and the Urgent Care Center, we will continue to offer same-day results for Covid-19 testing. Our streamlined process has safely been brought indoors and expanded to care for our public. Testing will continue Monday - Friday, with expanded hours of 8 AM – 11 AM and 4 PM -6 PM.

DON'T HESITATE TO GET HELP: If you are experiencing serious or life-threatening symptoms (chest pain, stroke symptoms, etc.), you should immediately come to EPH to get attention for that emergent condition. You are safe coming to the emergency department for emergency situations, we have a very well-protected setup to ensure your safety from COVID or other infections while you are receiving attention. Do not delay service for any serious medical condition out of COVID fear.

PHYSICIAN CLINIC OPEN FOR BUSINESS: Our physician clinic is ready to safely see you, for any type of appointments, including routine, non-acute appointments. You can visit your PCP now to address your regular checkups and chronic conditions. We take all precautions, beyond and in addition to, the front-door screening, to keep our patients safe and to maintain social distancing. Techniques of staggered appointment times and social-distancing blocks help reduce the number of patients arriving at any one time. We get you into our exam rooms quickly to minimize waiting room time. We're as safe as we can be for you.

MANAGING FLU SEASON: We're now into the "normal" flu season. All employees are required to get flu shots and we recommend all residents (adult and child) get the vaccine unless prevented by other health issues.

CONTINUE TO SCREEN FROM HOME: One of the best safety measures you can take 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. A nurse is available for questions at any time. Anyone calling for

COVID information can call the clinic registration desk at 586-2200 and then be transferred to the COVID triage nurse. We have been taking approximately 20 calls per day.

7 Operations Significant Developments

7.1 Executive Summary – Significant Items Not Otherwise Covered

None.

8 Medical Staff Credentialing Report

Ms. Muno motioned to approve the Medical Staff Credentialing report as submitted. Dr. Alper seconded the motion, which carried unanimously.

9 Review any Action Items and Due Dates

EPH Living Center Alternatives Taskforce meeting – November 11 at 4:30 p.m.

10 Potential Agenda Items for December 8, 2020 Regular Board Meeting

2021 Budget approval

11 Adjournment

Ms. Muno motioned to adjourn the meeting at 6:42 p.m. Ms. Begley 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 – November 16, 2020

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

Other Attendees
Mr. Vern Carda, CEO
Mr. Tim Cashman, CFO
Ms. Pat Samples, CNO
Mr. Gary Hall, COO

Call to Order
The meeting was called to order at 4:17 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.

Mr. Pinkham motioned to move into Executive Session, pursuant to §§ 24-6-402(4)(e), C.R.S. for the purpose of determining positions relative to matters that may be subject to negotiations; developing strategy for negotiations and Section 24-6-402(4)(f), C.R.S. for the purpose of discussing personnel matters. Ms. Muno seconded the motion, which carried unanimously.

With no further discussion to be conducted, Mr. Pinkham motioned to adjourn the Executive Session and concluded the meeting at 6:03 p.m. Ms. Begley seconded the motion, which carried unanimously.

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

ESTES PARK HEALTH
SPECIAL BOARD OF DIRECTORS'
Meeting Minutes – November 20, 2020

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

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

Community Attendees (via webinar):
Karen Sackett, Barbara Keilty, Wendy Rigby, Cindy Leaycraft and Gerald Mayo

1. **Call to Order**
   The Special Board meeting was called to order at 3:04 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 presented. Mr. Pinkham seconded the motion, which carried unanimously.

3. **Public Comments on Items Not on the Agenda**
   None.

4. **General Board Comments**
   None.

5. **Discussion of EPH Living Center Alternatives**
   5.1 Brief History and Context
   In March 2020, as the coronavirus pandemic developed, EPH Board first asked EPH Senior Leadership Team for plans to deal with the pandemic and how to mitigate pandemic impacts on EPH.

Significant financial losses occurred in 2020 and were projected to continue into 2021 and beyond.

- Projected losses required EPH to evaluate all programs and personnel for cost reduction opportunities
- Without significant expense reductions, EPH projected to be unable to continue financially beyond 2021.
- Phase 1 among other actions, with all-employee salary and benefits reductions and all-department cost cutting
- Phase 2 among other actions, Reduction in Force affecting 27 positions, Urgent Care changes, etc.
- Long-term financial losses at the EPH Living Center were among many options evaluated

Differing points of view and EPHLC alternatives have been discussed in five meetings dedicated to EPH and EPHLC, and parts of two EPH Board meetings.

- Two EPH Board Meetings: Aug 31 and Sep 29, 2020
- Three Tele-Townhalls: Sep 6, Sep 23, Oct 7, 2020 for a total of 7hr 30min
- One "Deep Dive EPH and EPHLC Finance" meeting: Sep 30, 2020 for 2hr 49min
- One Task Force organization meeting: Oct 11, 2020 for 1hr 41 min
- Total meeting time: approximately 12 hours not including discussion time in the two EPH Board meetings

5.2 Brief Review of Process and Current Status

- EPH Senior Leadership Team (SLT) and EPH Board have a sense of urgency about finding significant expense reduction options for EPH.
- EPH SLT and Board are confident in the validity and accuracy of EPH and EPHLC financials.
- Because of its small size alone, plus declining occupancy, and increasing expenses related to regulatory compliance, EPHLC is expected to continue to have financial losses.
- EPHLC at its current size is not independently financially viable and, given EPH's current and projected financial challenges, EPH will not be able to continue to subsidize EPHLC's losses.
- Because EPHLC at its current size is not independently financially viable, and EPH will not be able to subsidize its losses, for EPHLC to continue operations, another source of ongoing operational subsidies would be needed.
- Who would operate EPHLC in the future?
- Nationally, facilities like EPHLC face staffing challenges that may affect the quality of care and financial viability.

5.3 Good Samaritan Society Will Accept EPHLC Residents

If the EPH Board decides to close the EPH Living Center, the Good Samaritan Society's locations in Fort Collins Village, Loveland Village, and Bonello Community in Greeley would be able to accept all EPH Living Center residents if that were the resident's or their Power of Attorney's choice.

5.4 Brief Review of EPHLC Nov. 18 Taskforce Discussion

A summary of the previous task force meeting was provided, and the community members updated SLT on developments. It was agreed by the Board and task force members that an election referendum for community support of an additional tax would not be pursued. The community members are now focused on retaining a third party to run the Living Center.

5.5 The EPH Board does not support continuing to operate the Estes Park Health Living Center within Estes Park Health organization

Ms. Muno agrees with the statement. This has been an extremely difficult topic to consider. The meetings that were conducted with the public showed the Board how critical the Living Center is to the community, but in examining the financials, it was realized that there are better models than what the hospital can provide. Due to infrastructure issues, economic size and staffing limitations, it has become apparent that the Living Center cannot continue to operate under the hospital.

Ms. Begley agrees with the statement. The Living Center is not, nor has it been paying for itself in a long time. It is not sustainable.

Dr. Alper agrees with the statement. Based on the $7MM deficit projected for 2021, if the hospital does not take significant action it may not survive. This has been an extremely difficult decision to make, and unfortunately it does negatively impact some community members. The Board is trying to make the best decision for the long-term stable healthcare in the Estes Park community.

Mr. Pinkham agrees with the statement. The Living Center is not paying for itself and it's a significant drain on the hospital finances.

Dr. Batey agrees with the statement. The unsurmountable financial challenges and extremely difficult staffing challenges make operating the Living Center under the hospital unsustainable. There are other facilities that are better suited for memory care and other types of care that patients require.

5.6 The EPH Board does not object to community members seeking to establish a Special Taxing District, independent of Estes Park Health, that would produce tax support for an organization, also independent of Estes Park Health, that would operate a local Skilled Nursing Facility

Ms. Muno agrees with the statement. The Board will be supportive of the community establishing a special taxing district if they desire.

Ms. Begley agrees with the statement.

Dr. Alper agrees with the statement. It is ultimately good to get overall community feedback and support for the effort.

Mr. Pinkham agrees with the statement.

Dr. Batey agrees with the statement. It is great for communities to come together to find solutions to community issues.

5.7 The Estes Park Health Board of Directors does not object to an additional financial review, funded by community members, of Estes Park Health and the Estes Park Health Living Center

Ms. Muno agrees with the statement. The Board and SLT were willing to offer their assistance to identify a party to perform a financial review, however, the community members have identified their preferred individual.

Ms. Begley agrees with the statement. She offered her assistance to the community members should they request it. The hospital did have two outside entities perform a financial review and those reports are publicly available.

Dr. Alper agrees with the statement.

Mr. Pinkham agrees with the statement.

Dr. Batey agrees with the statement. The Board did obtain an independent financial assessment, but if the community wants to pursue and pay for another one then there is no objection.

5.8 Any other EPHLC Discussion Items

None.

Questions and Comments from community attendees:

C. This is the second time that the Board has mentioned that Good Sam is willing to take the Living Center residents. The Board seems to miss the point of how traumatic it will be to move the residents. It's not as generous an offer as it appears. A memory unit was mentioned, but there is not a resident at the Living Center that is an Alzheimer's patient. The SLT and Board are making decisions with no experience. The special district needs to be dissolved, the Board and SLT need to be removed and a professional healthcare system needs to run EPH.

C. Having been the CEO at EPH many years ago, I found that with the right team it was a great place to work and I do not agree that bringing in another group to run the hospital is the best option. When the hospital provided CNA training it was able to recruit people to work there. It is a matter of how hard you work to impact the community. It is extremely hard to accept that the hospital wants to eliminate the Living Center. Having residents close to family is important to the residents and their family members.

Q. Why were questions not addressed by the Board that have been raised in various meetings?

A. Ms. Begley stated that she would address all questions raised if Mr. Mayo would contact her.

C. Mr. Mayo stated the questions should be addressed in a public meeting.

C. Typically, a task force is defined as two groups working together to reach a goal. The Board Chair has treated the task force community members with condescension. Every one of the ideas presented were shot down one by one. It was embarrassing. The Board made up their minds before August and has wasted community time in order to try to prove transparency.

A. Ms. Begley stated that the Board did not previously consider, nor has there been any vote on closing the Living Center. This is not what the Board desires, but it needs to be done for the long-term financial viability of the hospital.

C. I have been to every meeting and there has not been one comment from the Board that spoke positively about saving the Living Center, nor has the Board presented any alternatives to closing. I firmly believe that there has been no desire by the Board to save the Living Center.

C. It feels like the task force meetings are a more corporate view at looking at EPH and bringing in companies to do audits. It has felt like the Board members were talking down to the community members. The community members wanted to help the Living Center and the hospital but will now

only focus on the Living Center. It is sad to see that it has come to the point where the Living Center will separate from the hospital.

Comments from Board members and Vern Carda, CEO:
Dr. Alper: The community perception is unfortunate, but the Board has investigated everything that was feasible to keep the Living Center open while also maintaining the hospital as a viable organization that can serve the community. The Board knows the decision will profoundly affect people lives, but it had to make the best overall decision for the entire community.
Mr. Pinkham: It has been a clash between compassion and reality in order to sustain the hospital.
Ms. Begley: No comments.
Ms. Muno: No comments.
Dr. Batey: Appreciates the feedback, but strongly disagrees with the community members assessment of the Board's character.
Mr. Carda: This is a difficult topic and creates a lot of discussion when you talk about the needs of the hospital and the lives that it impacts. The goal is to continue to serve the entire community.

6 Review any Action Items and Due Dates

None.

7 Adjournment

Mr. Pinkham motioned to adjourn the meeting at 3:52 p.m. Ms. Begley 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 – November 30, 2020

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

Other Attendees
Mr. Vern Carda, CEO
Mr. Tim Cashman, CFO (via web)
Ms. Pat Samples, CNO
Mr. Gary Hall, COO (via web)

Call to Order
The meeting was called to order at 4:05 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.

Dr. Alper motioned to move into Executive Session, pursuant to §§ 24-6-402(4)(e), C.R.S. for the purpose of determining positions relative to matters that may be subject to negotiations; developing strategy for negotiations and Section 24-6-402(4)(f), C.R.S. for the purpose of discussing personnel matters. Ms. Begley seconded the motion, which carried unanimously.

With no further discussion to be conducted, the Board adjourned from Executive Session at 5:30 p.m.

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

Estes Park Health Home Health Care
Estes Park Health Home Care and
Estes Park Health Hospice
Professional Advisory Committee
Wednesday, December 2, 2020
Timberline Conference Room, Estes Park Health

AGENDA

I. Welcome

II. Approve of Previous Minutes, December 4, 2019

III. People & Culture
- Staff Recruitment and Retention
- Personnel files
- Education
- Competencies
- Organizational Structure

IV. Excellence & Quality
- OASIS-D
- Quality Management Program
- OASIS-C Quality Indicators
- Hospice Quality Measures--HIS
- Home Care Quality Measures
- CASPER Reports
- Policies and Procedures
- Computer System
- Record Review
- Contracts
- Licenses
- Surveys

V. Customer Service
- HHCAHPS/ Home Health Care Patient Satisfaction Surveys
- Home Care Satisfaction Surveys
- Hospice Satisfaction Surveys

VI. Financial Management
- Financial Figures Year to Date

VII. Community & Services
- Services We Provide
- Grant-Funded Programs
- Volume/Census/Graphs
- Community

Estes Park Health Home Health Care
Estes Park Health Home Care and
Estes Park Health Hospice
Professional Advisory Committee Members

Guy VanDerWerf	Medical Director, MD
Vern Carda	Estes Park Health, CEO
Patience Samples	Estes Park Health, CNO
Sarah Bosko	Director Home Health/Hospice, RN
Sherry Schmitt	Clinical Coordinator, RN
Emily Weber	Registered Nurse
Nancy Bell	Social Worker, MSW
Herm Weaver	Chaplain
Brooke Lockard	Physical Therapist
Beckie Greer	Occupational Therapist
Anne Boyd	Speech Therapist
Erin Hayes	Certified Nurse Assistant
Theresa Oja	Community Member, nurse
David Batey	Representing EPH Board Member

Estes Park Health Home Health Care
Estes Park Health Home Care and
Estes Park Health Hospice
Professional Advisory Committee
Wednesday, December 2, 2020
Timberline Conference Room, Estes Park Health

Mission Statement

Estes Park Health Home Health Care, Estes Park Health Home Care, and Estes Park Health Hospice are departments of Estes Park Health and the programs reflect its Mission, Vision, and Values. It is our mission to provide the highest quality and cost-effective care and service available in the Estes Valley.

Pillars of Excellence

1. People & Culture
2. Excellence & Quality
3. Customer Service
4. Financial Management
5. Community & Services

People & Culture

Estes Park Health Home Health Care, Estes Park Health Home Care, and Estes Park Health Hospice employ and share approximately 17.75 FTEs (34 employees) between these three agencies with the following professional staff:

- Medical Director
- Director (1.0 FTE)
- Two Clinical Coordinators (1.8 FTE)
- Six registered nurses (4.5 FTE)
- Five registered nurses PRN (1.0 FTE)
- One physical therapist (1.0 FTE)
- One physical therapist PRN (.6 FTE)
- One occupational therapist (1.0 FTE)
- One speech therapist PRN (.05 FTE)
- One medical social worker (.5 FTE)
- One medical social worker PRN (.1 FTE)
- One certified nurse assistant (.8 FTE)
- One certified nurse assistant PRN (.1 FTE)
- Two personal care providers (2.0 FTE)
- Four personal care providers PRN (.8 FTE)
- One office coordinator (.8 FTE)
- One clinical secretary/receptionist (.8 FTE)
- One secretary PRN (.3 FTE)
- One chaplain (.55 FTE)
- Ten Hospice volunteers (on hold due to COVID)

Staff Recruitment and Retention

- Jeremy Plume, PCP/HMK resigned January 2020
- Emily Balduzzi, CNA left June 2020
- Valerie Newcomer, PCP/HMK re-located August 2020
- Cindy Bolt, PCP/HMK resigned September 2020
- Brenda Fox, chaplain PRN resigned November 2020

- Roy Riddel, PT PRN hired January 2020
- Lisa McFarlane, PCP/HMK hired February 2020
- Cindy Bolt, PCP/HMK hired March 2020
- Brooke Lockard, PT hired April 2020
- Monica Luttrell, PCP/HMK hired June 2020
- Milka Dorman, PCP/HMK hired August 2020
- Anna Hayes, PCP/HMK hired August 2020
- Karen Luttrell, RN transferred from med-surg to HHC/Hospice October 2020

Valerie Riffle, clinical coordinator transitioned to PRN and Emily Weber is currenting training/transitioning into the clinical coordinator role.

The open positions we have currently are: fulltime personal care provider/homemaker and PRN occupational therapist.

Personnel files

All employees and volunteers upon hire go through the Estes Park Health orientation and a criminal background check. Personnel files are maintained with a signed job description, a copy of current driver's license, car insurance, CPR, appropriate professional license, performance evaluations, completed competencies, and education completion certificates.

Education

Ongoing education is important to all levels of staff members. State licensure requires each direct care staff working with hospice to complete 20 hours of education. We collect feedback from staff on what topics would be helpful to provide better quality care. We had multiple in-services planned for 2020, but due to COVID the in-person educational sessions were canceled March forward. The educational topics completed this year include but were not limited to:

- Compassion Fatigue by Herm Weaver, Chaplain
- OASIS-D Functional Items—how to score by Lauren Dudas, physical therapist
- Community Paramedics by Sharon Lowry-Bielmaier and Mike Bielmaier
- PCP/HMK/Aide meeting by Sarah Bosko, director
- Annual Nurse Competency Meeting by Becky Curtin, RN; Candy Wall, RN; Emily Weber, RN; and Kathleen Theriault, RN
- Online Relias Courses:
  Advance Directives
  Annual Fire Safety Review

Bloodborne Pathogens
CAUTI
Cultural and Age Related Competencies
End of Life Care - Compassionate Care, Organ Donation
Ethics
Handoff Communication
Magnitude of the Problem of CLABSIs
Magnitude of the Problem of MDROs
Placement and Care of CVCs
Prevention and Control of MDROs
Religion and Spirituality
Restraint and Seclusion
SSI
Whistleblower Protection
Cultural Diversity
EPMC Emergency Preparedness Review
HIPAA: The Basics
Infection Control
Preventing Slips, Trips and Falls
Rapid Review: Care of a Peripheral IV
Abuse: Mandatory Reportable Incidents
Alarm Safety
Allergies and Allergic Reactions
Back Safety
Computer Security
Disaster Recovery and Emergency Preparedness
Fire Safety
Hazardous Materials/SDS
Informed Consent
Kinds and Causes of Adverse Events and Medical Errors
Patient Bill of Rights
Radiation Safety/Electrical Safety
Recognizing Abuse
Reducing and Reporting Adverse Medical Events and Medical Errors
Responsible Use of Social Media
Sexual Harassment
The False Claims Act and Medicare Fraud/Abuse
Workplace Violence
Safe Transfers
The Two Most Common Forms of Workplace Violence: Hostile Encounters and Domestic Violence
Understanding Pain in Palliative Care

Sarah Bosko and Sherry Schmitt attended the virtual Colorado Home Care Association and Hospice Association training in October where they completed the 12 hours of required annual administrative training. Nancy Bell continues to strengthen her skills by obtaining a certificate for social workers on Advance

Practice in Palliative and Hospice Care through the Shiley Institute for Palliative Care at California State University.

Competencies

Every new hire completes a competency check-off during orientation. Direct care staff complete a skills check-off/evaluation via a home visit annually. Nursing staff complete annual check-off/competencies.

Organizational Structure

The department is structured with the Clinical Coordinator/Supervisor(s) responsible for coordination of day to day patient care. The overall daily operations are under the direction of a Registered Nurse/Director who reports to the Chief Clinical Officer of Estes Park Health. The Medical Director oversees medical concerns of the hospice and home health care departments. The Professional Advisory Committee (PAC) is a committee made up of Home Health Care and Hospice staff, EPH staff, community members, and a representing Board member that meets at least annually to review the progress and effectiveness of the programs, including quality measures, finances, customer satisfaction and further marketing plans. Ultimately, the department reports to the Park Hospital District Board of Directors. The director presents a report quarterly to the Board of Directors.

--see organizational charts on 2020 PAC Spreadsheets document

Excellence & Quality

OASIS-D

January 1, 2019 changes were made to the Outcome and Assessment Information Set (OASIS) item collection by the Centers for Medicare & Medicaid Services (CMS). The new version of the assessment is known as "OASIS-D". There were 28 items that were removed and 6 new complex multifaceted questions added. These changes have been challenging for staff as they require the staff members to do more in-depth functional assessments on each patient.

Quality Management Program

It is a requirement for every licensed home care and hospice agency to have a quality management program. The quality management program must be appropriate to the size and type of agency and should evaluate the quality of consumer care and safety. Throughout this year, we have reviewed our quality management programs--adjusting as needed and strengthening the program.

--see attached 2020 Home Health Care, Hospice, and Home Care quality dashboards in the 2020 PAC Spreadsheets document

OASIS-C Quality Indicators

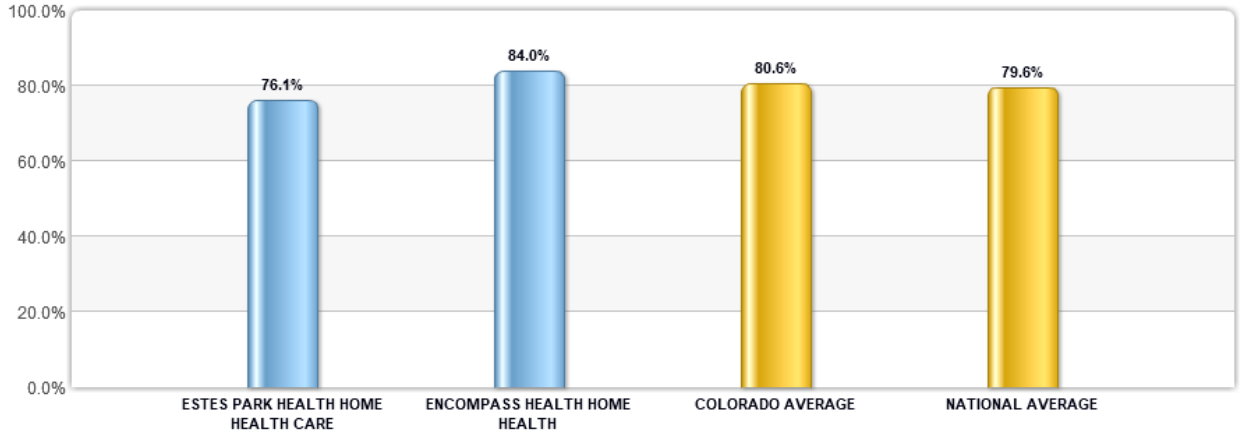
Outcome and Assessment Information Set (OASIS) data is used to calculate the home health quality measures (both outcome and process measures). OASIS is the instrument and data collection tool used to collect and

report home health agency performance. These indicators of home health care quality are also known as 'quality measures.' The quality measures are publicly reported on Home Health Compare. It provides data on the quality of services provided by Medicare-certified home health agencies.

Here are the outcomes/quality indicators from the Home Health Outcome and Assessment Information Set (OASIS) C during the time period January 01, 2019 - December 31, 2019. These graphs compare the national average, Colorado state average, Estes Park Health Home Health Care, and one other home health agency in Larimer County (Encompass Home Health of Colorado—proprietary).

As you will see in this data, there are areas for improvement and also areas in which we excel. Each staff member in filling out the OASIS-C on admission and discharge must paint a picture of the patient's status by correctly answering the OASIS-C questions. In the areas where improvement is needed, we drill down, do specific education, as well as work on proper documentation techniques. Several of these quality measures are a part of our quality management program.

Quality of Patient Care Measures:
How often patients got better at walking or moving around



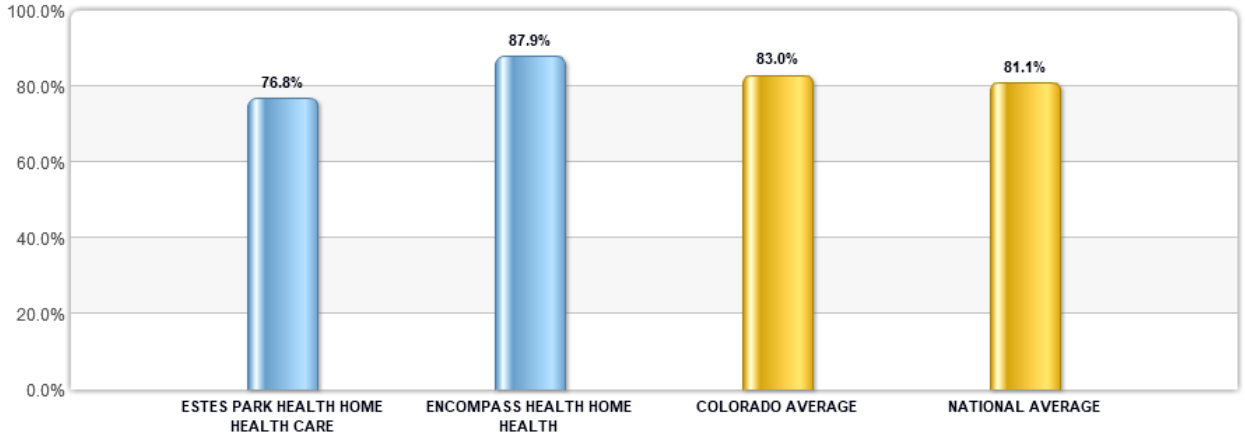
(Our score from a year ago=62.7%)

What does it mean?
This shows how often the home health team helped patients improve their ability to walk or move around.

Why is this information important?
Some patients may need help from a person or equipment (like a cane) to walk safely. If they use a wheelchair, they may have difficulty moving around safely. Getting better at walking or moving around in a wheelchair may be a sign that they are making progress and meeting the goals of the plan of care. In order to be as independent as possible, patients should be encouraged to walk, move around, and do as much as they can themselves, even if it takes more time. Both the home health team and family caregivers should encourage patients to be as active as they can safely be. The home health team will evaluate patients' needs for, and teach patients how to use any special devices or

equipment that will help increase their ability to perform some activities without help.

