MINUTES
Cheshire County Commissioners Meeting
Friday July 8, 2016 10:00AM
County Hall Building
Commissioners Conference Room
12 Court Street
Keene, NH 03431

PRESENT: Commissioners, Stillman Rogers, Charles Weed, and Peter Graves
STAFF: County Administrator Coates, Finance Director Trombly, Maplewood Administrator Kindopp, and Assistant County Administrator (ACA) Bouchard

At 10:00AM Chair Rogers opened the meeting and recognized Maplewood Administrator Kindopp for the purpose of receiving her Maplewood Options Summary / Recommendation report.

Kindopp presented the following report to the Commissioners;

Future of Maplewood Administrator's Summary/Recommendations (July 2016)

Timeline overview of the process:

As early as 2007, talks began regarding the aging infrastructure of Maplewood. The 2008 budget included moneys to initiate a study of the condition of the building, the winning bid was an architectural firm called WarrenStreet and they had a Civil Engineer, a Structural Engineer, a Mechanical Engineer, an Electrical Engineer, and an architectural team study and report on all relevant elements of the building and grounds. While the report was officially completed by October of 2008, the sudden change in our country's financial status delayed the presentation to the Delegation until November 14th, 2009. The title of the document was "Maplewood Nursing Home Feasibility Study, Existing Conditions Survey, 9/24/2008". It was completed by WarrenStreet and McFarland Johnson.

Then in 2011, a firm named Premier Healthcare Resources won a bid to study the operations of Maplewood and their document was completed in 2012 and titled "Maplewood Nursing Home Operational Assessment". Other studies were completed including a costing option for outsourcing or selling the operations (Marcus and Millichap) and this plus the previous studies were collated and included in a document titled "1st Compendium Report Regarding Maplewood Nursing Home" and was published January 1, 2013.

In the summer of 2013, a task force was put together to study and consider what would be in the best interest of the citizens of our county relative to the future of Maplewood. This task force met regularly over the course of 1 year and tackled questions including if the County needs to be in this business, why we operate at a deficit, some understanding of the payment structure and the historical and current facility operations. Some meetings included teleconferencing with other states/counties who had either successfully closed their county home, attempted to but were blocked and other relevant operational experiences including outsourcing. This committee heard from various providers in and around the county, from our medical director and from our contracted geriatric psychiatrist to better understand the patient population we serve and the function we offer within this county as well as some specialized care we are able to provide.

Speakers included the State Long Term Care Ombudsman, the CEO of a major for profit nursing home operation within our state (that had contracted for about 2 years to operate Sullivan County before Sullivan County resumed full control and operations). The committee toured all local area homes as well as some other County operations. They learned of a newer model of long term care and began studying more about the Green House® operations including having a speaker come in to better describe this option. They heard from Steve Norton about what to expect from our State that is leading the country in aging and who is credited with coining the now famous phrase "silver tsunami". A completed report and recommendation was presented to the Delegation on August 15th 2014. The Delegation took the report as informational and discussed the necessary next steps.

Due to the fact that this first study committee learned about a new operational configuration, a feasibility study of this newer small house model (Green House®) was completed by the administrator and finance director to predict annual operational costs and staffing requirements. In January of 2015, a subcommittee of the Delegation to study the Future of Maplewood was convened and began meeting regularly to consider options including; closing or outsourcing and costs, upgrading, rebuilding or building new.

On June 26th, the subcommittee requested the Commissioners initiate an RFP and contract with a single entity to develop multiple detailed plans, and estimates of various costs of 7 specified plans and to report back no later than October 1, 2015. On July 2, the RFP was sent to multiple architects, publications and other relevant sites. On July 9th, an optional information meeting was hosted at Maplewood with a tour offered at the end. Proposals were due back July 31st, and on August 4th a subcommittee of 3 opened the bids and scored them as described in the RFP.

On August 5th, the Commissioners were apprised of the recommendation by the subcommittee.

On August 17th, the County proposed to the executive body of the Delegation a funding source to complete the proposed study and the Delegation was alerted that the recommended firm was EGA. On August 24th, the full body of the Delegation voted and approved the necessary funding source to enable proceeding with contracting for this work. On September 3rd, administration met with EGA to initiate the terms of the contract. On September 21st, the first draft of the contract was received, and by September 29th, the contract negotiations were completed and the signed contract was finalized.