How often patients got better at getting in and out of bed



(Our score from a year ago=75.4%)

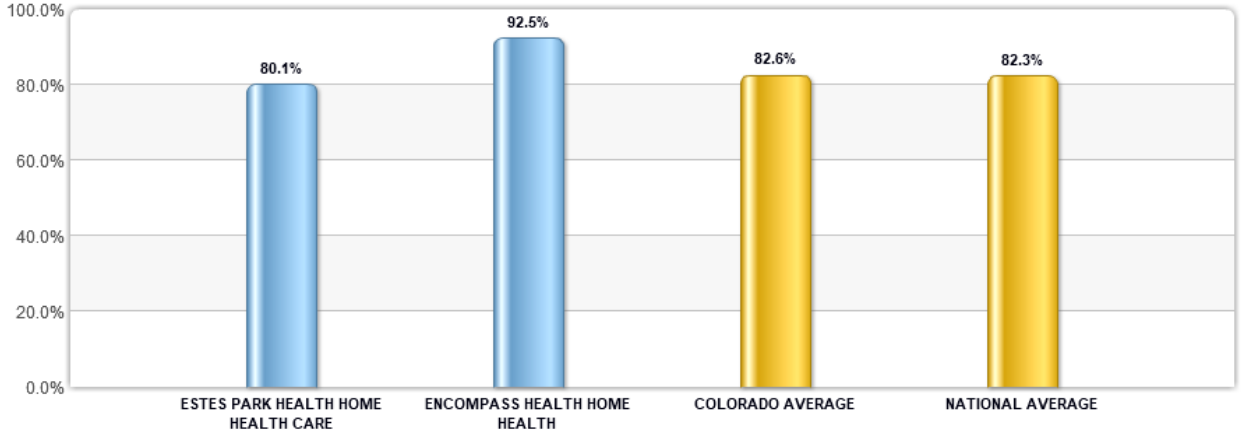
What does it mean?

This shows how often the home health team helped patients improve their ability to get in and out of bed.

Why is this information important?

A patient's ability to get in and out of bed by himself/herself is a first step toward doing many other things like getting dressed or getting to the toilet. This is especially important if family caregivers aren't available to help when home health care ends. The home health team and informal caregivers should encourage patients to do as much as they can for themselves. Patients who can get in and out of bed with little help may be more independent, feel better about themselves, and stay more active. The home health team evaluates patients' needs, and teaches patients how to use any special devices or equipment that may increase their ability to perform some activities without the assistance of another person.

How often patients got better at bathing

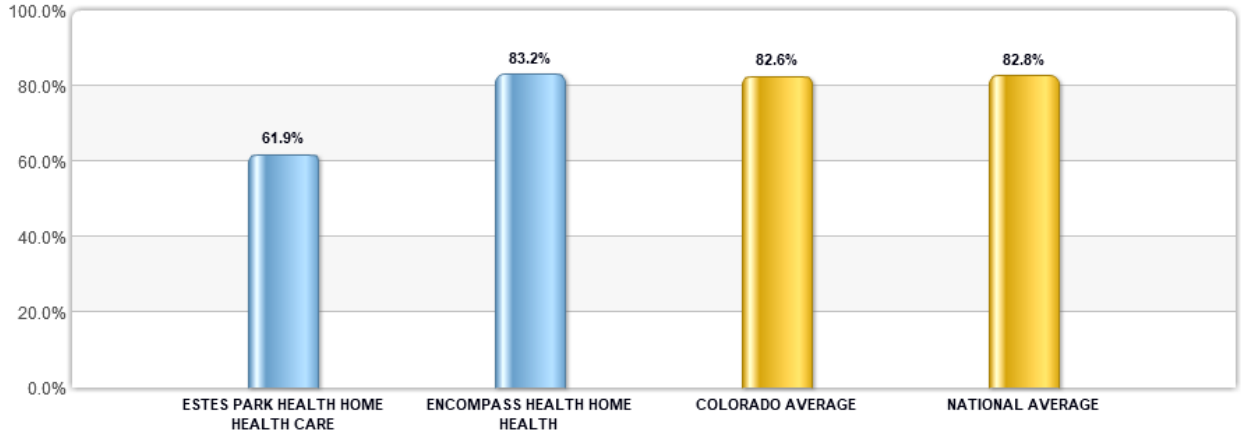


(Our score from a year ago=72.4%)

What does it mean?
This shows how often the home health team helped patients improve their ability to bathe.

Why is this information important?
Being able to bathe is an important element in patients' ability to be more independent, stay clean, stay healthy, and feel good about themselves. However, there are certain physical abilities (motor skills) required to take a bath (or shower). Patients may need help from a person or special equipment in order to bathe. A patient's physical abilities can be developed or maintained by managing medical symptoms or through physical or occupational therapy. Getting better at bathing may mean that less assistance is needed to bathe or that assistive equipment is needed to bathe independently. Both can be signs that the patient is making progress and meeting the goals of the plan of care. The home health team and caregivers should encourage patients to do as much for themselves as they can, even if this takes more time. The home health team evaluates patients' needs, and teaches patients how to use any special devices or equipment that may be needed. Being able to perform activities like bathing independently are especially important if there are no informal caregivers who can help when home health care ends. If a patient stops taking care of himself/herself, this may mean that the patient's health has gotten worse. Some patients will lose functions in their basic daily activities even though the home health team provides good care.

How often patients' breathing improved



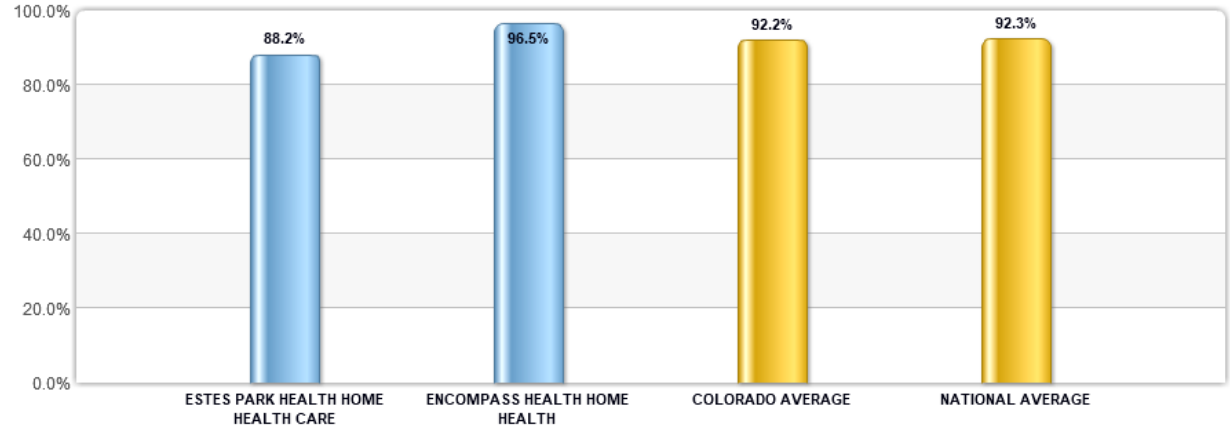
(Our score from a year ago=69.7%)

What does it mean?
This shows how often the home health team helped improve patients' breathing, meaning patients had less shortness of breath.

Why is this information important?
Shortness of breath, or difficulty breathing, is uncomfortable and may make patients anxious. Many patients with heart or lung problems have shortness of breath because they can't get enough oxygen to their lungs. Shortness of breath is associated with breathing faster than normal and feeling like there is

not enough air. Shortness of breath can also make a patient tire easily and be unable to do normal activities. The home health team, in consultation with the doctor, should check the patients' breathing and teach them ways to make breathing easier and more efficient; including: • Quitting smoking and avoiding secondary smoke • Performing breathing exercises • Positioning to breathe easier and encouraging relaxation • Using several pillows to sleep • Planning for rest periods between activities • Limiting talking, if talking causes shortness of breath • Opening a window or using a fan to get air moving • Using a humidifier in the winter • Using oxygen or medicine correctly, as ordered by the doctor. Some patients who have a chronic breathing problem like emphysema may not get better even though the home health team gives good care.

How often patients' wounds improved or healed after an operation



(Our score from a year ago=90.0%)

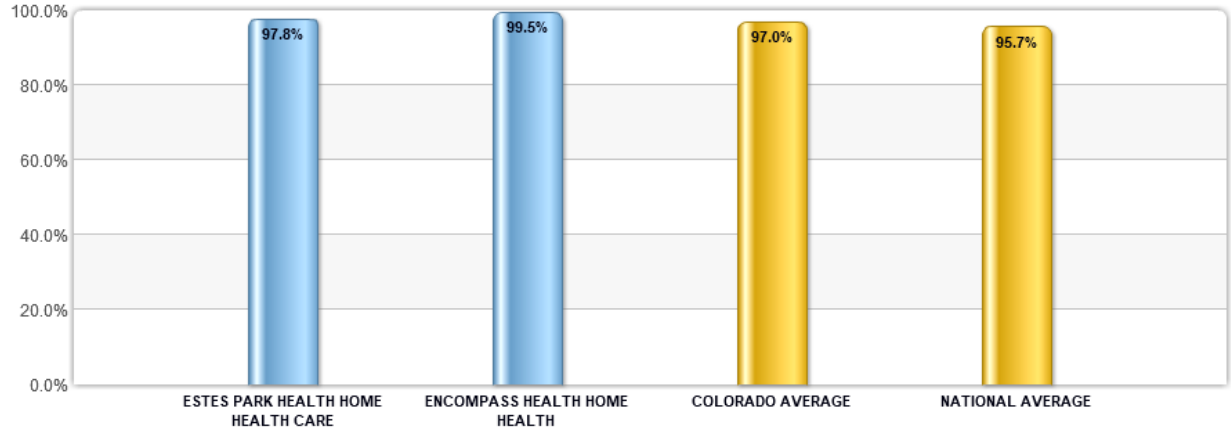
What does it mean?

This shows how often the home health team helped patients' wounds improve or heal after an operation. Normal wound healing after an operation is an important marker of good care.

Why is this information important?

One way to measure the quality of care that home health agencies give is to look at how well their patients' wounds heal after an operation. Patients whose wounds heal normally generally feel better and can get back to their daily activities sooner than those whose wounds don't heal normally. The home health team can assist with wound healing in several ways: • Change the wound dressing, per doctor's orders, or teach the patient or caregiver to change the dressing • Teach the patient or caregiver about the following: • Signs of wound healing • The types of foods that promote healing and restore normal functioning • Any drugs the doctor has ordered, such as drugs used to relieve pain • Any signs of infection or other problems. If any signs of infection or other problems are present, the nurse should contact the doctor and ask if there are additional orders. If the patient sees signs of infection or has concerns about the wound on a day when the nurse is not scheduled to visit, the patient should be instructed to call the home health team to schedule a visit as soon as possible to look at the wound, or call the doctor. Some patients may not improve, or may get worse, even though the home health team provides good care.

How often the home health team began their patients' care in a timely manner



(Our score from a year ago=98.8%)

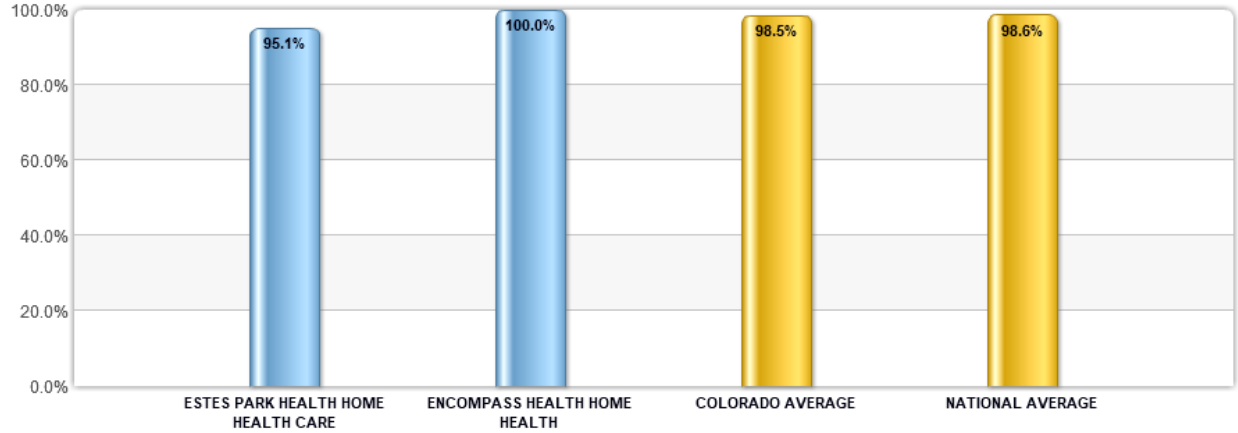
What does it mean?

This shows how often the home health team began a patient's care: • On the date the doctor ordered • Within two days after the agency was notified of the order • Within two days of the patient coming home from the hospital or other facility. The doctor's order may or may not specify a start date. If the order doesn't include a specific start date, home care should start either within two days after the agency was notified of the order or within two days of the date the patient was discharged.

Why is this information important?

It is important for patients to get the home health care they need, when they need it. If home health care is delayed, the patient's condition could worsen.

How often the home health team taught patients (or their family caregivers) about their drugs



(Our score from a year ago=95.1%)

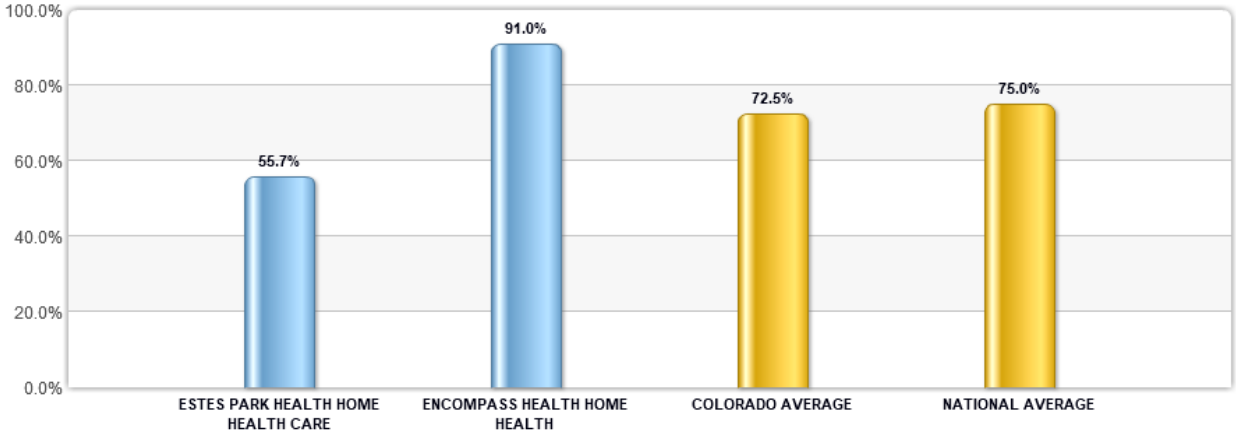
What does it mean?

This shows how often the home health team taught patients or their family caregivers about their drugs (including prescription drugs, over-the-counter drugs, vitamins, and herbal supplements). This teaching includes the following: •

When and how to take each drug • How to tell whether each drug is working • What side effects to watch for • What to do if side effects happen.

Why is this information important?
When patients understand how their drugs work, they're more likely to take them correctly, and less likely to make a mistake that may cause harm.

How often patients got better at taking their drugs correctly by mouth

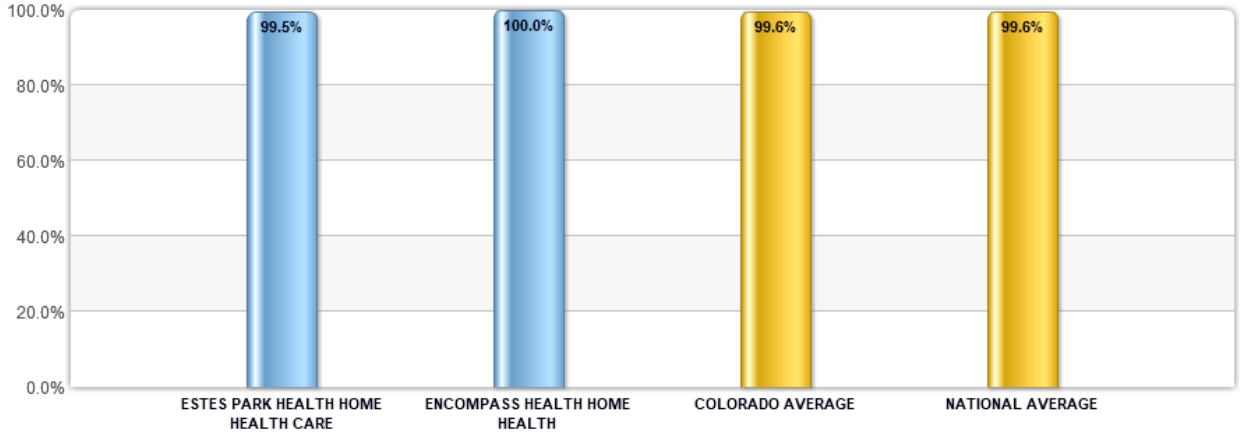


(Our score from a year ago=60.8%)

What does it mean?
This shows how often the home health team helped patients get better at taking their prescription and other drugs correctly (including prescription drugs, over-the-counter drugs, vitamins, and herbal supplements). The measure includes only drugs the patient takes by mouth.

Why is this information important?
For drugs to work properly, they need to be taken correctly. Taking too much or too little can keep the drugs from working properly and could cause unintended harm including death. The home health team can help teach ways to organize drugs and to take them properly. Getting better at taking drugs correctly means the home health team is doing a good job teaching patients how to take their drugs and about the harm that can occur if they don't follow these instructions. Communication among the patient, doctor, and the home health team is important. Specific items that should be discussed include: • All the prescription and other drugs the patient takes • Allergic reactions or bad reactions (like rashes or dizziness) to any drugs in the past • If a drug isn't working (for example, if the patient still hurts after taking pain medication). Some patients may not get better at taking their drugs even though the home health team provides good care.

How often the home health team checked patients' risk of falling



(Our score from a year ago=100.0%)

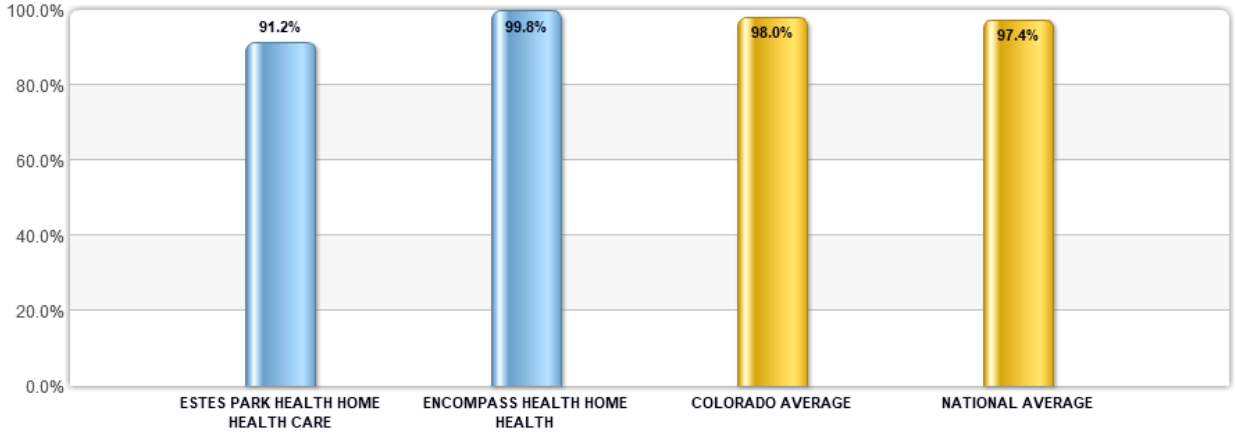
What does it mean?

This shows how often the home health team checked patients who are 65 and older to see if these patients might be in danger of falling down and hurting themselves. When home health care starts, the home health nurse will check for anything that could make a patient more likely to fall and hurt themselves, including:• A history of falling• A mental health condition• A drug regimen that includes many different drugs• Conditions in the home that may cause falls• Difficulty moving around• Difficulty getting to and from the toilet.

Why is this information important?

Falls can seriously affect the health of an older person. By checking older people and their homes for things that could increase the chances of falling, the home health team can suggest ways to prevent falls and help keep patients safe.

How often the home health team checked patients for depression



(Our score from a year ago=94.0%)

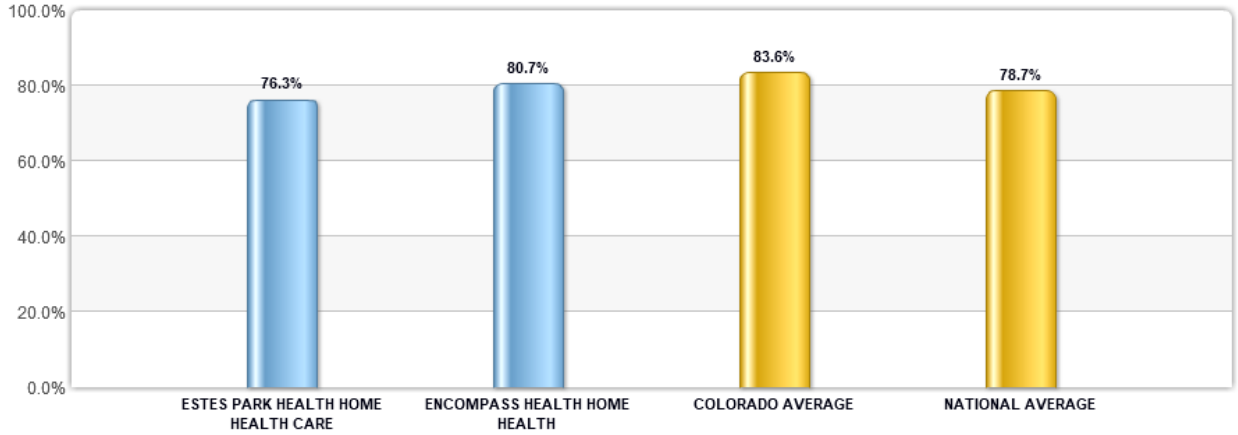
What does it mean?

This shows how often the home health team checked to see if patients were feeling especially sad or depressed. The home health team cares for their patients' mental and physical health. Some patients who need home health care may feel depressed, which may affect their recovery and their overall

health. Some questions the home health team may ask to find out if patients are depressed are: "Over the last two weeks, how often have you had little or no interest in doing things?" or "How often have you felt down, depressed, or hopeless?"

Why is this information important?
When patients who may be depressed get the help they need, it helps their recovery and may improve their overall health.

How often the home health team determined whether patients received a flu shot for the current flu season

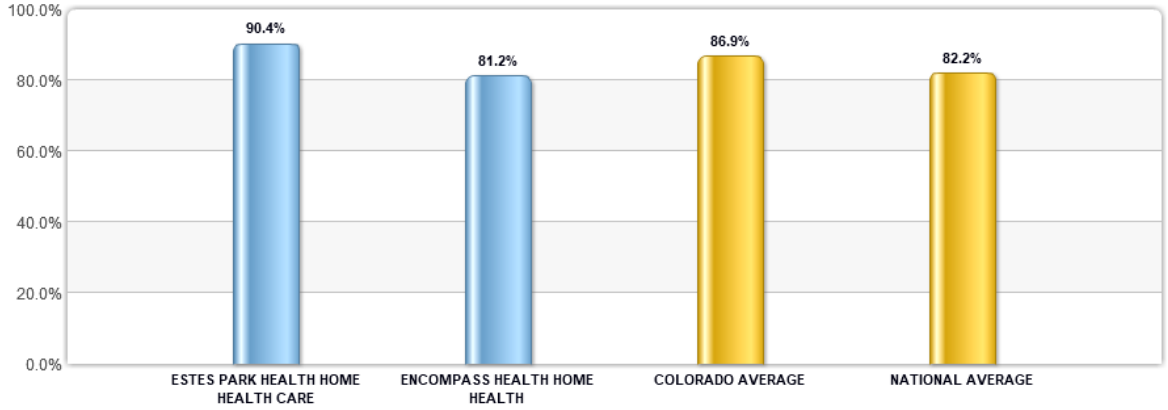


(Our score from a year ago=77.2%)

What does it mean?
The home health team should always consider whether each patient needs a flu shot for the current flu season. This shows how often the home health team found out if a patient needed or already received a flu shot.

Why is this information important?
Home health patients may be in danger of getting very sick from the flu because they already have a medical condition that may affect their ability to fight the flu. A yearly flu shot is an important way to keep from getting the flu.

How often the home health team determined whether their patients received a pneumococcal vaccine (pneumonia shot)

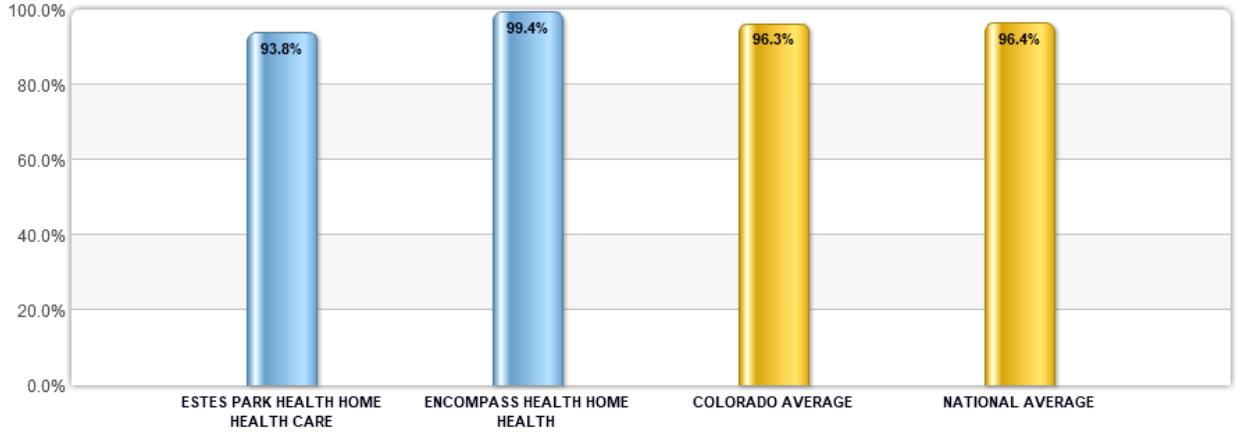


(Our score from a year ago=88.8%)

What does it mean?
The home health team should always ask if their patients have ever had a pneumonia shot. This shows how often the home health team found out if the patient needed or already received a pneumonia vaccine.

Why is this information important?
Home health patients may be in danger of getting very sick from pneumonia, a serious lung infection, because they already have a medical condition that may affect their ability to fight pneumonia. A pneumonia vaccine may help prevent some types of pneumonia.

For patients with diabetes, how often the home health team got doctor's orders, gave foot care, and taught patients about foot care

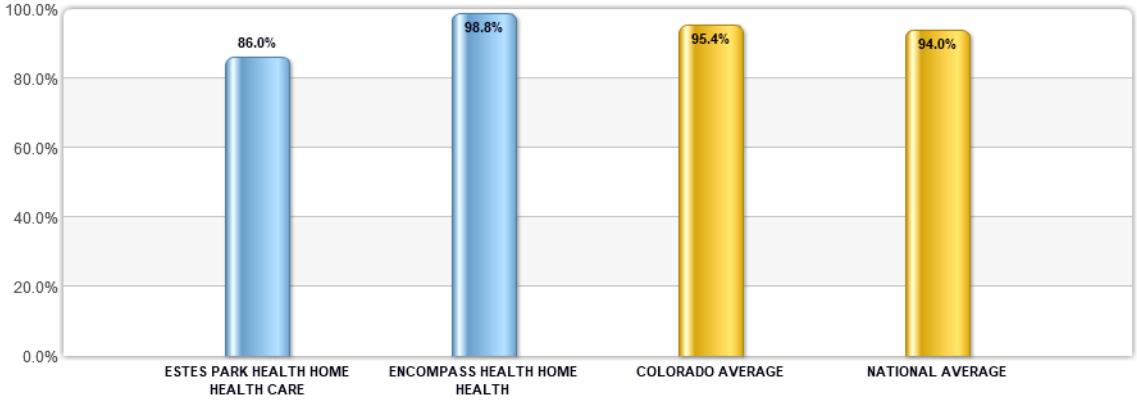


(Our score from a year ago=98.0%)

What does it mean?
This shows how often the doctor's orders included diabetic foot care and how often the home health team checked the feet of patients with diabetes for problems and taught patients (or their caregivers) special foot care.

Why is this information important?
Patients with diabetes are at greater risk of having problems with the blood circulation in their feet and therefore need regular foot care. Even a small problem like a cut or a blister can lead to serious health problems, including having to remove a toe or the foot (amputation). Regular foot care helps prevent these problems and keeps patients with diabetes healthy.

How often physician-recommended actions to address medication issues were completed timely



(Our score from a year ago=73.7%)

What does it mean?

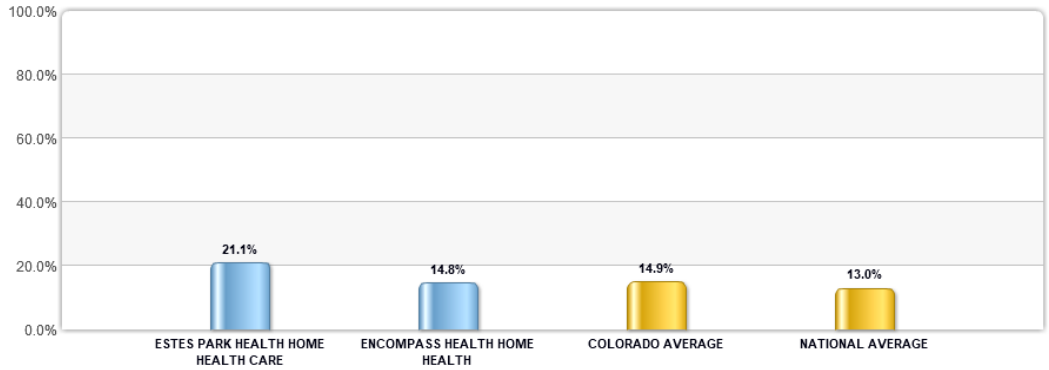
This measure shows the percentage of home health quality episodes in which a drug regimen review was conducted at the start of care or resumption of care and clinicians completed actions recommended from timely follow-up with a physician, each time potential or actual clinically significant medication issues were identified. Higher percentages are better.

Why is this information important?

Performing a medication reconciliation and drug regimen review for each patient at the start of care and resumption of care can help reduce adverse drug events (ADEs) by identifying clinically significant medication errors before an ADE can occur. Home health agencies can help to prevent ADEs by:

1. Educating staff on how to conduct drug regimen reviews and identify risks and problems, as well as to be observant for medication issues
2. Implementing a system to ensure that each patient's medication usage is evaluated when home health starts and on an ongoing basis
3. Identifying risks and problems and acted upon in a timely manner
4. Promptly communicating medication risks and problems to the patient's physician and implementing their recommended actions.

How often patients receiving home health care needed any urgent, unplanned care in the hospital emergency room – without being admitted to the hospital

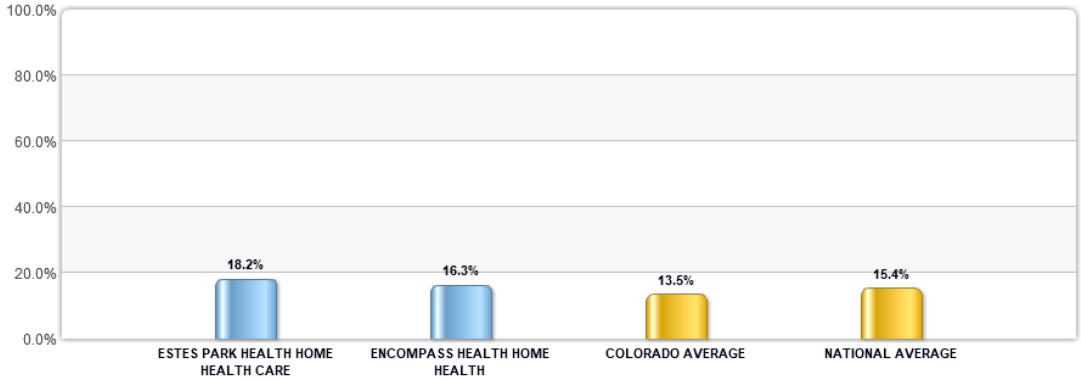


(Our score from a year ago=13.4%)

This shows how often patients went to the emergency room while under the care of the home health team.

Why is this information important?
Some home health patients may need to go to the emergency room, even if they are getting good care. For example, some chronic medical conditions can't be cured and, over time, may make a patient's health worse. For some patients, a readmission to the hospital may be a planned part of continuing treatment for their medical conditions. However, some inpatient hospital care may be avoided if the home health team is doing a good job checking the patient at each visit to find problems early, and communicating regularly with the doctor and other members of the team about the patient's condition. The home health team should check how the patient is eating, drinking, how well they are taking their prescription and other drugs, and how safe the home environment is. If the patient shows signs of getting worse, the home health team should notify the doctor as soon as possible. In some cases, the doctor will want to see the patient or have the patient go to an urgent care facility or a hospital. Lower numbers are better for this measure, because the home health team, in many instances, can prevent the need for hospital care. At the same time, the home health team should ensure that patients who need emergency help are seen as soon as possible.

How often home health patients had to be admitted to the hospital



(Our score from a year ago=9.2%)

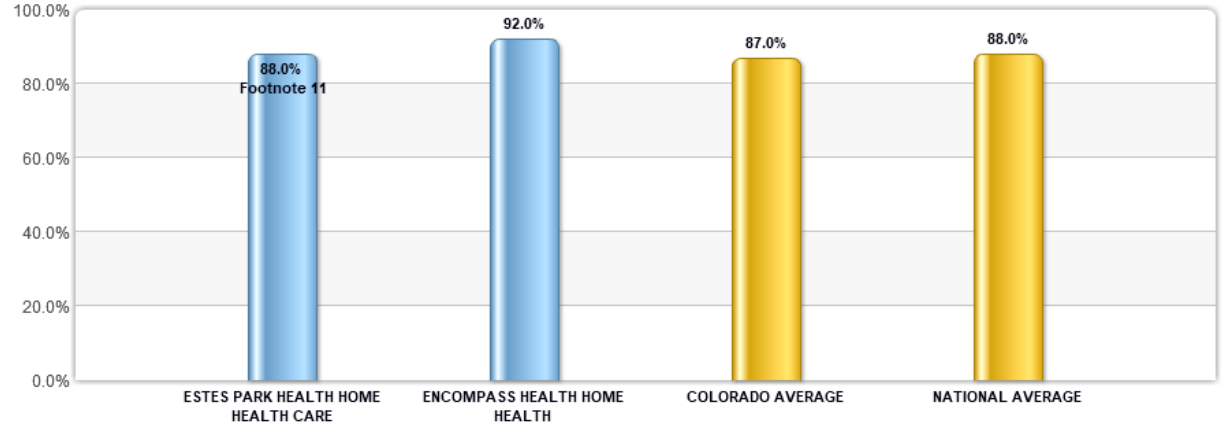
What does it mean?
This shows how often patients were admitted to the hospital while under the care of the home health team.

Why is this information important?
Some home health patients may need to be admitted to the hospital, even if they're getting good care. For example, some chronic medical conditions can't be cured and, over time, may make a patient's health worse. For some patients, a readmission to the hospital may be a planned part of continuing treatment for their medical conditions. However, some inpatient hospital care may be avoided if the home health team is doing a good job checking the patient at each visit to find problems early, and communicating regularly with the doctor and other members of the team about the patient's condition. The home health

team should check how the patient is eating, drinking, how well they're taking their prescription and other drugs, and how safe the home environment is. If the patient shows signs of getting worse, the home health team should notify the doctor as soon as possible. In some cases, the doctor will want to see the patient or have the patient go to an urgent care facility or a hospital. Lower numbers are better for this measure, because the home health team, in many instances, can prevent the need for hospital care. At the same time, the home health team should ensure that patients who need hospital care are hospitalized as soon as possible. Lower numbers are better for this measure.

Patient Survey Results:
The following information comes from the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) Patient Experience of Care Survey during the time period January 01, 2019 - December 31, 2019. This data is also publicly reported on Home Care Compare.

How often the home health team gave care in a professional way

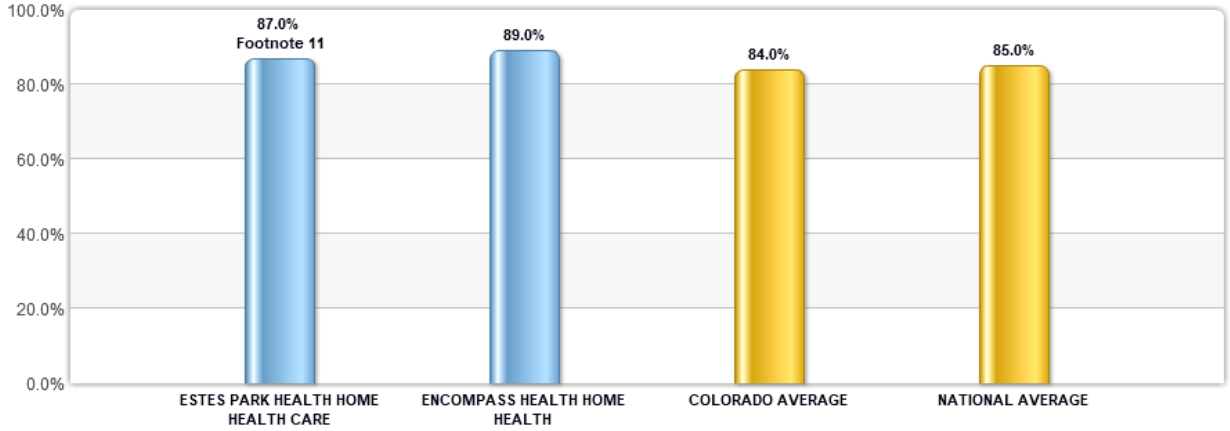


[11] Fewer than 70 patients completed the survey. Use the scores shown, if any, with caution as the number of surveys may be too low to accurately tell how an agency is doing.

(Our score from a year ago=88.0%)

What does it mean?
Patients who got home health services during the current reporting period reported how often their home health team gave care in a professional way. "Gave care in a professional way" means that: There were no problems with the home health care; Providers were always gentle; Providers were always respectful; Providers were always up-to-date about the patient's treatment. This shows the percent of patients surveyed who said the home health team gave care in a professional way.

How well did the home health team communicate with patients



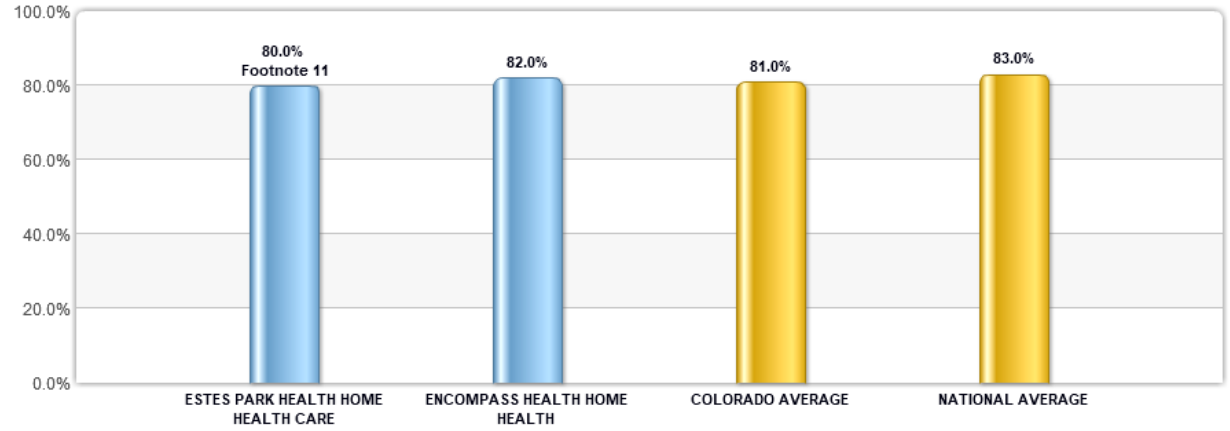
[11] Fewer than 70 patients completed the survey. Use the scores shown, if any, with caution as the number of surveys may be too low to accurately tell how an agency is doing.

(Our score from a year ago=85.0%)

What does it mean?

Patients who got home health services during the current reporting period reported how well their home health team communicated. "Communicated well" means that the home health agency did all of the following: explained services before giving them, gave advice promptly, always said when staff would arrive, always explained things clearly, always listened carefully. This shows the percent of patients surveyed who said the home health team always communicated well.

Did the home health team discuss medicines, pain, and home safety with patients



[11] Fewer than 70 patients completed the survey. Use the scores shown, if any, with caution as the number of surveys may be too low to accurately tell how an agency is doing.

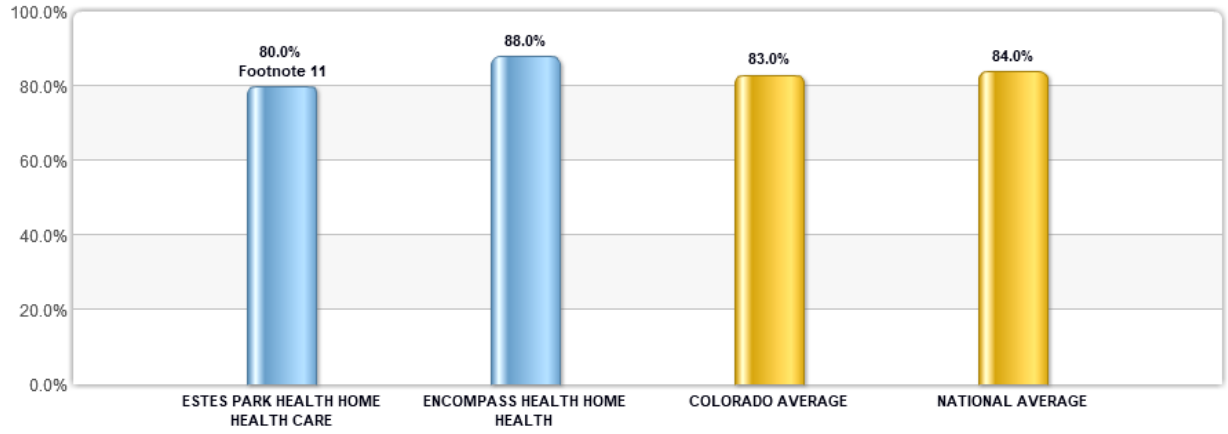
(Our score from a year ago=80.0%)

What does it mean?

Patients who got home health services during the current reporting period reported if their home health team talked with them about: Medicines, Pain, Getting around their home safely. This shows the percent of patients surveyed

who said the home health team discussed medicines, pain, and home safety with them.

How do patients rate the overall care from the home health agency



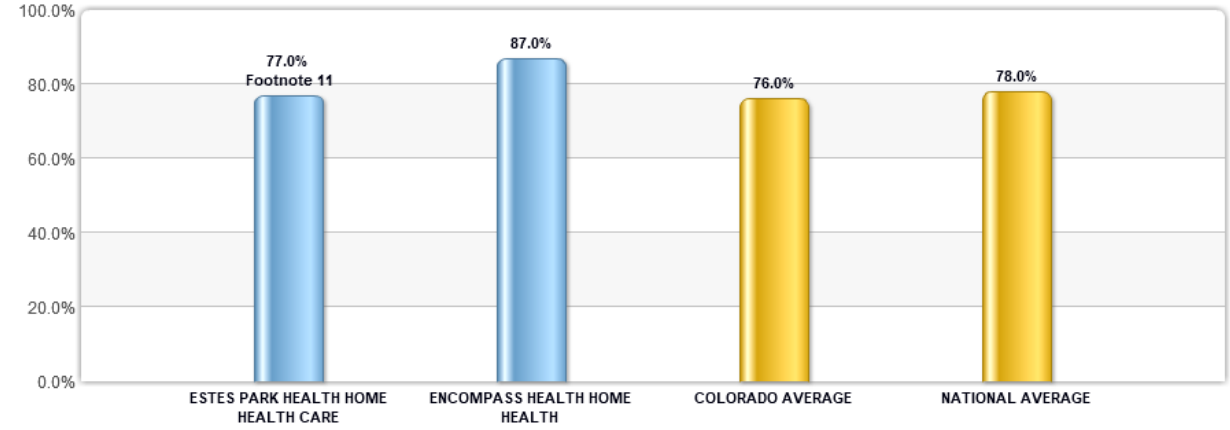
[11] Fewer than 70 patients completed the survey. Use the scores shown, if any, with caution as the number of surveys may be too low to accurately tell how an agency is doing.

(Our score from a year ago=76.0%)

What does it mean?

Patients who got home health services during the current reporting period answered a separate question that asked for an overall rating of the home health care services. Ratings were on a scale from 0 to 10: "0" means "worst home health care possible", "10" means "best home health care possible" This shows the percent of patients surveyed who gave their agency a 9 or 10 on a scale of 0 (lowest) to 10 (highest).

Would patients recommend the home health agency to friends and family



[11] Fewer than 70 patients completed the survey. Use the scores shown, if any, with caution as the number of surveys may be too low to accurately tell how an agency is doing.

(Our score from a year ago=75.0%)

What does it mean?

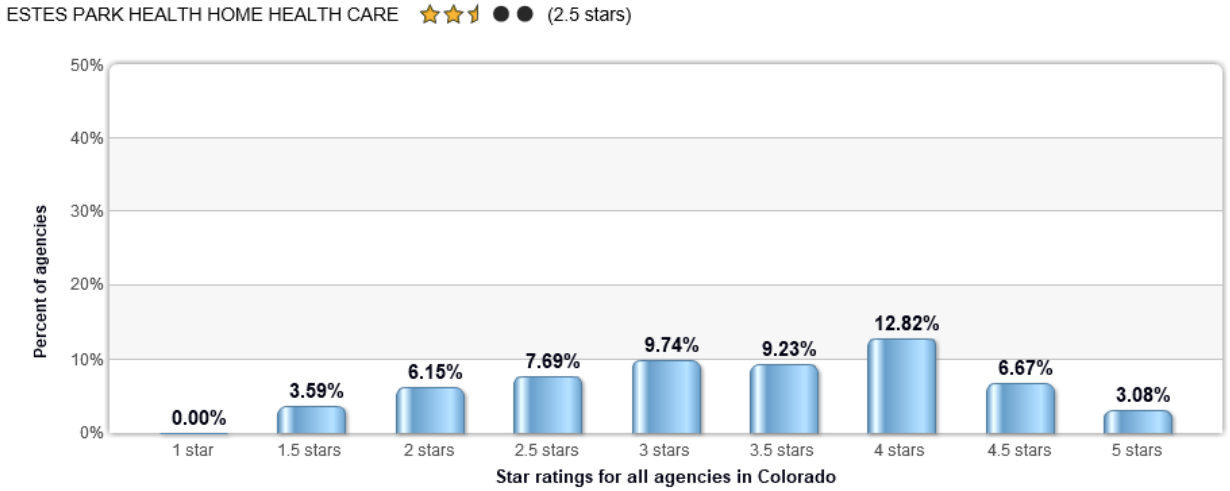
Patients who got home health services during the current reporting period reported whether they would recommend the home health agency to their

friends and family. This shows the percent of patients surveyed who said yes, they would definitely recommend the home health agency.

Home Health Star Rating

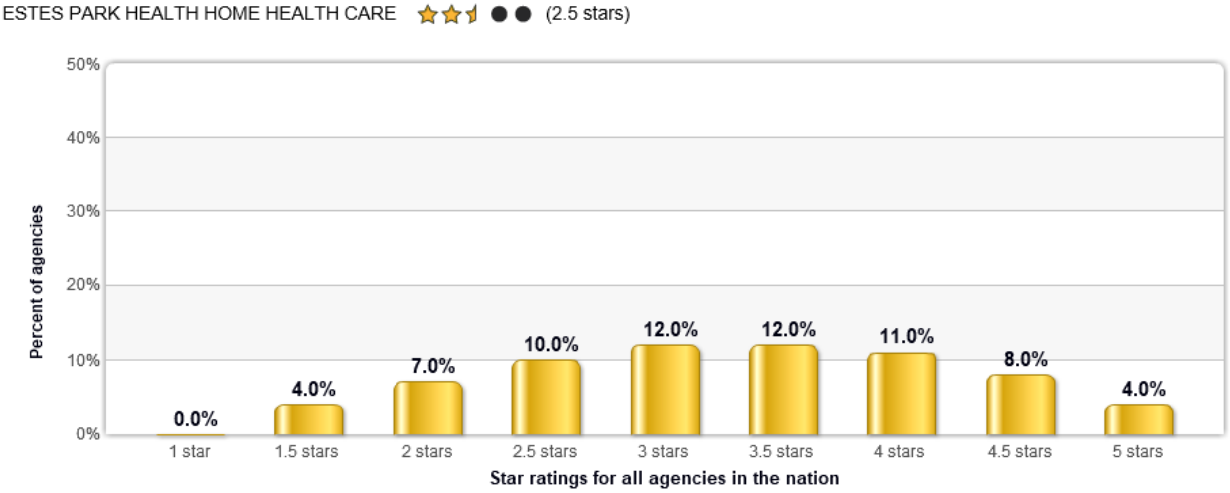
Home health agencies are a part of the Centers for Medicare and Medicaid Services (CMS) 5-star rating system. The quality of patient care star rating summarizes 8 of the 23 quality measures reported on Home Health Compare. It provides a single indicator of an agency's performance compared to other agencies. Across the country, most agencies fall "in the middle" with 3 or 3½ stars.

Here are the quality of patient care star ratings for the our agency compared to the star ratings for all home health agencies in Colorado.



(Our score from a year ago=3 stars)

Here are the quality of patient care star ratings for the our agency compared to the star ratings for all home health agencies nationwide.



(Our score from a year ago=3 stars)

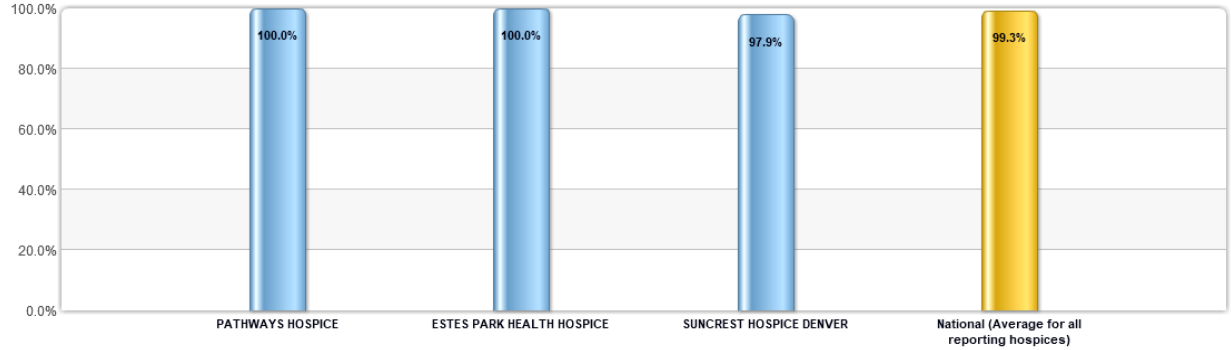
Hospice Quality Measures--HIS

The Hospice Item Set (HIS), is a patient-level data collection tool developed as part of the Hospice Quality Reporting Program (HQRP), that is

used to calculate 7 quality measures (Patients Treated with an Opioid who are Given a Bowel Regimen, Pain Screening, Pain Assessment, Dyspnea Screening, Dyspnea Treatment, Treatment Preferences, Beliefs/Values Addressed). We must collect data and submit 2 HIS records for each patient admitted to our organization – an HIS-Admission record and an HIS-Discharge record. The HIS is electronically completed and submitted to Centers for Medicare & Medicaid Services (CMS) on an ongoing basis. The data from those assessments is used to calculate the 7 quality measures that are publicly reported.

The data is publicly available on Hospice Compare. Listed in this report is data from time period January 1, 2019 to December 31, 2019. Below are percentages from Medicare's official site under the Hospice Compare section. This compares the national average, Estes Park Health Hospice, and two other hospice agencies in Colorado (Pathways Hospice—non-profit and Suncrest Hospice Denver—for-profit).