Work began that fall by EGA to study the building, the land and initiate conceptual architectural plans for 6 of the options. Once the plans were developed fully enough for use for the operational study, then finance and administration began studying and planning the operations of each permutation and combination.

The first of a series of 3 presentations by EGA to the Delegation was in February of 2016, with the second presentation done in March of 2016, and the final in April of 2016. By the end of

April, the Delegation chose to offer 5 County wide public sessions to be prepared for and venues to be booked. The 5 sessions took place in June of 2016.

I have emphasized my firm professional recommendation for why private rooms ought to be prioritized and summarized the reasons on a flip-chart based on studies.

Administrator's overview of the 8 EGA Proposed Options for the Future of Maplewood:

Option 1; County to close or outsource the operations. Not recommended – while initial savings would be achieved, there would be no further control over the operation and our historical mission driven operation would cease and eventually there would either be a change in the quality of the operation with an increased challenge for the indigent of our county to find long term care within this county and/or there would be pressure from the operators for a county subsidy to continue to care for the indigent. I believe this option would result in a short term savings to the county, but a long term loss to our constituents and I predict the hospital would have more burden than currently they have for care of the indigent. It wouldn't surprise me if even the hospital were to have discussions with the county due to the additional burdens this scenario would most undoubtedly cause.

Option 2; continue operations in Westmoreland without major construction; operate on a crisis management platform. Not recommended. The main building has been in continuous operation now for 40 years. During public meetings, a theme emerged about a house being 40 years old and ought not be in a condition as to need so much work. The conclusion some made was that we must not have maintained this building. Perhaps we have not made sufficient improvements over the many years to keep up with the wear and tear, however if one considers a typical home having 4 occupants, with 365 days of use over 40 years – plus perhaps 2 guests stay about 28 days each year (to account for stays as well as visitor entertainment hosted at the house) over the 40 years, this would give a sum of nearly 70,000 units of use – just to quantify and create a perspective. Compare now the nursing home with 150 resident beds x 365 days' x 40 years, plus up to 300 staff x 365 days' x 40 years, plus 10,500 signed in visitors each year x 40 years – this sum is nearly 7 million units. So, a typical 40-year-old house is used only 1% as much as a 40-year-old nursing home with 150 beds. Even if we omit staff and visitors and use only the resident days to compare, it still would only equate to less than 3% of use as compared to the house scenario. While this facility was built in part to sustain this kind of beating, it is time to make major improvements and upgrades to this well used building.

One issue not yet discussed is that the Feds have slowly and steadily increased rules and regulations over the years since Maplewood was built. One example is that now we are required to offer private settings for specific functions including social services and nursing interviews. Our double rooms do not achieve this, nor does our traditional model of nursing home with long corridors and no privacy on any resident unit. While we can invite a resident downstairs to the social services office, this is not practical, and in most cases, residents wave the option and

tolerate the very public space to answer very private questions minimally every 12 weeks as required by the government (not to forget the daily question about one's bowel movement – always awkward when the resident asks you to repeat your question more loudly). Even options A1 and A2 will not alleviate this situation; however, A2 has more potential if altered from the conceptual drawings.

Option 3; "A1 Infrastructure Plus". Not recommended. The economy of scale plus the layout of this building would not significantly change the staffing needs; a 20% reduction in resident capacity would not achieve a 20% reduction in operational costs. This option is the most disruptive by far (even admittedly by the architects and other professionals who worked with us on the operational study) of all options to residents and staff during a prolonged 3+ years of construction. To complete this, 36 beds (12/floor as renovations have to be accomplished vertically due to plumbing/electrical chases) would be pulled out of service for phase 1 and would take about 6 months to complete. The next phases (2 through 6) would take 24 beds (8/floor) out of service and we predict we would require 1 additional staff member to simply focus on being the transitional care coordinator to juggle this challenge. In the end, we lose 30 beds permanently to achieve the minimum standards of the American's with Disabilities act (ADA). This would result in maintaining the 6 current private rooms with toilets – the toilet room would be adjusted to meet ADA requirements and slightly decrease the overall room square footage (*this would also occur in the A2 scenario), then 30 rooms would become "single" but with 2 sharing an ADA toilet, while the remaining 84 rooms would still be double rooms with 4 sharing a toilet that would still not meet ADA requirements.