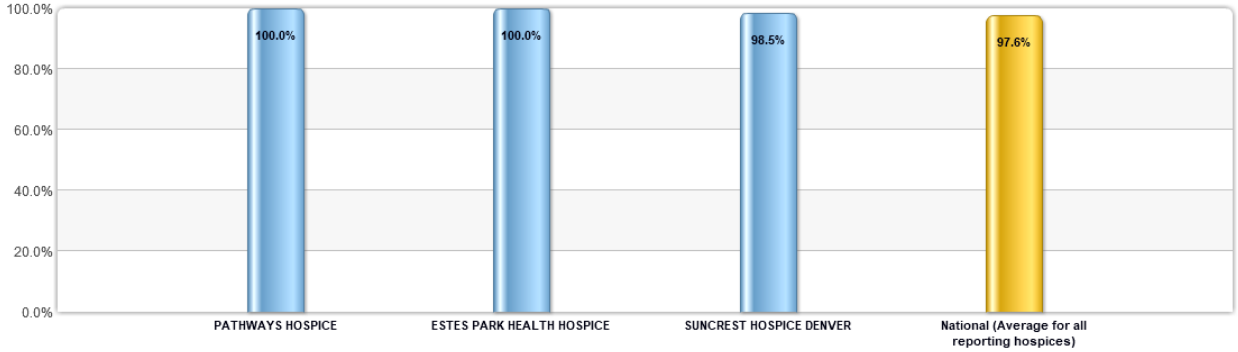
Patients and caregivers who are asked about treatment preferences like hospitalization and resuscitation at the beginning of hospice care



(Our score from a year ago=100.0%)

Having discussion with hospice staff about treatments that patients want or don't want helps ensure that patients get the care they want at the end of life.

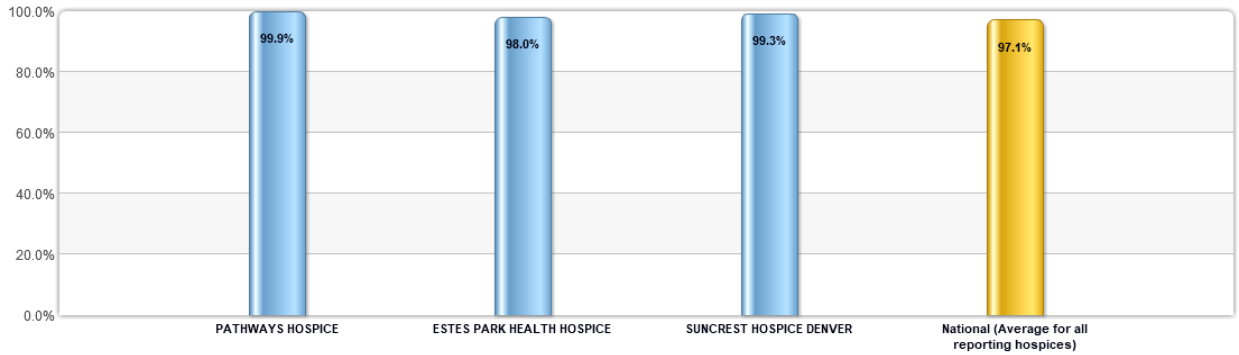
Patients or caregivers who were asked about their beliefs and values at the beginning of hospice care



(Our score from a year ago=100.0%)

Patients and caregivers should have the opportunity to discuss their spiritual and religious needs, beliefs and values to help ensure these care needs are met.

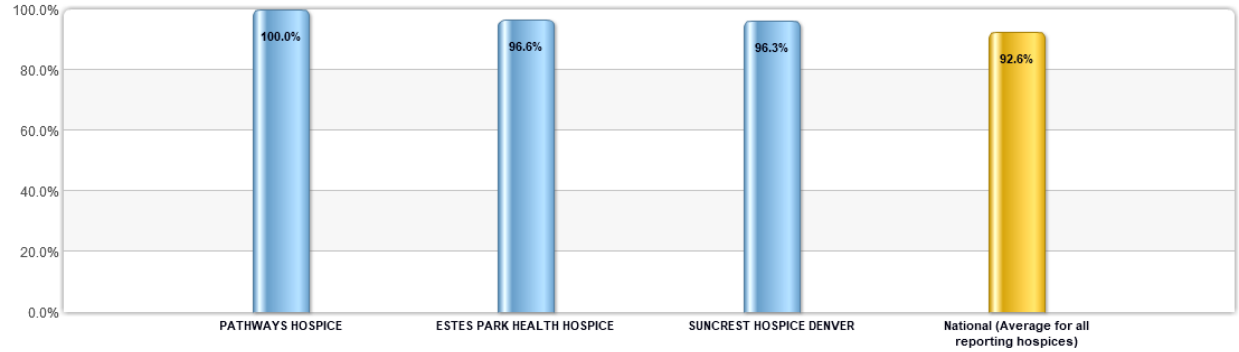
Patients who were checked for pain at the beginning of hospice care



(Our score from a year ago=100.0%)

Pain is common and often undertreated for hospice patients. It can interfere with patients' daily activities and can be very distressing for patients and families.

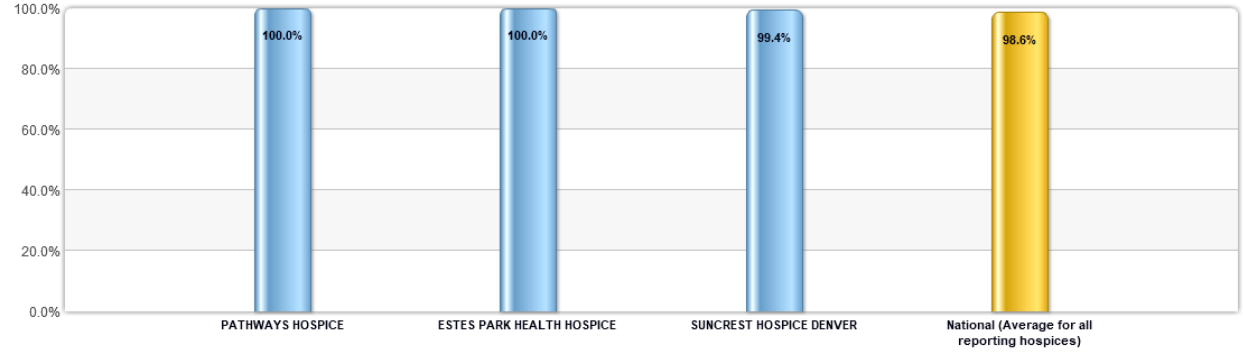
Patients who got a timely and thorough pain assessment when pain was identified as a problem



(Our score from a year ago=not available)

Within a day of finding that pain is a problem, hospice staff should collect information about the pain, like its location, how long it lasts, and its severity.

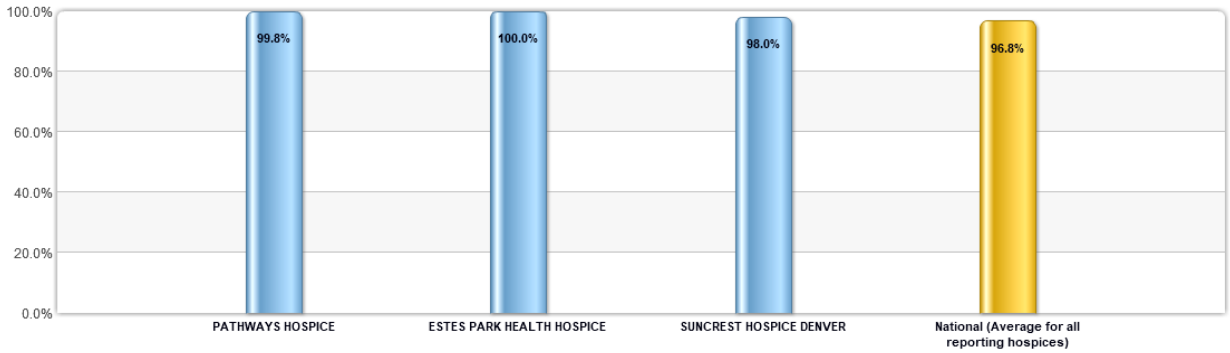
Patients who were checked for shortness of breath at the beginning of hospice care



(Our score from a year ago=100.0%)

Shortness of breath is common and often undertreated in hospice patients. It can interfere with patients' routine and can be upsetting for patients and families.

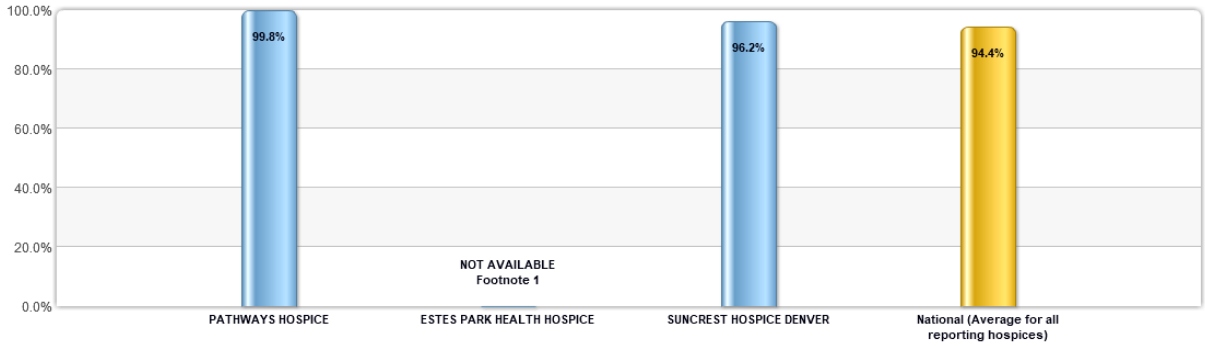
Patients who got timely treatment for shortness of breath



(Our score from a year ago=not available)

Within a day of finding that shortness of breath is a problem, hospice staff should start treatment. Treatment can be medications, relaxation or breathing exercises.

Patients taking opioid pain medication who were offered care for constipation



[1] The number of patient stays is too small to report (less than 20 patient stays).

(Our score from a year ago=not available)

Constipation is a side effect of opioid use. Staff can recommend treatment options, like laxatives or fiber, to prevent and treat opioid-related constipation.

Home Care Quality Measures

For non-medical home care, we have three quality measures—client satisfaction, number of missed visits documented correctly, and replacement aide/visit offered for missed visit. These results are monitored and are a part of the ongoing quality management program.

CASPER Reports

We have a variety of reports available to us from CASPER reporting. These reports are pulled routinely, tracked/trended, and monitored. The Agency Patient-Related Characteristics Report is a report for our Medicare/Medicaid patients. This report has interesting information such as our average patient age, % female, % Caucasian, living situation and availability of care, % needing oxygen, % of different diagnoses, length of stay etc. The Outcome Report and HHA Process Measures Report have end result outcomes of our services. These

reports compare Sept 2018-Aug 2019 with Sept 2019-Aug 2020 and the national reference.

--see attached 2020 Agency Patient-Related Characteristics (Case Mix) Report, 2020 Outcome Report, and 2020 HHA Process Measures Report.

Policies and Procedures

Home Health Care and Hospice have Policies and Procedures created by The Corridor Group, Inc that meet both the state and federal guidelines to ensure compliance with the regulatory bodies. All updated department policies and procedures must be approved by the Professional Advisory Committee or designee in correlation with the governing body of the Board.

Estes Park Health uses an online policy manager where the hospital-wide policies and procedures are kept.

Computer System

We use the electronic medical record (EMR) system Brightree/Matrixcare. Brightree/Matrixcare is a cloud-based software program. The clinicians document their visits in the field on iPads. Brightree/Matrixcare does not require an internet connection or cell service to document or save in the home—which is essential due to limited internet access/cell service in many of the homes we visit. There is also an office software that is used by office staff, the clinical coordinators, and billing personnel. We continue to find ways to revise processes and educate staff on the most efficient ways to use Brightree/Matrixcare.

Record Review

Many processes changed with our transition from paper to an electronic medical record system. Record review changed significantly. We review 100% of documentation for a new admission, any recertification, and any start of care evaluations regardless of payer source. All such documentation is reviewed thoroughly by a nurse who rejects the work and sends it back for corrections as needed. A briefer review for corrections done and other key items is completed by the clinical coordinators before closing these assessments. All OASIS-C/HIS are reviewed and submitted to Medicare within the designated timeline requirements.

All charts are also reviewed before they are discharged and ready for billing to ensure critical items are completed. The discharge reviewer looks at and checks order compliance and visit completion to be sure that all required documentation is in place, appropriate documents are signed by the physician, and care plans are resolved.

Contracts

We continue to update and renew yearly contracts for services and agreements required to provide care.

Licenses

We continue to be licensed by the state of Colorado with three licenses: Home Care Agency Class A-Medical, Home Care Agency Class B-Non-Medical,

and Hospice. Each year we go through a renewal application process for each of these licenses.

Surveys

We are surveyed at least every three years by the Colorado Department of Health and Environment. Because we have three licenses/sets of regulations, there can be three separate surveys. These surveys are a three day (or more) extensive process which includes home visits, chart reviews, and review of our quality management program, policies, board minutes, complaint logs, personnel records, organizational chart, admission packets, documentation of staff education, emergency preparedness plan, contracts, and any other documentation they may request.

Our last survey was conducted December 17-20, 2018 by the Colorado Department of Public Health and Environment. It involved four full days of home visits, chart reviews, staff interviews, and review of our QAPI program, our bereavement program, our volunteer program, plus requests for many other pieces of documentation. There were only 2 small deficiencies.

Customer Service

We currently use NRC Health for our patient satisfaction surveys/HHCAHPS for both home health care and hospice services.

HHCAHPS/Home Health Care Patient Satisfaction Surveys

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey, hereafter referred to as the "Home Health Care CAHPS Survey" or "HHCAHPS," is designed to measure the experiences of people receiving home health care from Medicare-certified home health agencies. The HHCAHPS is conducted for home health agencies by approved HHCAHPS Survey vendors. Estes Park Health changed the HHCAHPS vendor in 2020 from Press Ganey to NRC Health. The questions asked on the survey after discharge are specific to the details of the care patients received while on home health care.

Comments sometimes accompany our NRC Health surveys. We also get many direct thank you notes from families throughout the year. Following are a few comments we received this year:

"I thank you for all the help you both have given me. You are angels of mercy."

"Thank you for the help, ideas, and dedication to assist him to be stronger and more capable at moving around. We enjoyed the friendliness, expert skills, and knowledge they shared with us. Thank you for tall the precautions you each took to come here during this time of pandemic. Health Care is a demanding and risky profession. All of you seem to enjoy it. For that we are very grateful and fell fortunate to have you services this community."

"Always polite, helpful. All the health care providers were very professional and caring!"

"Always prompt + very helpful."

"Grateful to all - nurse figured out I had a chemical burn over hip incision that became MRSA. Probably saved my life."

"Very courteous and knowledgeable. Showed concern for my wellbeing. Followed up with phone calls sometime."

"Everyone of the caregivers was knowledgeable, caring, effective and professional."

"They are all fabulous and sweet. Kind, thorough, definitely good at what they all did. Excellent."

"On their last visit, I was supplied with Estes Park Health's 24/7 emergency nurse phone number and encouraged not to hesitate to use it if I felt the need. Our home agency is like having a large security blanket!"

"Health care nurse was great and right on top of it."

"All were friendly, helpful and sympathetic."

"Very well trained and to the point with service. I appreciate the great health care they provided me!"

Below are the 2020 year to date home health care scores:

HHCAHPS Stoplight Report

Service Dates From Oct 1, 2019 to Sep 30, 2020

https://catalyst.nrcpicker.com/eph/hhcahps/default.aspx November 24, 2020

	Benchmarks		Calendar Year	Estes Park Home Health Care HHCAHPS			
Overall	NRC 50th Percentile*	NRC 75th Percentile	Current YTD	Qtr 3 2020‡	Qtr 2 2020	Qtr 1 2020	Qtr 4 2019
We want to know your rating of your care from this agency's home health providers. Using any number from 0 to 10, where 0 is the worst home health care possible and 10 is the best home health care possible, what number would you use to rate your care from this agency's home health providers?	87.7% (n=35,479)	90.8% (n=35,479)	85.0% PR=31 (n=40)	72.7%µ (n=11)	90.0%µ (n=10)	89.5%µ (n=19)	--

Key Drivers	NRC 50th Percentile*	NRC 75th Percentile	Current YTD	Qtr 3 2020‡	Qtr 2 2020	Qtr 1 2020	Qtr 4 2019
Care of Patient	90.5% (n=36,287)	92.2% (n=36,287)	84.9% PR=7 (n=43)	79.5%µ (n=11)	80.8%µ (n=13)	90.8%µ (n=19)	--
Specific Care Issues	87.6% (n=30,651)	90.7% (n=30,651)	76.5% PR=2 (n=35)	67.8%µ (n=9)	75.4%µ (n=11)	82.6%µ (n=15)	--
Provider Communication	88.3% (n=35,987)	90.4% (n=35,987)	79.9% PR=4 (n=43)	75.9%µ (n=11)	80.9%µ (n=13)	81.6%µ (n=19)	--

Home Care Satisfaction Surveys

Most of the time, our non-medical clients with home care stay on our service for years. Therefore we do not send out satisfaction surveys at the end of their services. However, these clients have supervisory visits at least every 90 days and at these visits they are asked whether they are satisfied with our services.

Hospice Satisfaction Surveys

Since we are exempt from Medicare's Hospice CAHPS Survey (a post-death survey focused on patient and caregiver perspectives related to their experience of our care) the information from our standard family/caregiver satisfaction surveys after the patient's death is not publicly reported. We track our survey results quarterly and some of those results are reflected in our hospice quality dashboard.

HSCAHPS Stoplight Report

Service Dates From Oct 1, 2019 to Sep 30, 2020

https://catalyst.nrcpicker.com/eph/hscahps/default.aspx November 24, 2020

	Benchmarks		Calendar Year	Estes Park Health Hospice Overall			
Overall	NRC 50th Percentile*	NRC 75th Percentile	Current YTD	Qtr 3 2020	Qtr 2 2020	Qtr 1 2020	Qtr 4 2019
Please answer the following questions about your family member's care from the hospice named on the survey cover. Do not include care from other hospices in your answers. Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member's hospice care?	87.0% (n=9,053)	89.4% (n=9,053)	93.3%µ PR=97 (n=15)	100.0%µ (n=7)	75.0%µ (n=4)	100.0%µ (n=4)	--

Key Drivers	NRC 50th Percentile*	NRC 75th Percentile	Current YTD	Qtr 3 2020	Qtr 2 2020	Qtr 1 2020	Qtr 4 2019
Understanding the Side Effects of Pain Medication	76.4% (n=8,078)	80.4% (n=8,078)	93.3%µ PR=100 (n=15)	100.0%µ (n=7)	75.0%µ (n=4)	100.0%µ (n=4)	--
Hospice Team Communication	82.2% (n=9,083)	85.1% (n=9,083)	83.2%µ PR=56 (n=15)	84.8%µ (n=7)	76.3%µ (n=4)	87.5%µ (n=4)	--
Getting Timely Care	80.3% (n=8,991)	83.2% (n=8,991)	63.3%µ PR=1 (n=15)	64.3%µ (n=7)	62.5%µ (n=4)	62.5%µ (n=4)	--

With Hospice, we receive comments from our NRC Health surveys. We also get many direct thank you notes from families throughout the year. Many of these notes of appreciation were accompanied by donations. Following are a few comments we received this year:

"You were all so kind and a wonderful help to me."

"Thank you for the care and assistance each one of you gave during his three weeks in Hospice. Your words of encouragement and support made the process of losing my best friend a little more bearable. I'm especially grateful for your kindness."

"Thank you all for your love, care, and support during his final days on earth. I know it was really difficult for us to watch someone you love fade away before your eyes but it was also the most peaceful way for him."

"Thank you for your most kind loving caring attendance to my precious husband. I was so appreciative. Grateful you gave us instructions and guidance to keep my husband comfortable in his last hours."

"Everyone who came to our home was so wonderful and helpful before, during, and after his passing. He wished to die at home so with your assistance that was all possible."

"The care was superb."

"We signed up with hospice only 36 hours prior to Martin's death. The timing was such a gift. I needed them to guide me through the last hours."

"They were loving and helpful mainly to us as mom's caregivers. I appreciate so much the follow up phone call from the chaplain."

"I only have the highest praise from all those who became involved in his care. I felt relief to have such support as I tried to deal with his decline and passing."

"A very caring team and did their best to make him comfortable until the end."

"All the hospice team were absolutely outstanding with care, comfort and very professional! A blessing!"

"It was all good just right. My family member received the best care possible. Thank you all!"

"The team was a great help for me. Wonderful informative people. They do a fantastic job."

"Wonderful nurses!"

"Everyone was very nice and helpful during this emotional process. It has been hard to remember the whole weeks process as I pushed a lot of it to the "back of my mind" since my partner died 9 weeks ago."

"The entire staff was caring and wonderful. My mom was blessed to have her final days there."

"They all were very caring and kind to him and all of our family thank you!"

Financial Management

Financial Figures Year to Date (YTD)

2020 YTD Financials through October: (Three separate P&Ls for three agencies)
Home Health Care: Revenue ($853,593) is 18.9% above budget
Expenses ($1,090,317) are 14.3% above budget
Home Care (non-skilled): Revenue ($269,285) is 11.5% below budget
Expenses ($138,390) are 44.6% below budget
Hospice: Revenue ($478,597) is 14.8% above budget
Expenses ($256,708) are 30.5% below budget

2020 YTD Roll-up for all three agencies through October:
Total for all: Revenue ($1,601,475) is 12.6% above budget
Expenses ($1,485,415) are 1.1% below budget

Brightree/Matrixcare (our EMR company) is contracted and does our billing/revenue cycle. The director is involved in oversight of the billing process—which includes weekly calls with the contract billing team, fielding patient calls/inquiries about their bill, coordinating with the Estes Park Health Patient

Financial Services employee who posts the money, running reports for and addressing claims in validation holds, and assisting the billing personnel with any issues related to clinical/administrative questions/problems.

Community & Services

Services We Provide

The services/disciplines home health care (skilled) provides are: skilled nursing, physical therapy, occupational therapy, speech therapy, social work, and certified nursing assistants.

The services/disciplines home care (non-skilled) provides are: personal care workers and homemakers and lifeline units.

The services/disciplines hospice provides are: skilled nursing, social work, spiritual counseling, dietary counseling, bereavement counseling, physical therapy, occupational therapy, speech therapy, certified nursing assistants, music, and volunteers.

Grant-Funded Programs

Larimer County has a grant-funded program that funds non-medical personal care provider/homemaker services to clients. We are providing approximately 34-45hrs/month of services for 5-6 clients. This is an excellent service for those who cannot afford the services privately and/or those who are in the Medicaid application process.

Boulder County offers non-medical personal care provider/homemaker services similar to the Larimer County Title III program that is funded by their Office on Aging. We have a contract with them to provide non-medical services to clients in Allenspark and Pinewood Springs with excellent reimbursement. We are providing approximately 75-80hrs/month of service for 5-6 clients.

Volume/Census/Graphs

Our average daily census for all services is around 130. That number is made up of: skilled home health care about 45-50 patients (40%), non-skilled home care about 40-45 clients (32%), Lifeline about 30-35 clients (24%), and hospice about 5-7 patients (4%). We do over 8500 billable visits a year for around 350 patients.

Year to date, skilled home health care volume is 12.5% above last year. Non-skilled home care volume is 17.5% below last year. Hospice volume is 9% above last year. These graphs/numbers reflect data for comparison.

HHC (Home Health Care) Total Visits—see graph & below
2016 Jan- Oct = 4072 (total Jan- Dec = 4934)
2017 Jan- Oct = 4217 (total Jan- Dec = 4910)
2018 Jan- Oct = 4427 (total Jan- Dec = 5155)
2019 Jan- Oct = 3783 (total Jan- Dec =4518)
2020 Jan- Oct = 4255 (total Jan- Dec = yet to be determined)

HC (Home Care) Total Visits—see graph & below
2016 Jan- Oct = 2329 (total Jan- Dec = 2837)
2017 Jan- Oct = 2390 (total Jan- Dec = 2781)
2018 Jan- Oct = 2002 (total Jan- Dec = 2878)
2019 Jan- Oct = 2585 (total Jan- Dec = 2999)
2020 Jan- Oct = 2131 (total Jan- Dec = yet to be determined)

Hospice Days—see graph & below
2016 Jan- Oct =1569 (total Jan- Dec = 1906)
2017 Jan- Oct = 1361 (total Jan- Dec = 1797)
2018 Jan- Oct = 1192 (total Jan- Dec = 1618)
2019 Jan- Oct = 1839 (total Jan- Dec = 2205)
2020 Jan- Oct = 2005 (total Jan- Dec = yet to be determined)

Community

Our involvement in the community has been impacted significantly by the onset of COVID. Estes Valley Senior Resource Fair, educational in-services, book studies, rotary meetings were all canceled. There was limited person to person interaction with our Caregivers group and Grief Group; no hospice volunteer meetings or new volunteer orientation and training this year; and Herm was not able to be present at the two local ministerium. Most of Nancy's musical involvement in the community needed to be postponed. Still, there were opportunities to interact and we continue to give our best efforts at being connected to the community.

The Hospice Bereavement program reaches out regularly to care for persons from the community who have not been connected to Hospice. All of our staff refer people who could benefit from this service. Hospice volunteers continue calling families in our bereavement program and sending monthly mailings to support the work of grieving. Currently the Bereavement program includes 52 hospice families and 9 non-hospice community families.

Nancy attended an online caregiver support class called "Powerful Tools for Caregivers" hosted by the Estes Valley Library, to further educate herself and therefore provide more effective care for the many caregivers in our community.

Chaplains Herm and Brenda have been writing weekly reflections for hospital staff under the title *Medicine For the Soul.* The writings have found their way beyond the hospital throughout the community.

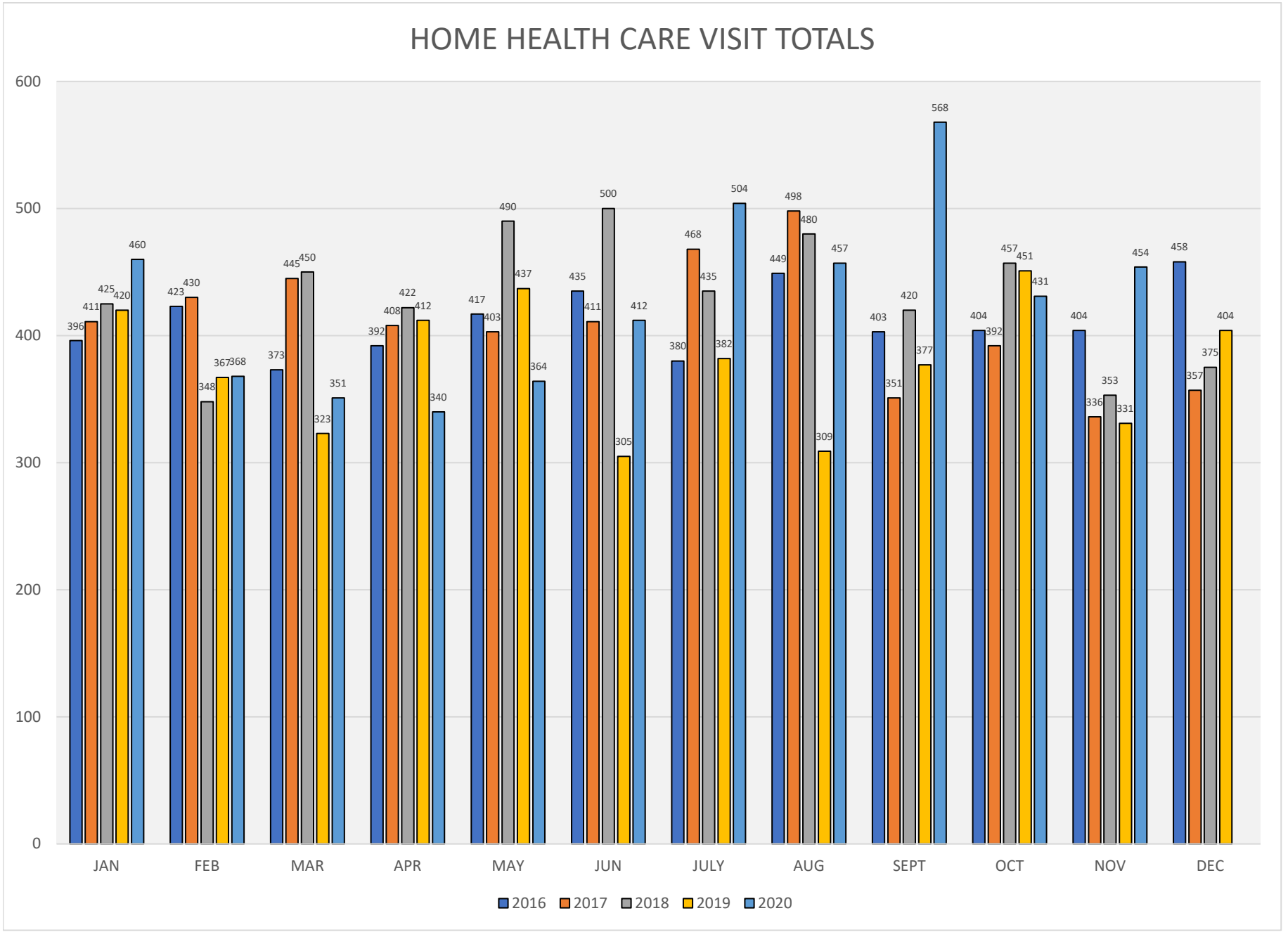
Ongoing Hospice support for the community includes The Good Grief Group, facilitated most of the year by Chaplain Herm Weaver, and the Caregiver Support Group, facilitated for some months by Nancy Bell, MSW (currently on hold). Herm recently helped the grief group to organize and develop its own leadership. He has begun a new support group that is aimed at people in the first year of loss. While it is a complicated time to begin a new group, they have begun meeting with the appropriate guidelines and anticipate meaningful interaction in the community with families in the first year of loss.

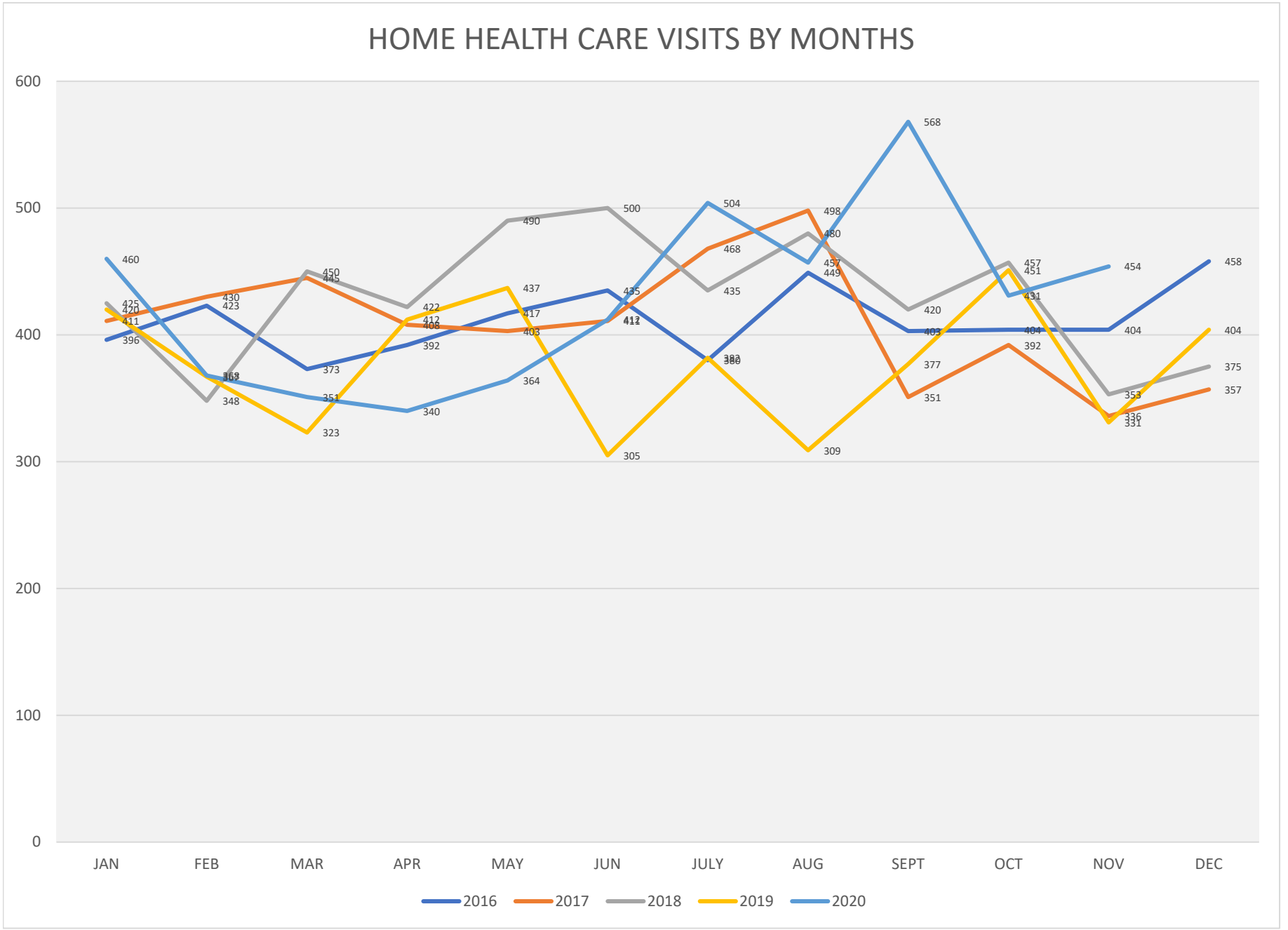
End of life activities such as funerals and memorial services have become increasingly complicated this year. Herm meets with families consistently to explore how and when and where to best honor their loved ones. Some families are choosing to wait for memorials until they can gather and be safe. Others choose to seek ways to have a memorial now. Helping families with those conversations, explorations, and planning in the middle of strong differing opinions is a growing part of the work. Recently Herm provided leadership for an outdoor memorial service beside the Big Thompson River and for a Zoom memorial for a family primarily in Missouri with members spread throughout the country. Imagining creative ways for families to find closure and say goodbye is filled with complexity.

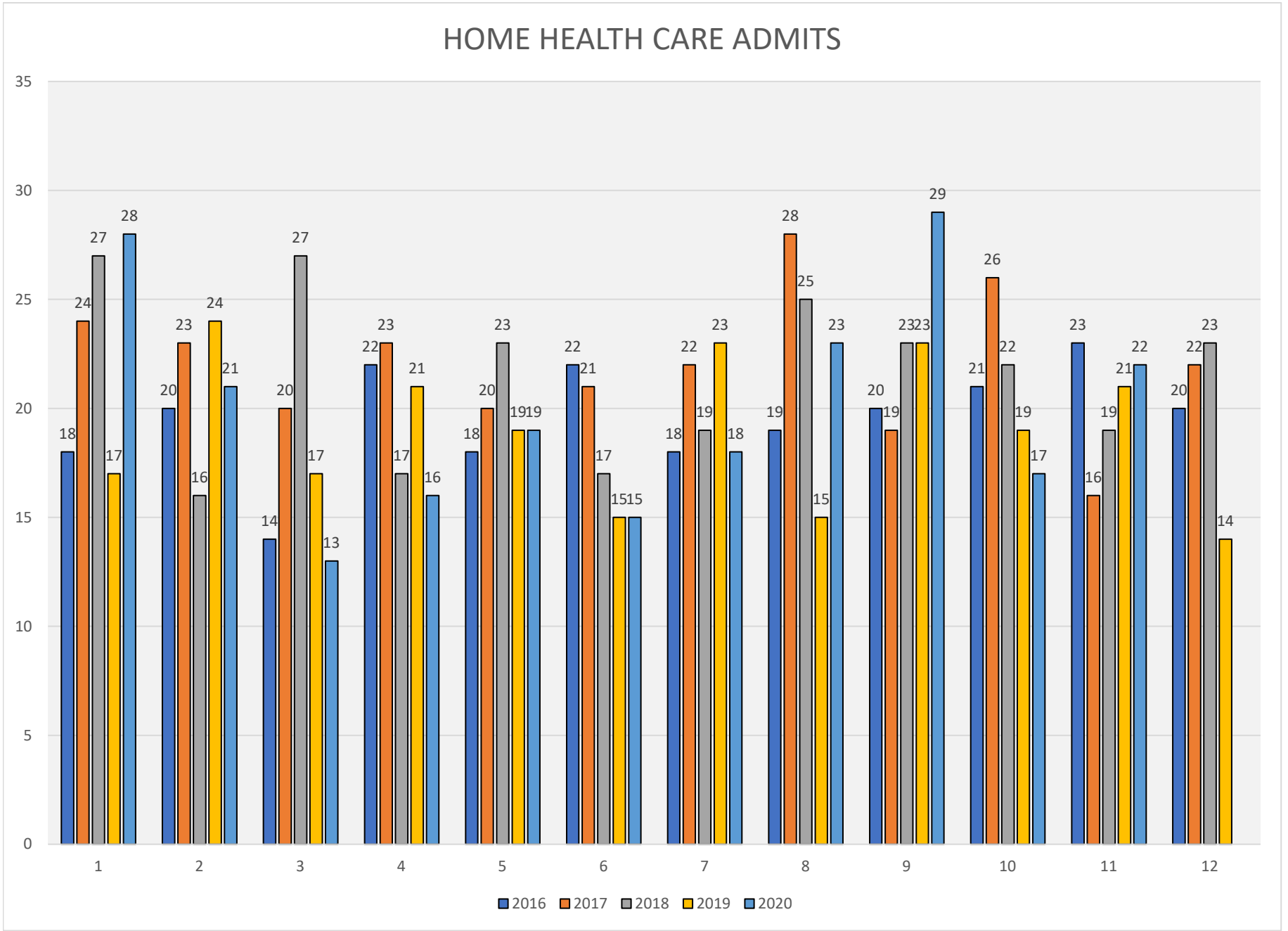
Again this holiday season we are planning a Holiday Remembrance for our Hospice families—via the mail this year. The ceremony is aimed primarily at Hospice families who have lost a loved one in the past year. This year there are 60 families included in the Remembrance and 17% of them have not been on hospice but are simply members of the community. Individualized ornaments have been made for remembering and honoring each of the persons who have died. This ornament is mailed with a commemorative bookmark and a letter of support.

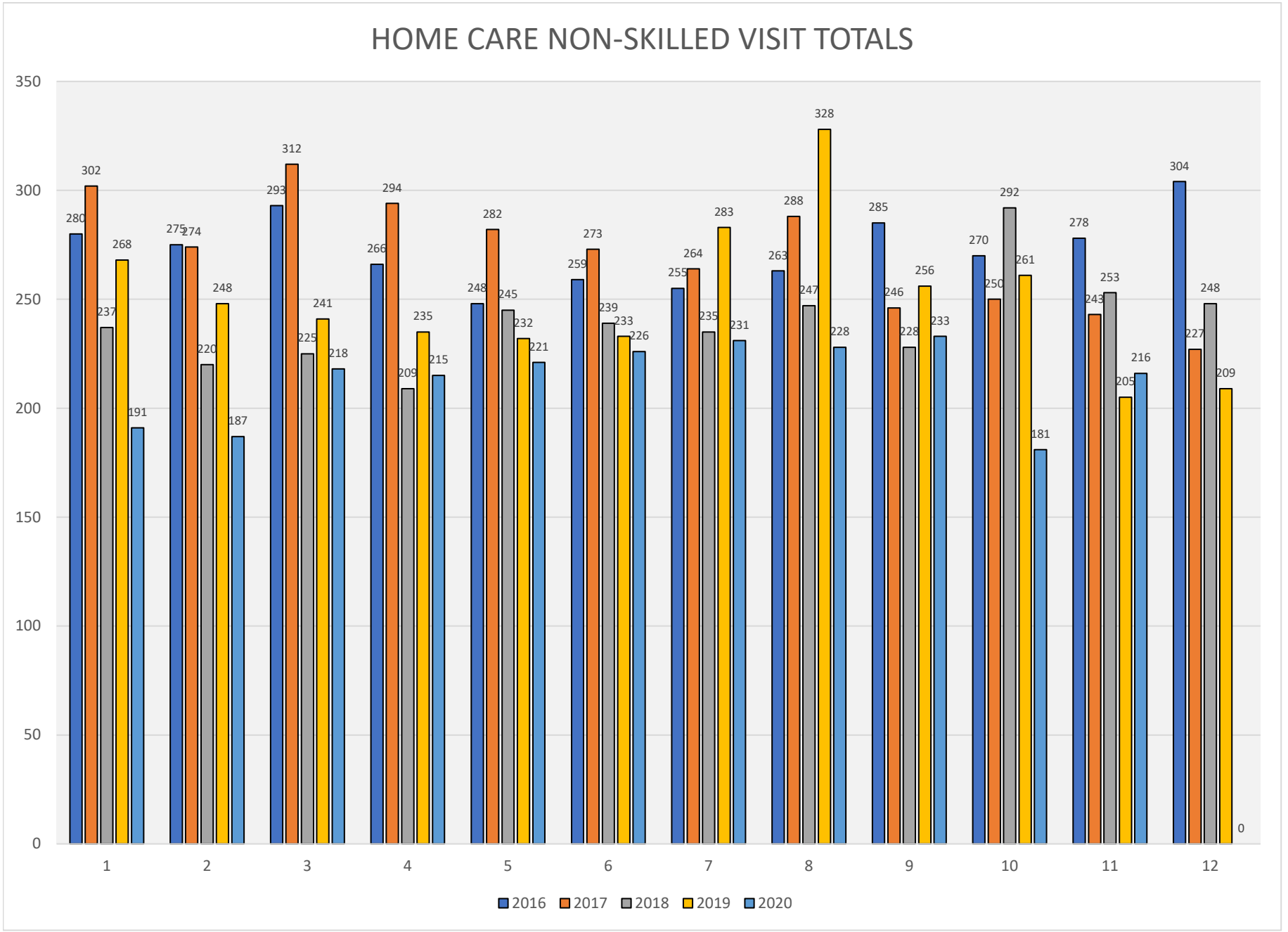
The impact of Home Health Care and Hospice in the community is a total team effort. Everyone on the team connects with the larger community in some way. It is not a task that is relegated to just a few. The administrative staff interact with families and patients throughout their time with us providing the foundation that allows the rest of us to work. The nurses and doctor care for the patient's physical needs and provide education for both the patient and the families on how to provide the best care. The CNA's are often beloved by the patient as they provide personal support and the PCP's provide household support that is critical to allowing patients to live at home. The MSWs help our families navigate the myriad of resources that are available to them and provide emotional support and counseling for patients/families living with acute and chronic illnesses as they walk through the aging to end-of-life process. The Chaplain is present for spiritual care for Hospice patients and families and provides a safe space to explore the sacred parts of end of life experiences. And finally, while our volunteers haven't been able to visit this year, they continue to provide a connection to the community by sending out bereavement mailers and calling the families who have lost loved ones. Together this team, Home Health Care and Hospice, provides a service that is vital and unparalleled in our community. We regularly receive financial contributions and calls and cards of appreciation confirming the value of each piece of care that is provided.

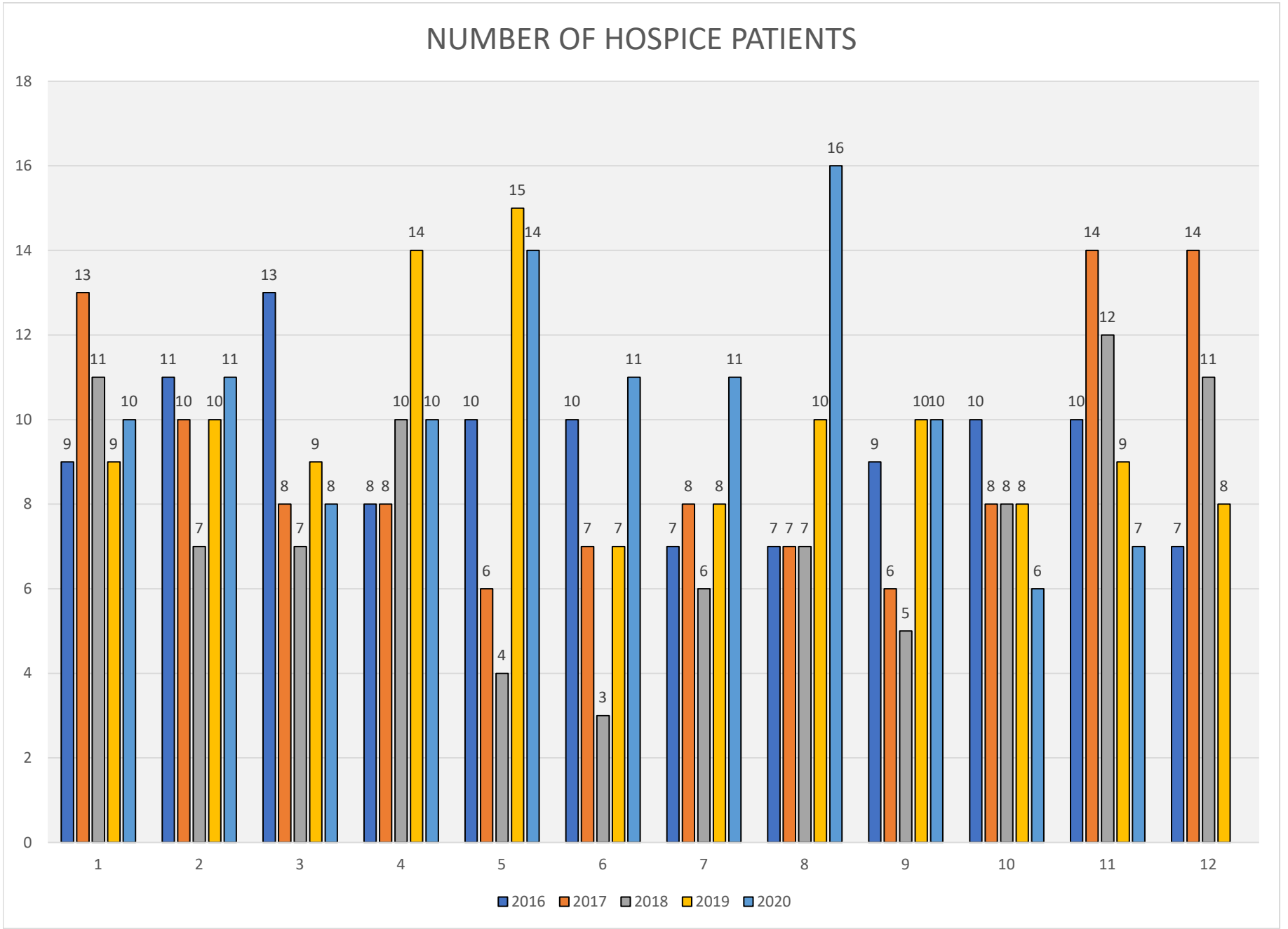
-Respectfully compiled by Sarah Bosko, RN, BSN, Director

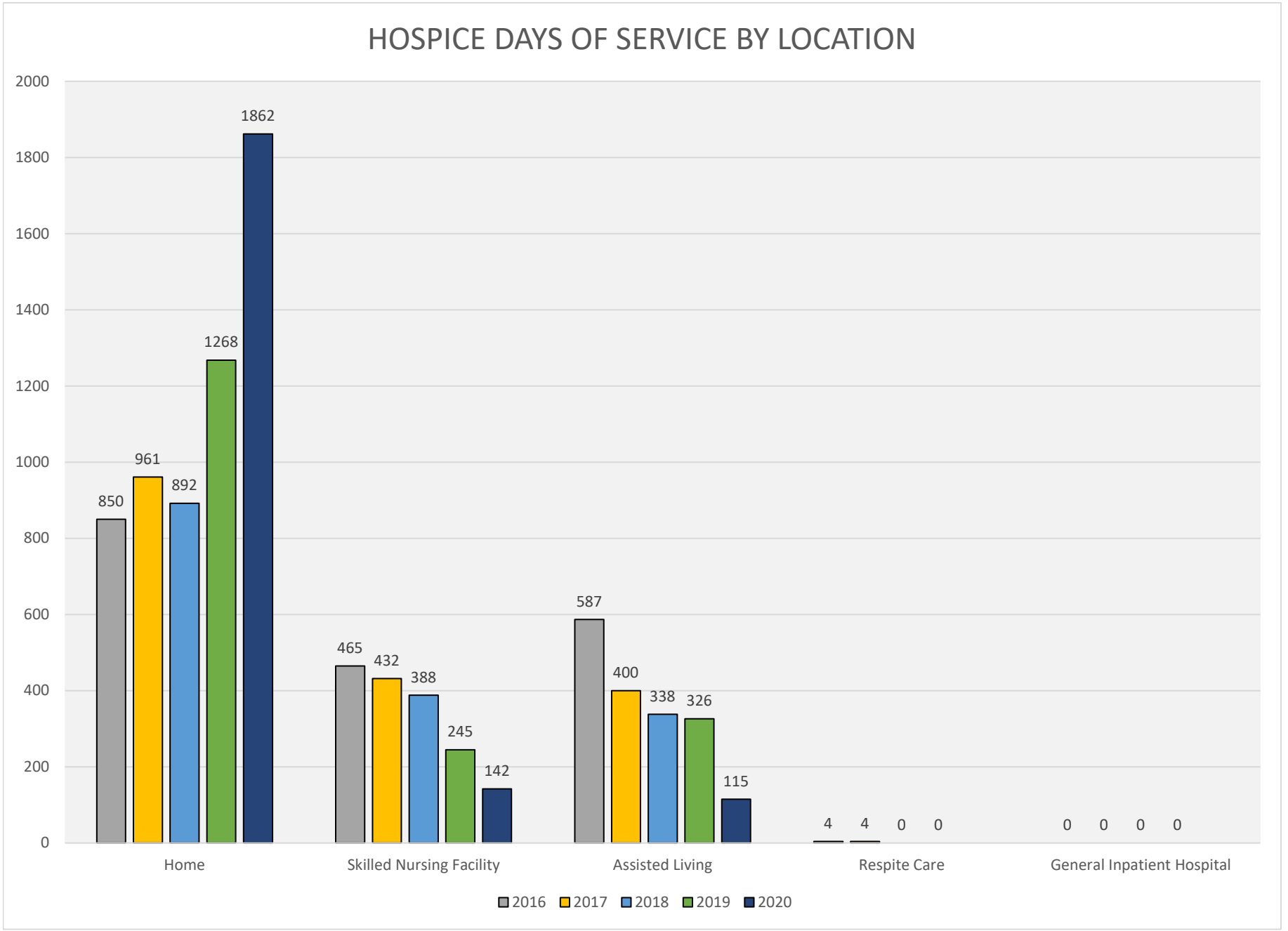

HOME HEALTH CARE VISIT TOTALS
600
500
400
300
200
100
0
JAN
FEB
MAR
APR
MAY
JUN
JULY
AUG
SEPT
OCT
NOV
DEC
396
411
425
420
460
423
430
348
367
368
373
445
450
323
351
392
408
422
412
340
417
403
490
437
364
435
411
500
305
412
380
468
435
382
504
449
498
480
309
457
403
351
420
377
568
404
392
457
451
431
404
336
353
331
454
458
357
375
404
2016
2017
2018
2019
2020

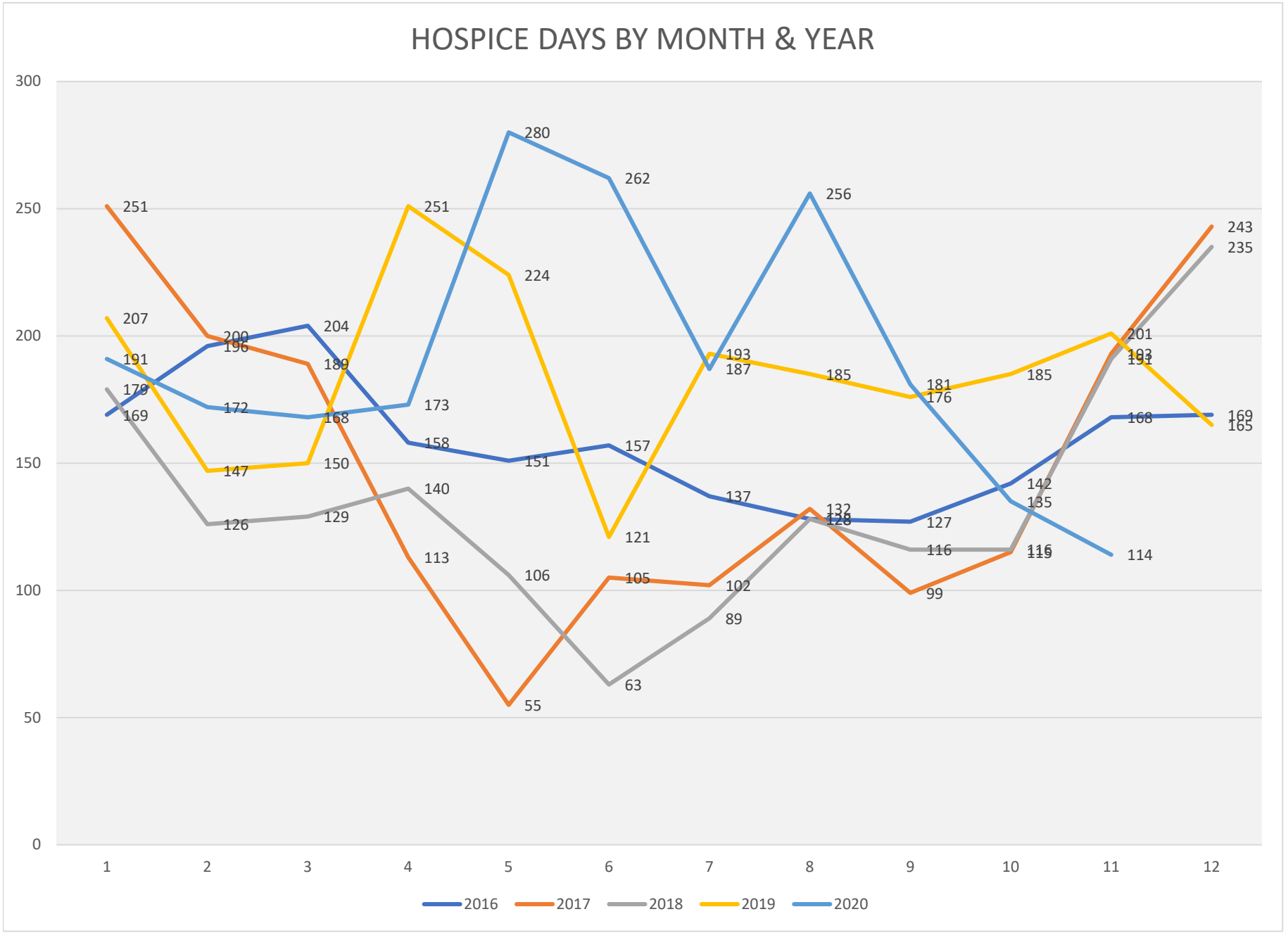

HOME HEALTH CARE VISITS BY MONTHS
600
500
400
300
200
100
0
JAN
FEB
MAR
APR
MAY
JUN
JULY
AUG
SEPT
OCT
NOV
DEC
2016
2017
2018
2019
2020

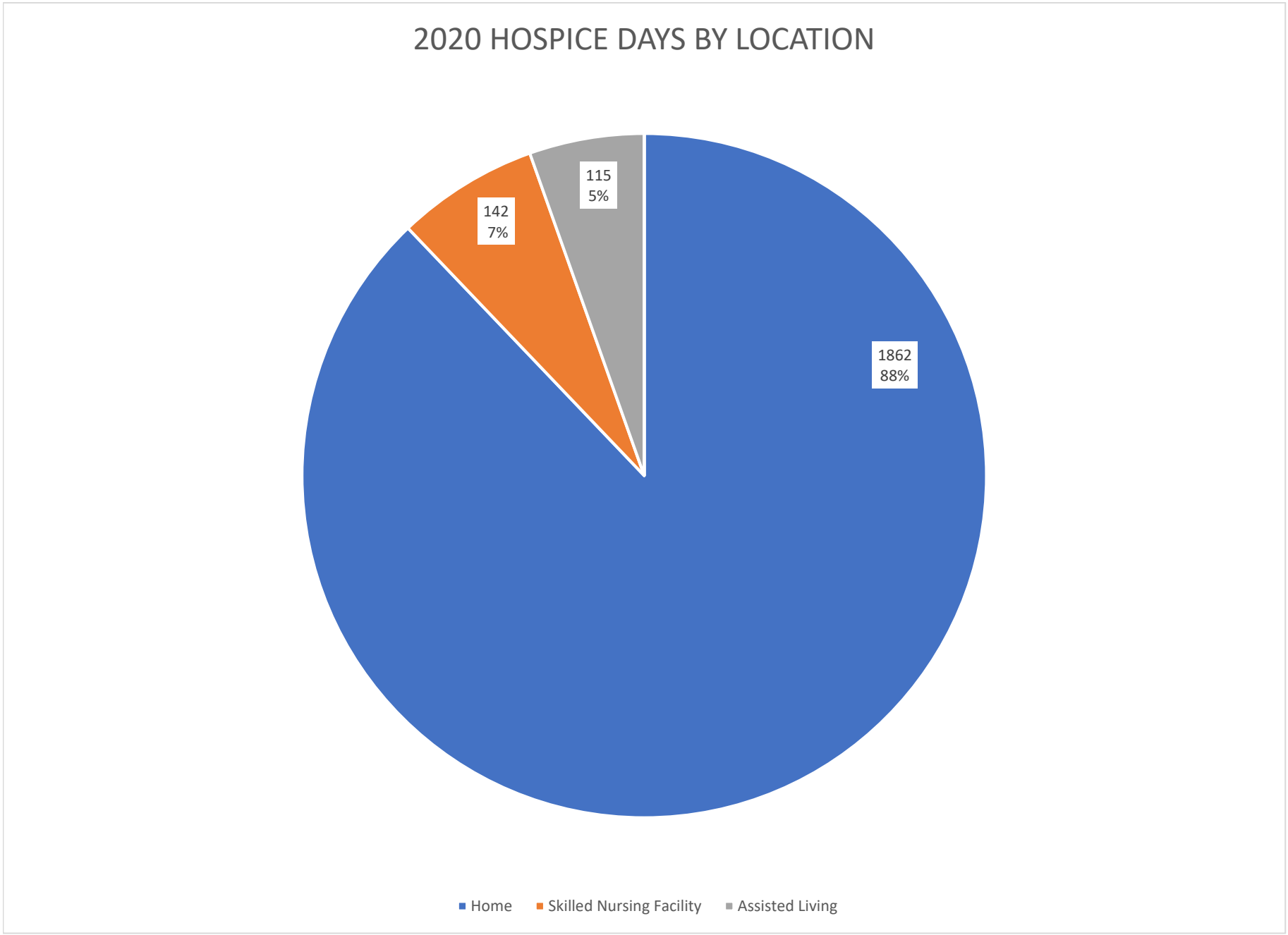

HOME HEALTH CARE ADMITS
35
30
25
20
15
10
5
0
1 2 3 4 5 6 7 8 9 10 11 12
2016 2017 2018 2019 2020
18 24 27 17 28
20 23 16 24 21
14 20 27 17 13
22 23 17 21 16
18 20 23 19 19
22 21 17 15 15
18 22 19 23 18
19 28 25 15 23
20 19 23 23 29
21 26 22 19 17
23 16 19 21 22
20 22 23 14


HOME CARE NON-SKILLED VISIT TOTALS
350
300
250
200
150
100
50
0
1
2
3
4
5
6
7
8
9
10
11
12
280
302
237
268
191
275
274
220
248
187
293
312
225
241
218
266
294
209
235
215
248
282
245
232
221
259
273
239
233
226
255
264
235
283
231
263
288
247
328
228
285
246
228
256
233
270
250
292
261
181
278
243
253
205
216
304
227
248
209
0
2016
2017
2018
2019
2020


NUMBER OF HOSPICE PATIENTS
18
16
14
12
10
8
6
4
2
0
1 2 3 4 5 6 7 8 9 10 11 12
2016 2017 2018 2019 2020


HOSPICE DAYS OF SERVICE BY LOCATION
2000
1800
1600
1400
1200
1000
800
600
400
200
0
850
961
892
1268
1862
465
432
388
245
142
587
400
338
326
115
4
4
0
0
0
0
0
0
Home
Skilled Nursing Facility
Assisted Living
Respite Care
General Inpatient Hospital
2016
2017
2018
2019
2020

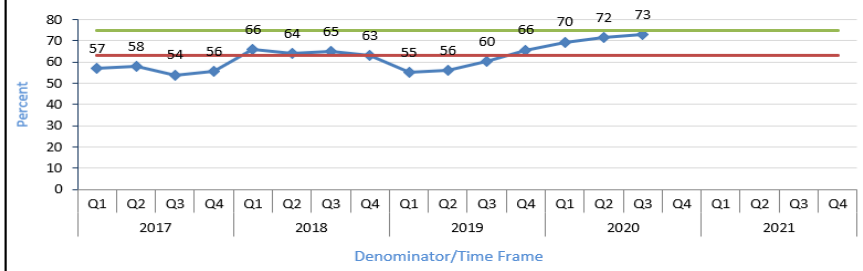

HOSPICE DAYS BY MONTH & YEAR
300
250
200
150
100
50
0
1
2
3
4
5
6
7
8
9
10
11
12
2016
2017
2018
2019
2020


2020 HOSPICE DAYS BY LOCATION
115
5%
142
7%
1862
88%
Home
Skilled Nursing Facility
Assisted Living

Initiative:

Measure: Improvement in Ambulation- Locomotion

Date:

Target	Results
	

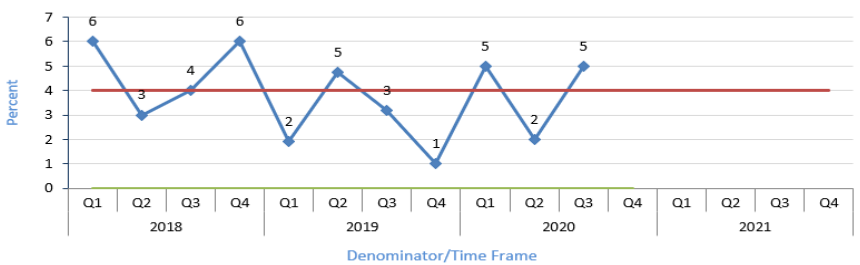
median
Goal

Interpretation of results and cause analysis	Response / actions
Percentage of home health quality episodes during which the patient improved in ability to ambulate.	

Initiative:

Measure: OASIS Timely Submission to CMS

Date:

Target	Results
	

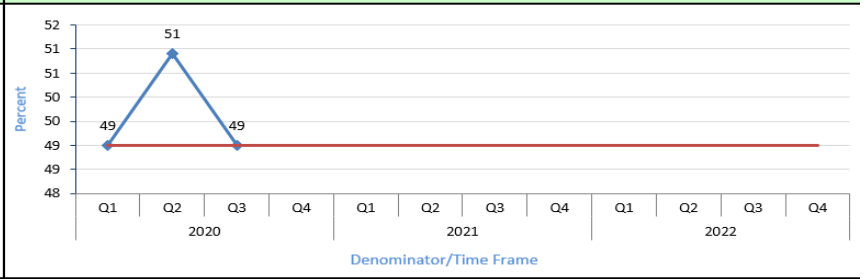
median
Goal

Interpretation of results and cause analysis	Response / actions
Percentage of OASIS assessments that are not submitted to CMS within 30 days of the M0090 date (submission date ≤30 days of M0090 date). denominator=OASIS assessments submitted to CMS numerator=OASIS assessments submitted within 30 days of the M0090 date	

Initiative:

Measure: Improve Patient Oral Medical Management

Date:

Target	Results
	

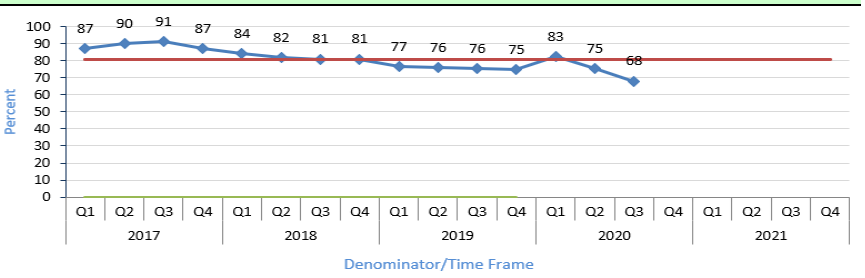
median
Goal

Interpretation of results and cause analysis	Response / actions
How often patients got better at taking their drugs correctly by mouth	

Initiative:

Measure: HH-CAHPS Specific Care Issues Mean

Date:

Target	Results
	

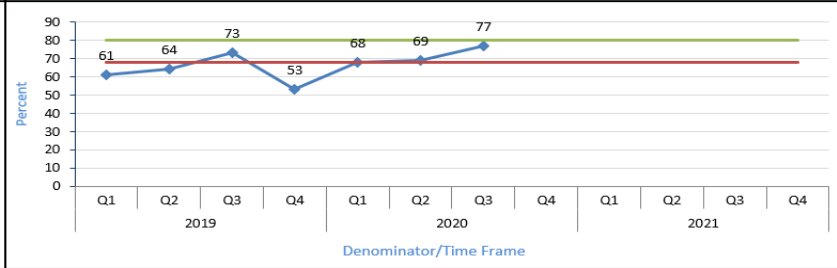
median
Goal

Interpretation of results and cause analysis	Response / actions
HH-CAHPS patient satisfaction survey--Specific Care Issues section mean score.	Jan 2020 switched to NRC Surveys.

Initiative:

Measure: Timely Therapy Evaluation

Date:

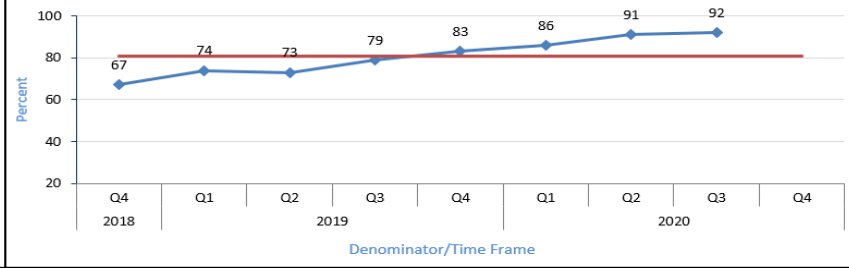
Target	Results
	

	Interpretation of results and cause analysis	Response / actions
median Goal	Patients seen in a timely manner (within 5 days after SOC) for an evaluation by the occupational therapist. Goal is 80%.	June 2020 started meeting weekly to review new admits/orders/timeliness.

Initiative:

Measure: Drug Regimen Review Conducted (Casper data with rolling timeframe)

Date:

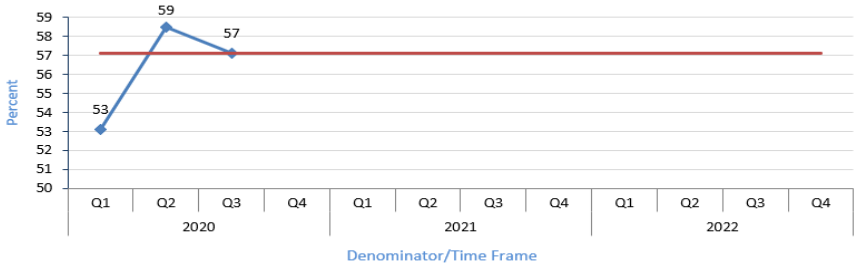
Target	Results
	

	Interpretation of results and cause analysis	Response / actions
median Goal	Drug Regimen Review Conducted with Follow-up for Identified Issues	

Initiative:

Measure: Improvement in Dyspnea

Date:

Target	Results
	

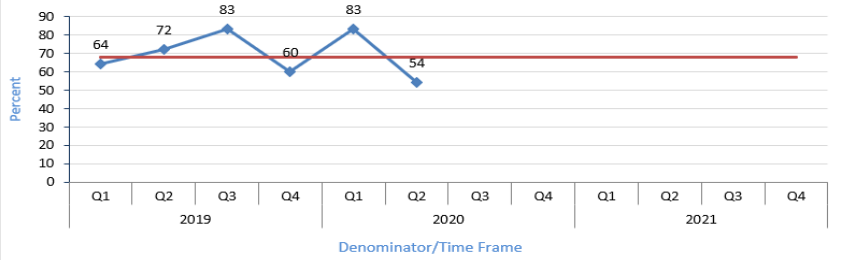
	Interpretation of results and cause analysis	Response / actions
median Goal	This measure reports the percentage of home health quality episodes during which the patient became less short of breath or dyspneic.	

Initiative:

Measure: Hospice LOS <30 days

Date:

Target	Results



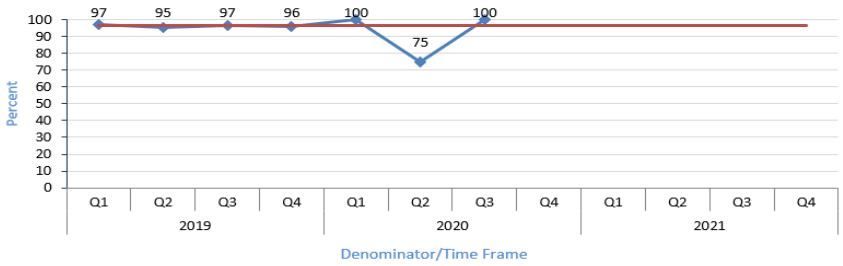
	Interpretation of results and cause analysis	Response / actions
median Goal	Percentage of Hospice patients whose length of stay is less than 30 days. Goal is <65%.	

Initiative:

Measure: Hospice Standard Overall Patient Satisfaction Mean

Date:

Target	Results



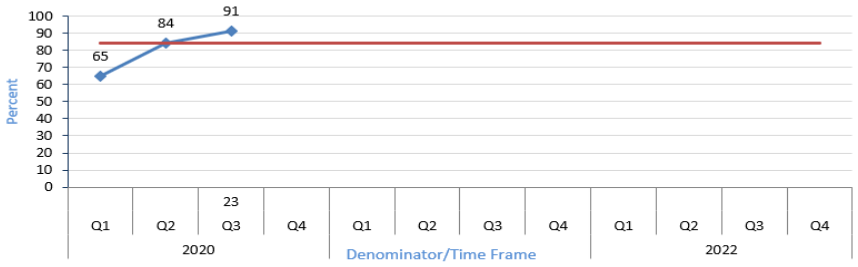
	Interpretation of results and cause analysis	Response / actions
median	Hospice Standard Overall Patient Satisfaction Mean	Due to low "n" numbers are doing a rolling 1 year average report. January 2020 went to NRC surveys--hence no rolling year report. 2nd Q2020 n=5.

Initiative:

Measure: Hospice Patients with Medication Checks at Every Visit (% with Care Plan)

Date: 1.1.2020

Target	Results

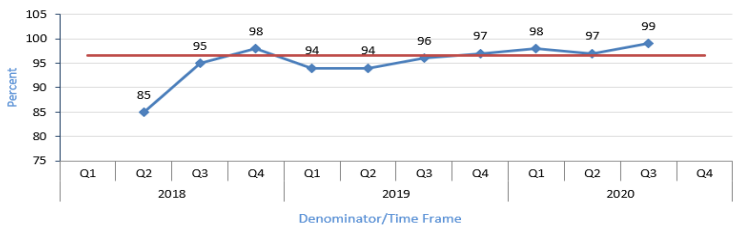


	Interpretation of results and cause analysis	Response / actions
median	Care Plan intervention in the chart to assess patient's medication supply at every visit and re-order refills as needed.	

Initiative:

Measure: Number of missed visits completed correctly

Date:

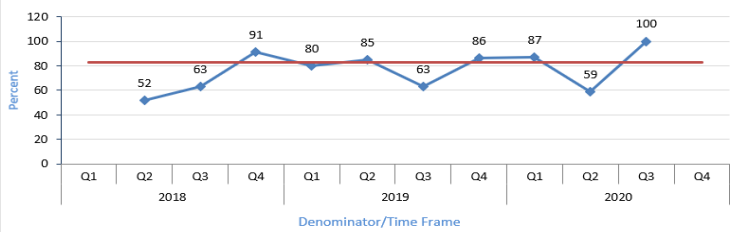
Target	Results
median Goal	

Interpretation of results and cause analysis	Response / actions
The number of missed visits completed/documented correctly by the aides.	New employees 2nd Q 2020

Initiative:

Measure: Number of missed visit (not initiated by client) where a replacement was offered?

Date:

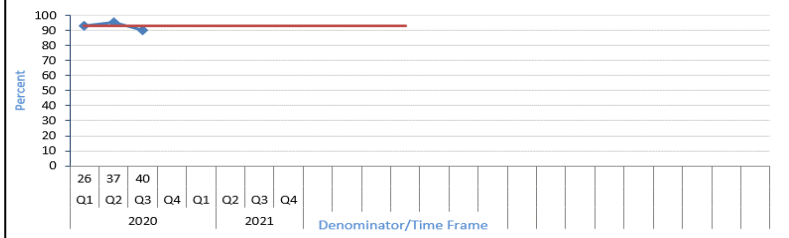
Target	Results
median Goal	

Interpretation of results and cause analysis	Response / actions
When a missed visit is initiated by the agency (ie aide is sick or on vacation, etc), did we offer a replacement aide?	Feb-July 2019 had 2-3 aides out on unexpected medical leaves. September-December had 2 aides out on medical leave/trying to hire more staff. 2Q2020 way less MVs by agency. July 2020--education done with HC supervisor about wording to clients/documentation.

Initiative:

Measure: Home Care 90 day Patient Satisfaction

Date:

Target	Results
median	

Interpretation of results and cause analysis	Response / actions
HC Supervisor will conduct a 90 day patient satisfaction assessment. Clients are asked to rate their satisfaction on a 0-10 scale. Results are averaged.	

ESTES PARK HEALTH

The Citizens of the Park Hospital District

Estes Park Health
Board of Directors

EPH Foundation
Kevin Mullin

Chief Executive Officer
Vern Carda

Medical Staff
John Meyer, MD

Human Resources *Vacant*

Employee Health

Chief Information Officer / Chief Operating Officer
Gary Hall

Information Technology
Sarah Waggoner

Dietary
Jacob Schmidt

Diagnostic Imaging
Brigitte Foust

Laboratory
Cynthia Berlanga

Rehabilitation Services
Nancy Karr

Pharmacy
Vacant

Marketing / Public Relations

Facilities Management

Environmental Services

Chief Nursing Officer
Pat Samples

Quality Management
Lesta Johnson

Inpatient Services
Karlye Pope

Surgery
Diane Darmody, Interim

Emergency / Trauma / Urgent Care
Leslie Roberts

EMS / Paramedics
Guy Beesley

Living Center
Matt Gordon

Home Health & Hospice
Sarah Bosko

Infection Control
Kim Smith

Chief Financial Officer
Tim Cashman

Patient Financial Services
Laurie Johnson

Finance
Laura Etling

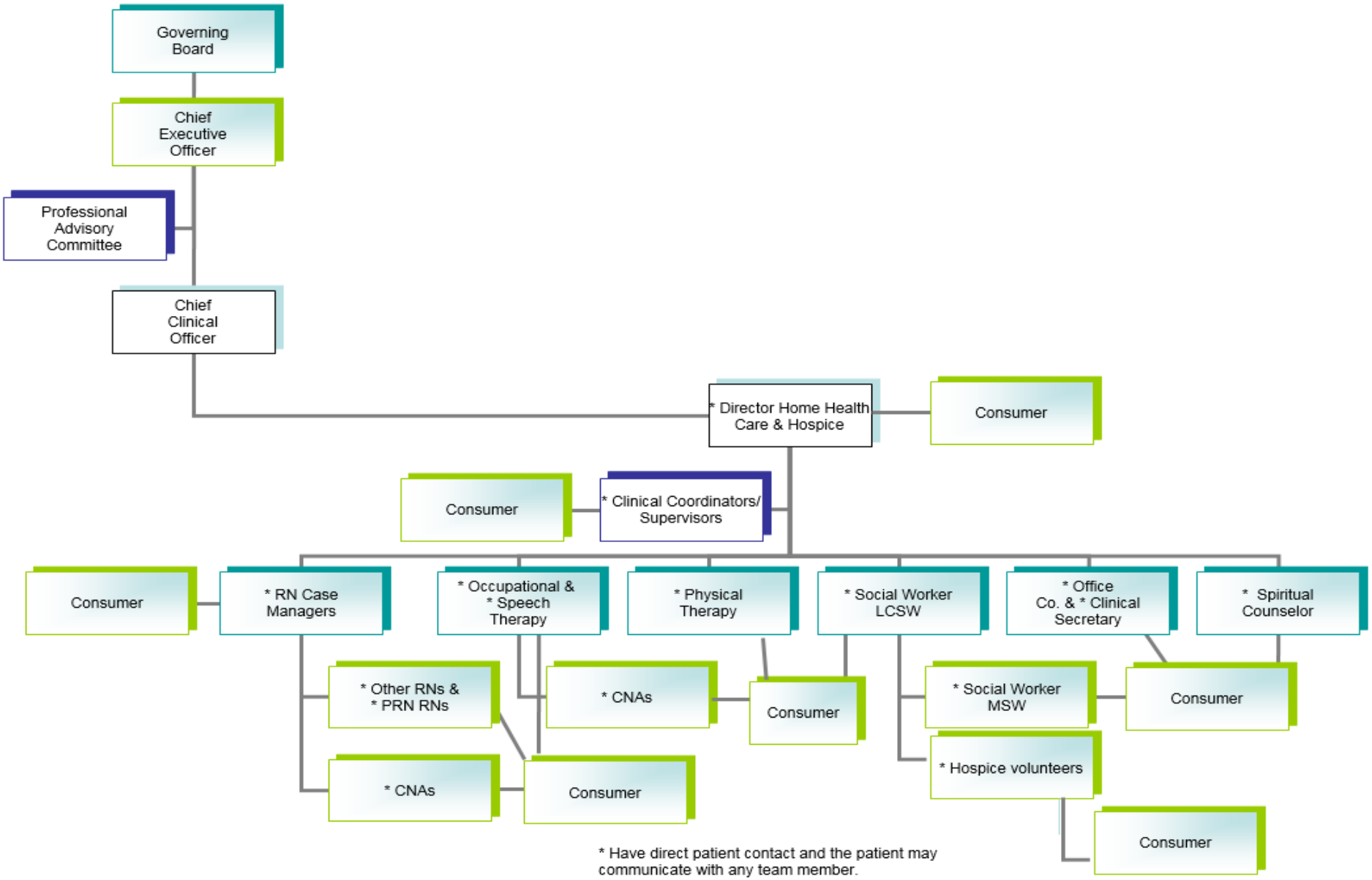
Health Information Management
Julie Glasgow

Materials Management
Dan Brandt

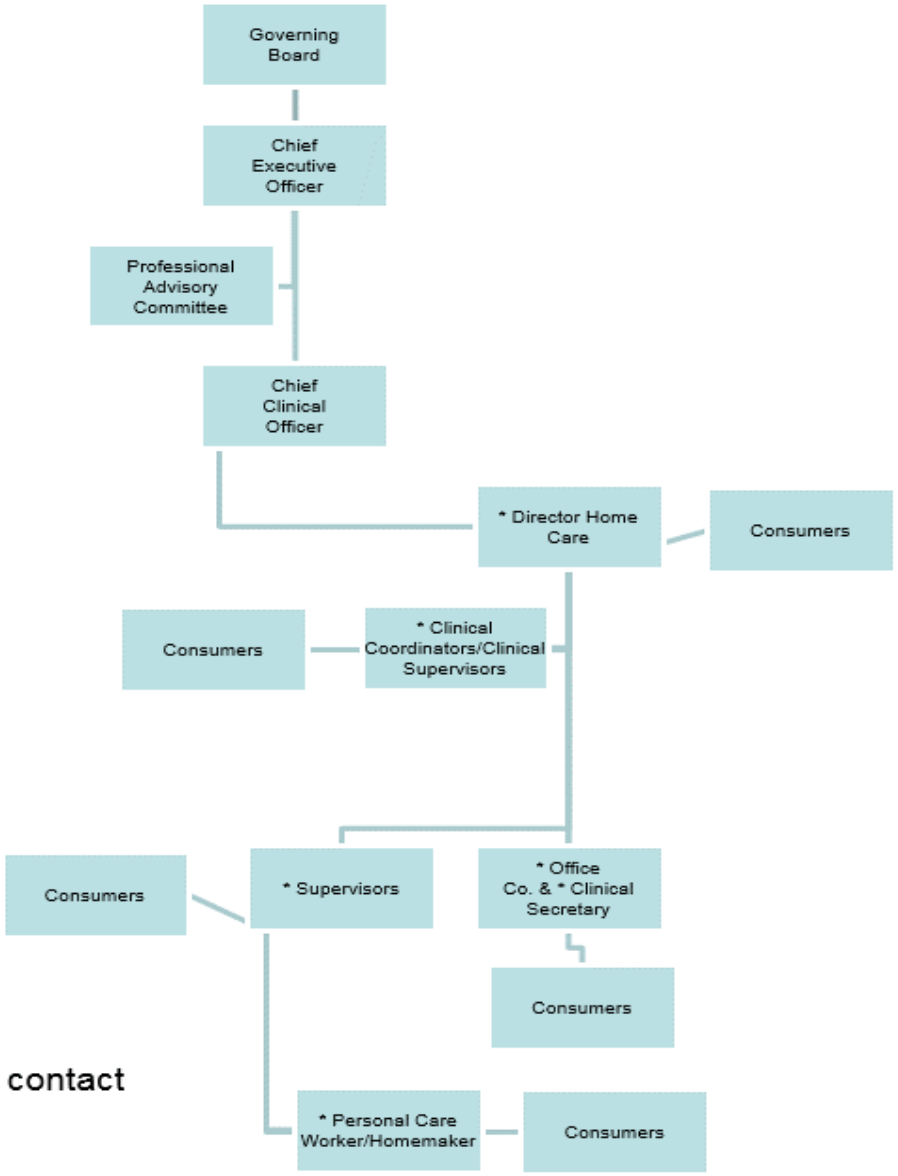
Practice Management
Lesta Johnson

Medical Staff Services
Andrea Thomas

Administration, Organizational Chart
Rev 11.19.20



Estes Park Health Home Health Care and Estes Park Health Hospice Organizational Chart



* Have direct consumer contact

Estes Park Health Home Care Organizational Chart

iQIES Report

Agency Patient-Related Characteristics (Case Mix) Report

Agency Name	ESTES PARK HEALTH HOME HEALTH CARE
CCN	067144
Agency ID	040307
City/State	ESTES PARK, CO
Medicaid Number	Not Applicable

Requested Current Period	09/2019 - 08/2020
Requested Prior Period	09/2018 - 08/2019
Actual Current Period	09/2019 - 08/2020
Actual Prior Period	09/2018 - 08/2019
# Current Cases	217
# Prior Cases	243
Number of National Cases	6,930,296
Report Run Date	11/25/2020

Agency Patient-Related Characteristics (Case Mix) Report

Definitions

HHA Obs – Home Health Agency's Observed Rate/Value is the agency's actual rate (e.g. xx.yy% of patients were Female) or average value (average age was xx.yy years) for patients served during the reporting period. These rates/values are not risk adjusted.
HHA Prior Obs[1] – Home Health Agency's Observed Rate/Value from the Prior Period is the agency's actual rate (e.g. xx.yy% of patients were Female) or average value (average age was xx.yy years) for patients served during the reporting period. These rates/values are not risk adjusted.
Nat'l Obs - National Observed Rate/Value is the actual rate (e.g. xx.yy% of patients were Female) or average value (average age was xx.yy years) for patients served by home health agencies nationally during the reporting period. These rates/values are not risk adjusted.
Asterisks – Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.
*The probability is 1% or less that this difference is due to chance, and 99% or more that the difference is real.
**The probability is 0.1% or less that this difference is due to chance, and 99.9% or more that the difference is real.

PATIENT HISTORY

Demographics

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Age (years)	76.30	77.63	75.57 **
Gender: Female (%)	59.45%	57.61%	59.60%
Race: Black (%)	0.00%	-	13.49% **
Race: White (%)	97.24%	96.71%	75.75% **
Race: Other (%)	0.92%	1.23%	10.51% **

Agency Patient-Related Characteristics (Case Mix) Report

Payment Source

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Any Medicare (%)	91.24%	88.07%	93.21%
Any Medicaid (%)	10.60%	10.70%	8.58%
Any HMO (%)	31.34%	26.75%	38.88%
Medicare HMO (%)	31.34%	26.75%	34.05%
Other (%)	0.92%	-	3.79%

Agency Patient-Related Characteristics (Case Mix) Report

Episode Start

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Episode timing: Early (%)	89.11%	95.45%	86.18%
Episode timing: Later (%)	8.91%	1.82%	6.87%
Episode timing: Unknown (%)	0.00%	0.45%	6.40% **

Agency Patient-Related Characteristics (Case Mix) Report

Inpatient Discharge

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Long-term nursing facility (%)	0.46%	1.65%	0.44%
Skilled nursing facility (%)	16.13%	11.52%	13.30%
Short-stay acute hospital (%)	59.62%	60.50%	51.45%
Long-term care hospital (%)	0.00%	-	0.44%
Inpatient rehab hospital/unit (%)	6.91%	15.23%	5.49%
Psychiatric hospital/unit (%)	1.84%	0.41%	0.30% *

Agency Patient-Related Characteristics (Case Mix) Report

Therapies

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
IV/infusion therapy (%)	6.91%	3.29%	3.78%
Parenteral nutrition (%)	0.00%	-	0.25%
Enteral nutrition (%)	1.38%	-	1.56%

Agency Patient-Related Characteristics (Case Mix) Report

GENERAL HEALTH STATUS

Hospitalization Risks

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Recent decline mental/emot/behav (%)	10.14%	11.52%	24.95% **
Multiple hospitalizations (%)	22.58%	16.46%	35.09% **
History of falls (%)	38.71%	28.40%	36.32%
5 or more medications (%)	93.55%	89.30%	92.96%
Frailty factors (%)	21.20%	21.81%	55.59% **
Other (%)	0.92%	-	3.79%
None (%)	1.84%	2.88%	1.04%

Agency Patient-Related Characteristics (Case Mix) Report

Body Mass Index

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Low Body Mass Index (%)	8.02%	8.23%	6.09%

Agency Patient-Related Characteristics (Case Mix) Report

LIVING ARRANGEMENT / ASSISTANCE

Current Situation

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Lives alone (%)	31.80%	28.40%	23.13% *
Lives with others (%)	61.75%	62.96%	65.42%
Lives in congregate situation (%)	4.61%	6.58%	10.90% *

Agency Patient-Related Characteristics (Case Mix) Report

Availability

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Around the clock (%)	67.74%	74.49%	72.61%
Regular daytime (%)	4.15%	3.29%	4.34%
Regular nighttime (%)	5.07%	1.23%	4.69%
Occasional (%)	17.05%	16.05%	16.59%
None (%)	1.84%	2.88%	1.04%

Agency Patient-Related Characteristics (Case Mix) Report

CARE MANAGEMENT

Supervision / Safety

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
None needed (%)	38.25%	22.22%	16.30% **
Caregiver provides (%)	40.09%	62.55%	41.65%
Caregiver training needed (%)	11.52%	9.05%	36.78% **
Uncertain/Unlikely to be provided (%)	1.84%	0.82%	2.66%
Needed, but not available (%)	5.99%	3.29%	2.04% **

Agency Patient-Related Characteristics (Case Mix) Report

SENSORY STATUS

Sensory Status

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Vision impairment (0-2)	0.11	0.13	0.32
Pain interfering with activity (0-4)	2.23	2.39	2.63 **

Agency Patient-Related Characteristics (Case Mix) Report

INTEGUMENTARY STATUS

Pressure Ulcers/Injuries

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Pressure ulcer/injury present (%)	7.98%	3.36%	5.29%
Stage II pressure ulcer count (#)	0.03	0.02	0.04
Stage III pressure ulcer count (#)	0.07	-	0.01
Stage IV pressure ulcer count (#)	0.01	0.00	0.01
Unstageable PU: Non-remove. dsg. count (#)	0.00	0.01	0.00
Unstageable PU: Slough/eschar count (#)	0.02	0.03	0.01
Unstageable PU: Deep tissue inj. count (#)	0.00	-	0.01
Stage I pressure injuries count (0-4)	0.04	0.03	0.02
Stage most problematic PU/injury (1-4)	2.60	1.50	2.16 *

Agency Patient-Related Characteristics (Case Mix) Report

Stasis Ulcers

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Stasis ulcer indicator (%)	5.07%	2.88%	2.52%
Stasis ulcer count (0-4)	0.08	0.01	0.04
Status most problematic stasis (0-3)	0.09	0.02	0.05

Agency Patient-Related Characteristics (Case Mix) Report

Surgical Wounds

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Surgical wound indicator (%)	36.87%	40.74%	26.77% *
Status most problematic surg. (0-3)	0.19	0.32	0.34

Agency Patient-Related Characteristics (Case Mix) Report

PHYSIOLOGICAL STATUS

Respiratory

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Dyspnea (0-4)	0.79	0.78	1.73 **

Agency Patient-Related Characteristics (Case Mix) Report

Elimination Status

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Urinary Tract Infection (%)	14.22%	10.97%	10.20%
Urinary incontinence/catheter (%)	50.23%	47.32%	55.90%
Bowel incontinence (0-5)	0.29	0.17	0.42
Bowel ostomy (%)	2.30%	2.88%	2.61%

Agency Patient-Related Characteristics (Case Mix) Report

NEURO / EMOTIONAL / BEHAVIORAL

Cognition

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Cognitive deficit (0-4)	0.62	0.48	0.69
Confusion frequency (0-4)	0.86	0.76	0.85

Agency Patient-Related Characteristics (Case Mix) Report

Emotional

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Anxiety level (0-3)	0.62	0.57	0.72
Depression evaluation indicator (%)	3.03%	3.74%	4.94%
PHQ-2: Interest/Pleasure (0-3)	0.19	0.13	0.23
PHQ-2: Down/Depressed (0-3)	0.21	0.21	0.25

Agency Patient-Related Characteristics (Case Mix) Report

Behavioral

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Memory deficit (%)	16.43%	11.76%	17.13%
Impaired decision-making (%)	20.19%	14.71%	22.61%
Verbal disruption (%)	3.29%	0.84%	1.24%
Physical aggression (%)	0.47%	-	0.65%
Disruptive/Inappropriate behavior (%)	0.47%	0.42%	0.67%
Delusional, hallucinatory, etc. (%)	2.82%	0.84%	1.32%
None demonstrated (%)	69.48%	77.31%	70.81%
Frequency of behavioral problems (0-5)	1.13	0.40	0.88

Agency Patient-Related Characteristics (Case Mix) Report

ACTIVITIES OF DAILY LIVING

SOC / ROC Status

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Grooming (0-3)	1.14	0.97	1.67 **
Dress upper body (0-3)	1.23	1.16	1.77 **
Dress lower body (0-3)	1.66	1.64	2.05 **
Bathing (0-6)	2.93	3.01	3.61 **
Toilet transfer (0-4)	0.91	0.90	1.56 **
Toileting hygiene (0-3)	1.14	1.13	1.80 **
Bed transferring (0-5)	1.31	1.09	1.93 **
Ambulation (0-6)	2.46	2.37	3.02 **
Eating (0-5)	0.53	0.52	0.87 **

Agency Patient-Related Characteristics (Case Mix) Report

FUNCTIONAL ABILITIES

Prior Functioning: Everyday Activities

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Prior Self Care (1-3)	2.52	2.56	2.39 **
Prior Indoor Mobility (Ambulation) (1-3)	2.81	2.79	2.55 **
Prior Stairs (1-3)	3.19	2.76	3.36
Prior Functional Cognition (1-3)	2.47	2.45	2.42

Agency Patient-Related Characteristics (Case Mix) Report

Prior Device Use

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Prior Manual wheelchair (%)	11.06%	5.76%	16.00%
Prior Motorized wheelchair/scooter (%)	7.37%	0.82%	3.93%
Prior Mechanical lift (%)	5.53%	0.41%	1.72% **
Prior Walker (%)	39.63%	19.34%	53.21% **
Prior Orthotics/Prosthetics (%)	2.30%	0.82%	1.24%
Prior Device: None (%)	49.31%	30.45%	37.43% **

Agency Patient-Related Characteristics (Case Mix) Report

Self Care

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Eating (1-6)	5.48	5.44	4.89 **
Eating (Not Attempted) (%)	0.46%	-	0.73%
Eating (Dash) (%)	0.00%	-	0.03%
Oral Hygiene (1-6)	4.90	5.07	4.44 **
Oral Hygiene (Not Attempted) (%)	0.00%	-	0.32%
Oral Hygiene (Dash) (%)	0.00%	-	0.05%
Toileting Hygiene (1-6)	4.61	4.64	3.59 **
Toileting Hygiene (Not Attempted) (%)	0.00%	-	0.33%
Toileting Hygiene (Dash) (%)	0.00%	-	0.05%
Shower/bathe self (1-6)	3.44	3.32	3.02 **
Shower/bathe self (Not Attempted) (%)	0.92%	7.41%	1.79%
Shower/bathe self (Dash) (%)	0.00%	-	0.07%

Agency Patient-Related Characteristics (Case Mix) Report

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Upper body dressing (1-6)	4.37	4.44	3.57 **
Upper body dressing (Not Attempted) (%)	0.00%	0.82%	0.27%
Upper body dressing (Dash) (%)	0.00%	-	0.04%
Lower body dressing (1-6)	3.59	3.51	3.10 **
Lower body dressing (Not Attempted) (%)	0.46%	1.23%	0.35%
Lower body dressing (Dash) (%)	0.00%	-	0.05%
Putting on/taking off footwear (1-6)	3.49	3.35	3.00 **
Putting on/taking off footwear (Not Attempted) (%)	1.38%	0.82%	1.08%
Putting on/taking off footwear (Dash) (%)	0.00%	-	0.07%

Agency Patient-Related Characteristics (Case Mix) Report

Mobility

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Roll left and right (1-6)	4.95	5.26	4.10 **
Roll left and right (Not Attempted) (%)	3.69%	7.00%	3.85%
Roll left and right (Dash) (%)	0.00%	-	0.18%
Sit to lying (1-6)	4.72	4.86	3.92 **
Sit to lying (Not Attempted) (%)	3.69%	0.82%	3.12%
Sit to lying (Dash) (%)	0.00%	-	0.18%
Lying to sitting on side of bed (1-6)	4.75	4.59	3.79 **
Lying to sitting on side of bed (Not Attempted) (%)	5.53%	1.23%	3.47%
Lying to sitting on side of bed (Dash) (%)	0.00%	0.41%	0.21%
Sit to stand (1-6)	4.55	4.60	3.59 **
Sit to stand (Not Attempted) (%)	5.07%	-	4.16%
Sit to stand (Dash) (%)	0.00%	-	0.10%

Agency Patient-Related Characteristics (Case Mix) Report

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Chair/bed to chair transfer (1-6)	4.30	4.26	3.50 **
Chair/bed to chair transfer (Not Attempted) (%)	3.23%	1.23%	3.54%
Chair/bed to chair transfer (Dash) (%)	0.00%	-	0.17%
Toilet transfer (1-6)	4.56	4.55	3.54 **
Toilet transfer (Not Attempted) (%)	3.69%	-	3.37%
Toilet transfer (Dash) (%)	0.00%	-	0.14%
Car transfer (1-6)	3.52	3.51	3.17 **
Car transfer (Not Attempted) (%)	9.68%	7.00%	29.09% **
Car transfer (Dash) (%)	0.46%	0.82%	0.86%
Walk 10 feet (1-6)	4.53	4.44	3.72 **
Walk 10 feet (Not Attempted) (%)	13.36%	2.88%	15.21%
Walk 10 feet (Dash) (%)	0.00%	-	0.21%
Walk 50 feet w 2 turns (1-6)	4.42	4.43	3.59 **
Walk 50 feet w 2 turns (Not Attempted) (%)	24.42%	9.88%	31.19%
Walk 50 feet w 2 turns (Dash) (%)	0.00%	-	0.45%

Agency Patient-Related Characteristics (Case Mix) Report

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Walk 150 feet (1-6)	4.41	4.01	3.40 **

Agency Patient-Related Characteristics (Case Mix) Report

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Walk 150 feet (Not Attempted) (%)	44.70%	17.28%	48.43%
Walk 150 feet (Dash) (%)	0.46%	0.41%	0.67%
Walk 10 feet uneven surfaces (1-6)	3.88	3.57	3.34 **
Walk 10 feet uneven surfaces (Not Attempted) (%)	45.16%	22.22%	49.41%
Walk 10 feet uneven surfaces (Dash) (%)	0.00%	1.23%	0.73%
1 step (curb) (1-6)	3.98	3.59	3.42 **
1 step (curb) (Not Attempted) (%)	35.48%	13.58%	45.32% *
1 step (curb) (Dash) (%)	0.46%	1.23%	0.82%
4 steps (1-6)	3.87	3.43	3.25 **
4 steps (Not Attempted) (%)	52.53%	23.05%	59.64%
4 steps (Dash) (%)	0.46%	2.06%	0.97%
12 steps (1-6)	3.82	3.29	3.05 **
12 steps (Not Attempted) (%)	68.20%	35.80%	70.71%
12 steps (Dash) (%)	0.46%	2.06%	1.08%
Picking up object (1-6)	3.28	3.32	3.10

Agency Patient-Related Characteristics (Case Mix) Report

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Picking up object (Not Attempted) (%)	20.28%	13.17%	27.08%

Agency Patient-Related Characteristics (Case Mix) Report

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Picking up object (Dash) (%)	0.46%	-	0.58%
Wheelchair or scooter (%)	22.58%	7.82%	20.49%
Wheel 50 feet w 2 turns (1-6)	3.61	3.07	2.83 **
Wheel 50 feet w 2 turns (Not Attempted) (%)	3.69%	1.65%	3.30%
Wheel 50 feet w 2 turns (Dash) (%)	0.00%	-	0.10%
Wheel 150 feet (1-6)	3.11	2.75	2.64
Wheel 150 feet (Not Attempted) (%)	5.99%	1.23%	5.39%
Wheel 150 feet (Dash) (%)	0.00%	-	0.15%

Agency Patient-Related Characteristics (Case Mix) Report

MEDICATIONS

Medication Status

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Drug regimen: problem found (%)	64.52%	59.67%	19.52% **
Mgmt. oral medications (0-3)	1.20	1.13	2.42 **
Mgmt. oral medications: NA (%)	0.46%	-	0.59%
Mgmt. injected medications (0-3)	1.24	1.20	2.39 **
Mgmt. injected medications: NA (%)	82.49%	79.42%	77.79%

Agency Patient-Related Characteristics (Case Mix) Report

THERAPY / PLAN OF CARE

Therapy Visits

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
# Therapy visits indicated (#)	6.55	5.60	7.23 **

Agency Patient-Related Characteristics (Case Mix) Report

PATIENT DIAGNOSTIC INFORMATION

Chronic Conditions

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Dependence in personal care (%)	34.10%	16.87%	49.84% **
Impaired ambulation/mobility (%)	39.63%	19.75%	52.74% **
Dependence in med. admin. (%)	64.98%	62.14%	93.08% **
Chronic pain (%)	64.98%	62.14%	93.08% **
Cognitive/mental/behavioral (%)	29.95%	22.22%	29.04%
Chronic pt. with caregiver (%)	67.28%	70.78%	76.04% *

Agency Patient-Related Characteristics (Case Mix) Report

Home Care Diagnoses

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Infections/parasitic diseases (%)	10.14%	4.53%	6.59%
Neoplasms (%)	12.44%	9.05%	9.36%
Endocrine/nutrit./metabolic (%)	27.19%	30.04%	47.64% **
Blood diseases (%)	11.06%	10.70%	10.15%
Mental diseases (%)	19.82%	24.69%	24.20%
Nervous system diseases (%)	33.18%	30.86%	22.73% **
Diseases of the eye (%)	3.69%	2.88%	2.22%
Diseases of the ear (%)	0.00%	-	1.01%
Circulatory system diseases (%)	67.28%	67.49%	79.71% **
Respiratory system diseases (%)	23.50%	19.34%	25.53%
Digestive system diseases (%)	14.75%	13.99%	12.61%
Skin/subcutaneous diseases (%)	11.06%	8.64%	12.62%

Agency Patient-Related Characteristics (Case Mix) Report

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Musculoskeletal sys. diseases (%)	33.64%	38.27%	35.96%
Genitourinary sys. diseases (%)	21.20%	19.75%	27.54%
Symptoms, signs, abnormal findings (%)	27.19%	27.16%	20.10%
Injury, poisoning, other external causes (%)	32.26%	26.75%	18.05% **
External causes of morbidity (%)	2.30%	2.88%	1.40%
Influences of health status (%)	32.72%	33.74%	34.85%

Agency Patient-Related Characteristics (Case Mix) Report

Active Diagnoses

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Diabetes Mellitus (%)	17.05%	21.81%	37.65% **
Peripheral vascular disease or peripheral arterial disease (%)	13.36%	13.99%	11.28%

Agency Patient-Related Characteristics (Case Mix) Report

PATIENT DISCHARGE INFORMATION

Length of Stay

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
LOS until discharge (in days)	51.53	54.47	56.17 *
LOS from 1 to 30 days (%)	59.45%	59.26%	46.45% **
LOS from 31 to 60 days (%)	29.03%	27.98%	34.98%
LOS from 61 to 120 days (%)	6.45%	6.58%	11.39%
LOS from 121 to 180 days (%)	2.76%	1.23%	3.30%
LOS more than 180 days (%)	2.30%	4.94%	3.88%

Agency Patient-Related Characteristics (Case Mix) Report

Reason for Emergent Care

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Improper medications (%)	0.00%	-	0.68%
Hypo/Hyperglycemia (%)	0.00%	-	1.45%
Other (%)	0.92%	-	3.79%
No emergent care (%)	73.49%	80.08%	75.85%

Agency Patient-Related Characteristics (Case Mix) Report

Falls

Domain	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Any falls since SOC/ROC (%)	0.00%	-	0.00%
Falls with no injury (%)	0.00%	-	0.00%
Falls with injury (except major) (%)	0.00%	-	0.00%
Falls with major injury (%)	0.00%	-	0.00%

iQIES Report

HHA Process Measures Report

Agency Name	ESTES PARK HEALTH HOME HEALTH CARE
CCN	067144
Agency ID	040307
City/State	ESTES PARK, CO
Medicaid Number	Not Applicable

Requested Current Period	09/2019 - 08/2020
Requested Prior Period	09/2018 - 08/2019
Actual Current Period	09/2019 - 08/2020
Actual Prior Period	09/2018 - 08/2019
# Current Cases	217
# Prior Cases	243
Number of Cases (National)	6930296
Report Run Date	11/25/2020

HHA Process Measures Report

Definitions

HHA Obs – Home Health Agency's Observed Rate is the HHA's actual performance for the measure for the selected period. This rate is not risk adjusted.
HHA Prior Obs[1] – Home Health Agency's Observed Rate from the Prior Period is the agency's prior performance for the measure for the selected period. This rate is not risk adjusted. Home Health Agencies that are newly certified will not have available data in the HHA Prior Obs fields until they have 12 months of data.
Nat'l Obs – National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]
Asterisks – Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.
* The probability is 10% or less that this difference is due to chance, and 90% of more that the difference is real.
** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.

Branch

ALL

Quality Measures

Timely Care

Process Quality Measure	HHA Obs Eligible Cases	HHA Obs Cases with Outcome	HHA Obs % of Cases with Outcome	HHA Prior Obs[1] Eligible Cases	HHA Prior Obs[1] % of Cases with Outcome	HHA Obs Significance	Nat'l Obs Eligible Cases	Nat'l Obs % of Cases with Outcome	Nat'l Obs Significance
Timely Initiation of Care	217	213	98%	243	96%	0.18	6922318	95%	0.05*

NOTE: When a measure value is calculated using less than 10 Episodes of Care, the statistical significance level will not be displayed on the report.
[1] Home Health Agencies that are newly certified will not have available data in the "HHA Prior Obs" fields until they have 12 months of data.

HHA Process Measures Report

Branch

ALL

Quality Measures

Education

Process Quality Measure	HHA Obs Eligible Cases	HHA Obs Cases with Outcome	HHA Obs % of Cases with Outcome	HHA Prior Obs[1] Eligible Cases	HHA Prior Obs[1] % of Cases with Outcome	HHA Obs Significance	Nat'l Obs Eligible Cases	Nat'l Obs % of Cases with Outcome	Nat'l Obs Significance
Drug Education On All Medications Provided To Patient/Caregiver During All EOC	209	204	98%	239	95%	0.21	6817044	99%	0.21

NOTE: When a measure value is calculated using less than 10 Episodes of Care, the statistical significance level will not be displayed on the report.
[1] Home Health Agencies that are newly certified will not have available data in the "HHA Prior Obs" fields until they have 12 months of data.

HHA Process Measures Report

Branch

ALL

Quality Measures

Prevention

Process Quality Measure	HHA Obs Eligible Cases	HHA Obs Cases with Outcome	HHA Obs % of Cases with Outcome	HHA Prior Obs[1] Eligible Cases	HHA Prior Obs[1] % of Cases with Outcome	HHA Obs Significance	Nat'l Obs Eligible Cases	Nat'l Obs % of Cases with Outcome	Nat'l Obs Significance
Influenza Immunization Received For Current Flu Season	140	105	75%	138	77%	0.83	4521705	78%	0.38
Drug Regimen Review Conducted with Follow-Up for Identified Issues	212	198	93%	236	82%	0.00	6882529	95%	0.35

NOTE: When a measure value is calculated using less than 10 Episodes of Care, the statistical significance level will not be displayed on the report.
[1] Home Health Agencies that are newly certified will not have available data in the "HHA Prior Obs" fields until they have 12 months of data.

Outcome Report

Agency Name	ESTES PARK HEALTH HOME HEALTH CARE
CCN	067144
Agency ID	040307
City/State	ESTES PARK, CO
Medicaid Number	Not Applicable

Requested Current Period	09/2019 - 08/2020
Requested Prior Period	09/2018 - 08/2019
Actual Current Period	09/2019 - 08/2020
Actual Prior Period	09/2018 - 08/2019
Report Run Date	11/25/2020

Outcome Report

Branch

ALL

Quality Measures

End Result Outcomes

 # Cases Curr: 165 **Prior:** 193
Number of Cases (National): 6,930,296

Definitions

HHA Obs - Home Health Agency's Observed Rate is the HHA's actual performance for the measure for the selected current period. This rate is not risk adjusted (RA).

HHA Adj Prior[1] – Home Health Agency's Adjusted Prior is the agency's prior performance for the measure for the selected prior period. This rate is adjusted and is calculated using the following formula: HHA Adj Prior = HHA Prior Obs + HHA curr pred - HHA prior pred.

HHA HHC RA - Home Health Agency's Home Health Compare Risk Adjusted Rate is the home health agency's Home Health Compare (HHC) risk adjusted performance for the measure for the selected period. Starting with Q1 of 2017, this rate will match the HHC rate for measures displayed on HHC when the reporting period for this report matches the HHC reporting period. If the two reporting periods do not align or if the measure is not displayed on HHC, the display for the HHC RA value will be omitted. This rate is adjusted and is calculated using the following formula: HHA RA = HHA Obs + Nat'l pred – HHA pred. This rate is only computed for measures with a risk-adjusted rate displayed on Home Health Compare.

Nat'l Obs - National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]

Asterisks - Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.
* The probability is 10% of less that this difference is due to chance, and 90% of more that the difference is real.
** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.

N/A = Not Applicable
- = No data available

End Result Outcomes (Risk Adjusted)	HHA Obs Eligible Cases	HHA Obs Cases with Outcome	HHA Obs % Cases with Outcome	HHA Adj Prior[1] Eligible Cases	HHA Adj Prior[1] % Cases with Outcome	HHA Obs Significance	HHA HHC RA Eligible Cases	HHA HHC RA % Cases with Outcome	HHA HHC RA Significance	Nat'l Obs Eligible Cases	Nat'l Obs % Cases with Outcome	Nat'l Obs Significance
Improvement in Bathing	157	129	82.2%	175	74.8%	0.14	-	-	N/A	4,979,473	83.1%	0.85
Improvement in Bed Transferring	140	97	69.3%	149	65.1%	0.53	-	-	N/A	4,898,739	81.9%	0.00**

Outcome Report

End Result Outcomes (Risk Adjusted)	HHA Obs Eligible Cases	HHA Obs Cases with Outcome	HHA Obs % Cases with Outcome	HHA Adj Prior[1] Eligible Cases	HHA Adj Prior[1] % Cases with Outcome	HHA Obs Significance	HHA HHC RA Eligible Cases	HHA HHC RA % Cases with Outcome	HHA HHC RA Significance	Nat'l Obs Eligible Cases	Nat'l Obs % Cases with Outcome	Nat'l Obs Significance
Improvement in Ambulation/ Locomotion	151	106	70.2%	177	62.5%	0.19	-	-	N/A	4,946,442	80.5%	0.00**
Improvement in Management of Oral Medications	96	44	45.8%	103	43.9%	0.87	-	-	N/A	4,655,443	77.0%	0.00**
Improvement in Dyspnea	85	47	55.3%	95	52.0%	0.73	-	-	N/A	4,154,674	83.5%	0.00**
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	165	0	0.0%	193	-00.0%	N/A	-	-	N/A	5,125,462	0.1%	1.00

NOTE: When a measure value is calculated using less than 10 episodes of care, the statistical significance level will not be displayed on the report.
[1] Home Health Agencies that are newly certified will not have available data in the "HHA Adj Prior" fields until they have 12 months of data.

Outcome Report

 # Cases Curr: 165 **Prior:** 193
Number of Cases (National): 6,930,296

Definitions
HHA Obs - Home Health Agency's Observed Rate is the HHA's actual performance for the measure for the selected current period. This rate is not risk adjusted (RA).
HHA Adj Prior[1] – Home Health Agency's Adjusted Prior is the agency's prior performance for the measure for the selected prior period. This rate is adjusted and is calculated using the following formula: HHA Adj Prior = HHA Prior Obs + HHA curr pred - HHA prior pred.
Nat'l Obs - National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]

Asterisks - Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.
* The probability is 10% of less that this difference is due to chance, and 90% of more that the difference is real.
** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.

N/A = Not Applicable
- = No data available

End Result Outcomes (Risk Adjusted)	HHA Obs Eligible Cases	HHA Obs Cases with Outcome	HHA Obs % Cases with Outcome	HHA Adj Prior[1] Eligible Cases	HHA Adj Prior[1] % Cases with Outcome	HHA Obs Significance	Nat'l Obs Eligible Cases	Nat'l Obs % Cases with Outcome	Nat'l Obs Significance
Improvement in Upper Body Dressing	130	110	84.6%	149	86.2%	0.87	4,851,897	81.6%	0.44
Improvement in Lower Body Dressing	144	117	81.2%	161	75.9%	0.31	4,895,902	80.9%	0.99
Improvement in Toilet Transferring	105	80	76.2%	129	84.1%	0.20	4,735,868	75.4%	0.94
Improvement in Bowel Incontinence	13	12	92.3%	11	84.2%	0.58	764,895	69.6%	0.13

Outcome Report

End Result Outcomes (Risk Adjusted)	HHA Obs Eligible Cases	HHA Obs Cases with Outcome	HHA Obs % Cases with Outcome	HHA Adj Prior[1] Eligible Cases	HHA Adj Prior[1] % Cases with Outcome	HHA Obs Significance	Nat'l Obs Eligible Cases	Nat'l Obs % Cases with Outcome	Nat'l Obs Significance
Improvement in Confusion Frequency	76	37	48.7%	74	57.1%	0.41	2,590,109	54.0%	0.42

NOTE: When a measure value is calculated using less than 10 episodes of care, the statistical significance level will not be displayed on the report.
[1] Home Health Agencies that are newly certified will not have available data in the "HHA Adj Prior" fields until they have 12 months of data.

Outcome Report

 # Cases Curr: 165 **Prior:** 193
Number of Cases (National): 6,930,296

Definitions
HHA Obs - Home Health Agency's Observed Rate is the HHA's actual performance for the measure for the selected current period. This rate is not risk adjusted (RA).
Nat'l Obs - National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]

Asterisks - Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.
* The probability is 10% of less that this difference is due to chance, and 90% of more that the difference is real.
** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.

N/A = Not Applicable
- = No data available

End Result Outcomes (Non Risk Adjusted)	HHA Obs Eligible Cases	HHA Obs Cases with Outcome	HHA Obs % Cases with Outcome	HHA Prior Obs[2] Eligible Cases	HHA Prior Obs[2] % Cases with Outcome	HHA Obs Significance	Nat'l Obs Eligible Cases	Nat'l Obs % Cases with Outcome	Nat'l Obs Significance
Stabilization in Grooming	158	156	98.7%	187	98.4%	1.00	4,652,318	98.2%	1.00
Stabilization in Bathing	152	151	99.3%	184	97.3%	0.23	4,668,937	98.1%	0.38
Stabilization in Toilet Transferring	156	155	99.4%	181	98.9%	1.00	4,525,572	98.1%	0.38
Stabilization in Toileting Hygiene	153	152	99.3%	180	98.3%	0.63	4,453,100	98.3%	0.53
Stabilization in Bed Transferring	160	157	98.1%	188	96.8%	0.52	4,990,953	98.4%	0.74
Stabilization in Management of Oral Medications	135	129	95.6%	156	91.7%	0.24	1,661,601	96.0%	0.66

Outcome Report

End Result Outcomes (Non Risk Adjusted)	HHA Obs Eligible Cases	HHA Obs Cases with Outcome	HHA Obs % Cases with Outcome	HHA Prior Obs[2] Eligible Cases	HHA Prior Obs[2] % Cases with Outcome	HHA Obs Significance	Nat'l Obs Eligible Cases	Nat'l Obs % Cases with Outcome	Nat'l Obs Significance
Application of Percent of Residents Experiencing One or More Falls with Major Injury	215	3	1.4%	240	1.3%	1.00	6,855,832	1.0%	0.47

NOTE: When a measure value is calculated using less than 10 episodes of care, the statistical significance level will not be displayed on the report.
[2] Home Health Agencies that are newly certified will not have available data in the "HHA Prior Obs" fields until they have 12 months of data.

Outcome Report

Branch

ALL

Quality Measures

Utilization Outcomes

 # Cases Curr: 217 **Prior:** 243
Number of Cases (National): 6,930,296

Definitions
HHA Obs - Home Health Agency's Observed Rate is the HHA's actual performance for the measure for the selected current period. This rate is not risk adjusted (RA).
HHA Adj Prior[1] – Home Health Agency's Adjusted Prior is the agency's prior performance for the measure for the selected prior period. This rate is adjusted and is calculated using the following formula: HHA Adj Prior = HHA Prior Obs + HHA curr pred - HHA prior pred.
Nat'l Obs - National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]

Asterisks - Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.
* The probability is 10% of less that this difference is due to chance, and 90% of more that the difference is real.
** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.

N/A = Not Applicable
- = No data available

Utilization Outcomes (Risk Adjusted)	HHA Obs Eligible Cases	HHA Obs Cases with Outcome	HHA Obs % Cases with Outcome	HHA Adj Prior[1] Eligible Cases	HHA Adj Prior[1] % Cases with Outcome	HHA Obs Significance	Nat'l Obs Eligible Cases	Nat'l Obs % Cases with Outcome	Nat'l Obs Significance
Discharged to Community	212	159	75.0%	234	75.9%	0.88	6,813,832	72.6%	0.49

NOTE: When a measure value is calculated using less than 10 episodes of care, the statistical significance level will not be displayed on the report.
[1] Home Health Agencies that are newly certified will not have available data in the "HHA Adj Prior" fields until they have 12 months of data.

Outcome Report

Branch

ALL

Quality Measures

Claims Based Outcomes

Requested Current Period (Claims): 09/2019 - 08/2020
Actual Current Period (Claims): 09/2019 - 03/2020
 # Cases Curr (Claims): 64 **Prior (Claims):** 89
Number of Cases (National) (Claims): 1,479,248

Definitions

HHA Obs - Home Health Agency's Observed Rate is the HHA's actual performance for the measure for the selected current period. This rate is not risk adjusted (RA).

HHA Adj Prior[1] – Home Health Agency's Adjusted Prior is the agency's prior performance for the measure for the selected prior period. This rate is adjusted and is calculated using the following formula: HHA Adj Prior = HHA Prior Obs + HHA curr pred - HHA prior pred.

HHA HHC RA - Home Health Agency's Home Health Compare Risk Adjusted Rate is the home health agency's Home Health Compare (HHC) risk adjusted performance for the measure for the selected period. Starting with Q1 of 2017, this rate will match the HHC rate for measures displayed on HHC when the reporting period for this report matches the HHC reporting period. If the two reporting periods do not align or if the measure is not displayed on HHC, the display for the HHC RA value will be omitted. This rate is adjusted and is calculated using the following formula: HHA RA = HHA Obs + Nat'l pred – HHA pred. This rate is only computed for measures with a risk-adjusted rate displayed on Home Health Compare.

Nat'l Obs - National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]

Asterisks - Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.

* The probability is 10% of less that this difference is due to chance, and 90% of more that the difference is real.

** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.

N/A = Not Applicable

- = No data available

Outcome Report

Claims Based Outcomes (Risk Adjusted)	HHA Obs Eligible Cases	HHA Obs Cases with Outcome	HHA Obs % Cases with Outcome	HHA Obs Significance	HHA Adj Prior[1] Eligible Cases	HHA Adj Prior[1] % Cases with Outcome	HHA HHC RA Eligible Cases	HHA HHC RA % Cases with Outcome	HHA HHC RA Significance	Nat'l Obs Eligible Cases	Nat'l Obs % Cases with Outcome	Nat'l Obs Significance
Acute Care Hospitalization During the First 60 Days of Home Health	64	8	12.5%	0.65	89	15.5%	-	-	N/A	1,479,248	14.8%	0.73
Emergency Department w/ o Hospitalization During the First 60 Days of Home Health	64	13	20.3%	0.39	89	14.3%	-	-	N/A	1,479,248	12.0%	0.05*

NOTE: When a measure value is calculated using less than 10 episodes of care, the statistical significance level will not be displayed on the report.
[1] Home Health Agencies that are newly certified will not have available data in the "HHA Adj Prior" fields until they have 12 months of data.

Outcome Report

Requested Current Period (Claims): 09/2019 - 08/2020
Actual Current Period (Claims): 01/2016 - 12/2018
 # Cases Curr: 183
Number of Cases (National): 4,062,390

Definitions

HHA Obs - Home Health Agency's Observed Rate is the HHA's actual performance for the measure for the selected current period. This rate is not risk adjusted (RA).

Nat'l Obs - National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]

Claims Based Outcomes (Risk Adjusted)	Current Period	HHA Obs Eligible Cases	HHA Obs Cases with Outcome	HHA Obs % Cases with Outcome	Nat'l Obs Eligible Cases	Nat'l Obs % Cases with Outcome	Nat'l Obs Significance	Agency Performance Category	Number of HHAs that Performed Better than the National Rate	Number of HHAs that Performed No Different than the National Rate	Number of HHAs that Perfomed Worse than the National Rate	Number of HHAs that Have Too Few Cases for Public Reporting
Potentially Preventable 30-Day Post-Discharge Readmission	01/2016 - 12/2018	183	4	2.2%	4,062,390	-	0.42	Same As National Rate	97	7,542	160	3,455
Discharge to Community	01/2017 - 12/2018	237	155	65.4%	6,183,160	-	0.00**	Worse Than National Rate	4,416	2,690	2,244	1,904

NOTE: When a measure value is calculated using less than 10 episodes of care, the statistical significance level will not be displayed on the report.

Outcome Report

Medicare Spending Per Beneficiary (MSPB) - Post-Acute Care Home Health

Requested Current Period (MSPB): 09/2019 - 08/2020
Actual Current Period (MSPB): 01/2017 - 12/2018

Table Legend
[a] PAC HH = Post-Acute Care Home Health
[b] The treatment period is the time during which the patient receives care from the attributed HH, and includes Part A, Part B and Durable Medical Equip Prosthetics, Orthotics and Supplies (DMEPOS) claims.
[c] The associated services period is the time during which any Medicare Part A and Part B services other than those in the treatment period are counted towards the episode spending.
Dash [-] = Value cannot be calculated
N/A = Not Available

Comparison Group	Number of Eligible Episodes	Average Spending Per Episode - Spending During Treatment Period[b]	Average Spending Per Episode - Spending During Associated Services Period[c]	Average Spending per Episode - Total Spending During Episode	MSPB Amount - Average Risk Adjusted Spending	MSPB Amount - National Median
Your Agency	271	$2,794	$6,695	$9,489	$9,778	$11,217
National	10,061,183	$3,014	$8,185	$11,199	$11,209	$11,217

Your Agency's MSPB PAC Score
(Your Agency's Risk Adjusted Spending Divided by the National Median)

0.87

U.S. Average MSPB Score
(National Risk Adjusted Spending Divided by the National Median)

1.00

NOTE: Patient-level data for claims-based measures are not included in patient-level quality measure reports.
Source: Medicare Fee-For-Service claims and eligibility files.

Explanation of Medicare Spending per Beneficiary (MSPB) Post-Acute Care (PAC) HHA Measure

The purpose of the MSPB-PAC measures are to support public reporting of resource use in PAC provider settings as well as provide actionable, transparent information to support PAC providers' efforts to promote care coordination and improve the efficiency of care provided to their patients. The measure is calculated as the ratio of the payment-standardized, risk-adjusted MSPB-PAC Amount for each agency divided by the episode-weighted median MSPB-PAC Amount across all agencies of the same type. For home health agencies, episodes are categorized as Partial Episode Payment (PEP), Low Utilization Payment Adjustment (LUPA), and all others (Standard) and agencies' episodes are compared only within each category. The figure below illustrates the episode window for calculating this measure. Beneficiary spending during the episode window is categorized as related to "Treatment" or "Associated Services." The episode window begins on the first day of the home health claim and ends 30 days after the Treatment Period ends (which is either 60 days or at discharge for PEP episodes). Spending is standardized, bottom-coded when necessary, and risk-adjusted.

Resources:

Home Health Quality Measures including MSPB PAC Measure Specifications, risk adjustment factors, and exclusion criteria: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index

EPH Board of Directors CNO Summary
December 2020

COVID Update

- Swabbing clinic is up and running, seeing 45-60/day M-F
- Larimer County Health Department placed us in the red category due to number of positive cases
    - No visitation policy except for a parent with a child, compassion care
    - All hospital employees to wear hospital mask
    - Minimize number of people in waiting room
    - No meals in cafeteria, or staff lounges unless able to sit 6 feet apart
    - Process identified to assess high risk patients for elective surgery and manage elective surgery volume with adequate bed usage
    - 50% of staff should work at home if possible
    - 2 weeks of PPE must be on hand
- Partnering with UCHealth to care for COVID patients
    - Nurse/physician line that will support us in the care of COVID patients, allowing us to keep more
    - Transfer if needed
- CHTC statewide collaborative to support patients getting to the right level of care
- Infection Prevention nurse working very closely with Larimer County health department for positive employees, patients and community members

HCAPS - Patient Experience

- YTD overall rating is 63.8%tile with quarter 3 at 81.0%tile and 4th quarter 100.0%tile
- Will be focusing on nurse communication, physician communication and care transition

Key Drivers	NRC 50th Percentile*	NRC 75th Percentile	Current YTD	Qtr 4 2020‡	Qtr 3 2020‡	Qtr 2 2020	Qtr 1 2020
Communication with Nurses	81.0%	83.7%	73.0% PR=6	100.0%µ	92.1%µ	53.3%µ	66.7%µ
Communication with Doctors	81.7%	84.6%	75.3% PR=11	100.0%µ	88.9%µ	58.3%µ	73.8%µ
Care Transitions	52.0%	56.4%	51.2% PR=44	66.7%µ	58.7%µ	40.7%µ	54.8%µ

- Action steps:
    - Hourly rounding
    - Bedside reporting
    - Leader rounding
    - Increasing social work coverage on M/S, ED and Birth Center to 6 days/week

DNV Survey December 8th

- Virtually - to survey after evacuation (will focus on Emergency Management, COVID and action plan)

Med/Surg

- Taking higher acuity patients
- Able to give Remdesivir per requirements
- Using EMT role as a patient care technician between ED/M-S and swabbing clinic - going well (used the EMTS from the reduction in force at the UCC)

Emergency Department/Urgent Care Center

- Combined the leader for both, doing well
- Shortened hours, working ok
- Continue to evaluate for best staffing mix
- Continue to be prepared for high volume COVID patients with appropriate PPE

Perioperative Services

- Hired a new director – Terri Neumann. She comes with extensive experience in surgery, large and small as well as team development skills

Quality

- Continue to refine quality report card for EPH and specific departments
- Preparing for the DNV survey on 12/8/2020
- Transition to another physician leader (Dr. Ken Epstein) for 2021

Living Center

- Testing twice a week per state requirement
- Have had one full week of no positive test of residents and employees
- Transitioning NHA role to interim (Matt resigned)
- Adequate PPE

ESTES PARK HEALTH

Chief of Staff Update

12/8/2020

John Meyer, MD

COVID UPDATE

- We continue to see a rise in cases
- Difficult to transfer down valley
- Please use the COVID hotline to get tested and not the ER
- Use the ER for severe symptoms
- Vaccine is coming out soon
- EPH Medical staff STRONGLY ENCOURAGES all employees to get vaccinated

ESTES PARK HEALTH

My Last Board Meeting

- Thank you
- Dr. Robyn Zehr will be your next Chief of Staff
- Dr. Bridget Dunn will be Vice Chief of Staff
- I will be Former Chief of Staff
- We want to thank Dr. Aaron Florence for serving as a chief for the past 6 years

ESTES PARK HEALTH

Executive Update – December, 2020

Strategic Plan Implementation Update

1. **Develop a system to maximize the contacts and reach of EPH directors, for the benefit of the Foundation.**
    - Done
        1. Board Development Committee has finalized strategy

2. **Improve Institutional Communication.**
    - Done
        1. Will improve on an ongoing basis, based on organizational learning

3. **Assess and Improve Onboarding Program for new EPHF Directors.**
    - Ongoing Implementation, no issues
        1. Director Survey done
        2. Board Development Committee updated Director Orientation Curriculum
            1. Additional improvement / tuning will continue as needed
        3. EPHF Mentor Program in process
            1. New Directors have been assigned Mentors effective January, 2021

4. **Improve Donor Retention to 57% per year by Year 3**
    - In process, according to schedule, no issues
        1. Staff working on strategy

Highlights since last Board Meeting

- Executed Phase 3, Annual Campaign strategy
    - Phase 1 – Building Modifications
    - Phase 2 – Additional Testing Capabilities
    - Phase 3 – Vaccination & Testing – Underserved

- Approved critical grant / additional RT-PCR assay testing system

- Recruited new Executive Assistant

General Board Update

- Financial
  - Challenging year, FR down 10% from budget through October, 2020
  - Operating Expenses have been reduced by 10% to offset
  - Staff and Board are working hard to achieve budgeted FR by 12/31/2020
  - 2021 budget draft assumes minimal growth, still significant unknowns

ESTES PARK HEALTH

EPH COVID-19 Pandemic Update
December 8, 2020

KEEPING EVERYONE SAFE AT EPH: We continue to focus on maximum safety at EPH. All staff, patients, and visitors must wear masks at all times, and we check temperatures and screen for symptoms and contact with potential infected parties at the entry doors for all employees, patients, and visitors. With the recent change to Level 4 (Red) in Larimer County, we've instituted or reinforced additional changes:

There will be no visitors allowed, except that an adult parent or guardian may arrive with their child, and an adult patient may bring their personal caregiver.
We will begin booking appointment times for laboratory tests to avoid congregation in the laboratory area. To help those with fasting labs, we will be booking times early in the morning so that patients can complete their lab draws fairly early in the morning.
For other waiting rooms (Rehab, Physician Clinic, Urgent Care, Radiology, Surgery, etc.), we have created workflows to ensure that the patient is taken rapidly to an exam or procedure room, to avoid congregation in those areas.
Employees who can work from home are working from home whenever possible during the Red status.

There are also some actions the public can take to help:
Arrive as close to their appointment time as possible.
Use the e-Check-in feature of their My Health Connections patient portal to reduce time at the registration desk and elsewhere. (If the patient is not currently a portal user, they may ask their primary care physician for an invitation.)
If a patient has a fever or other potential COVID symptoms, or may have been exposed to COVID, we continue to require that they call EPH before coming to an entrance.

COVID TESTING AT EPH: Our current swabbing process includes a Telehealth visit for personalized care and follow-up, along with a scheduled specimen collection date and time. Our streamlined process has safely been brought indoors and expanded to care for our public. Swabbing is Monday - Friday, 8 AM – 11 AM and 4 PM - 6 PM. Given current demand, results can take up to 24 hours. Our Foundation is working to purchase a second fast-turn analyzer to help with the volume and improve turnaround of delivery of results.

DON'T HESITATE TO GET HELP: If an individual is experiencing serious or life-threatening symptoms (chest pain, stroke symptoms, etc.), they should immediately come to EPH to get attention for that emergent condition. Our emergency department and processes are safe. Do not delay service for any serious medical condition out of COVID fear.

PHYSICIAN CLINIC OPEN FOR BUSINESS: Our physician clinic remains open to safely see patients, including for routine, non-acute appointments. You can visit your PCP now to address your regular checkups and chronic conditions. Techniques of staggered appointment times and social-distancing blocks help reduce the number of patients arriving at any one time. We get the patients into our exam rooms quickly to minimize waiting room time. And, of course, telehealth visits are also available.

CONTINUE TO SCREEN FROM HOME: One of the best safety measures that patients can take if they are concerned that they may have COVID-19 symptoms, or that they might have been exposed to an infected person, is to be screened over the phone (meaning "asked the key questions about symptoms and exposure to COVID-19"). A nurse is available for questions at any time. Anyone calling for COVID information can call the clinic registration desk at 586-2200 and then be transferred to the COVID triage nurse.

Park Hospital District Board
Timberline Conference Room
December 8, 2020

CREDENTIALING RECOMMENDATIONS

Credentials Committee approval: November 25, 2020
Present: Drs. Zehr (Chair), Florence, Meyer, Steve Alper, and Andrea Thomas

Medical Executive Committee approval: December 2, 2020

Privilege reinstatement request for low/no volume practitioner:

Woodard, Scott, M.D. — Courtesy to Active, General Surgery

Proposal: See attachment with additional conditions below

Conditions:

- ATLS certification within the next 3 months (signed up for 2/25/21-2/26/21);
- Total 9 months provisional status;
- Evaluate after 3 months or achieved 5 operative surgeries; and
- Evaluate after 6 months

Status change (Beginning 1/14/21)

Simon, Kaycee, CRNA — Locum tenens to APP