Option 4; "A2 New Wing". This option is recommended as the best option for the Westmoreland site. This option results in achieving the ADA compliance issues, while also achieving the infection prevention goal and single rooms with toilets. This would be moderately disruptive, and despite the joke by a resident of Assisted Living that most people living here are hard of hearing – not all are, and not all would tolerate the noise as well as they predict they will. Staff too that prefer to remain in this location indicate they are willing and ready for the disruption, however, with recent work on our roof, I can attest to the fact that as a society we have become more vociferous of our displeasures and staff too will find this more disruptive than they predict. I can't say if a longer period of disruption is more tolerable than a potential complete move of the residents/equipment to a new campus upwards of 15 miles away.

As long as the additional list of equipment and renovations is added, I believe this will be a suitable compromise and can give an additional 20+ years of reasonable operations with only some moderate capital needs along the way. Capital replacements will always be part of the budget requests regardless of if option A1 or A2 is chosen. Yearly capital requests at moderate levels will be required in comparison to any completely new building option.

A2 nearly doubles the square footage of each care unit and will require additional housekeepers as is in the EGA report. The same report also includes a high number of additional LNA FTE's.

We predict we will need to staff this option as 2 separate units of 25 (vs our current 1 unit of 50) and thus predict we need more LNA's particularly on the night shift. We also predict needing some additional hours of nurses on the night shift. The reality will be that we will need to work with the state to determine if the added square footage will in fact require additional licensed staff as was believed by EGA during our operation study if this is the chosen scenario, or if we will need to make that determination based on ensuring resident safety. We currently operate as many beds as we can safely staff, which is the reality of the future of the A2 operation if it were chosen as well.

While A2, B1, B2, B3 and B4 were just conceptual drawings – if any are chosen, more work will need to be done to include more staff in the planning phase as we predict some poor staff flow with design A2. Work with staff and the architectural team could address some of the predicted issues to achieve the best environment for residents while making any necessary adjustments to ensure effective and efficient staffing travel/movement patterns. While budgets will always be a limiting factor, any end result will undoubtedly be quite different than the initial concepts presented. A major drawback of A2 remains the long hallways of the original nursing halls. Perhaps compromises could be achieved to alter to a degree this undesirable design feature of this aged structure.

A major advantage of this option is to maintain the picturesque location. Many argue that a new setting would not be as beautiful. A compromise may need to be that giving up on being closer to a major center and the hospital is necessary to keep the positive aspects of this location. This will continue to have potential residents and potential staff possibly chose another location for their personal reasons. While we have tracked in recent years lost potential residents due to our distance, we admittedly have not tracked in any meaningful way if our picturesque country setting was a main reason we were chosen.

At public hearings, some admitted that they simply had no choice, that Maplewood was the only place that would accept their loved one for their specific reason. As the baby boomers age, we expect we won't have sufficient long term care beds. Despite the Federal directive to keep elders at home or in less institutional settings, these alternatives will be finite for any number of reasons, and at the height of the baby boomers aging process, I would predict that long term care facilities will run nearly completely full if the Certificate of Need board continues its' moratorium on beds. The limiting factor will be lack of staffing which is a National health care issue, and will affect all aspects of the healthcare system.

This brings me to another important issue. Staffing. Our region has suffered a significant shortage of health care professionals for a number of years. Therapists have been in high demand but short supply for 25 years now. The National Nursing shortage has not even reached its' predicted worst high and won't for another 5-10 years. Nationally we are reaching a crisis, State-wide we have reached a crisis, and just in our county, local long term care settings have suffered with 128.4 open positions; mostly nurses and LNA's (11 are therapists). This has led to bed

closures both at Maplewood as well as other health care operations in our region. Maplewood has recently begun to "recruit and retain" from within. One significant (and to me professionally THE MOST SIGNIFICANT) consideration we must make is relative to the ability to staff any of the options.

We heard at public hearings that a few staff in attendance recommended options in Keene, while the majority of those in attendance urged the decision to be made to keep the operation in Westmoreland. Some have shared publicly that they would not choose to follow Maplewood if it were to move. None have said publicly that they would leave it if chose to stay. A move to Keene (a city with a very low rate of unemployment of approximately 2%) would not guarantee additional staffing. We may certainly have some employed by other healthcare facilities chose to leave elsewhere and come work for the county. The Monadnock Region Healthcare Workforce Group has been studying the staffing challenges for over 6 months now – and those in Keene report that they lose staff to Massachusetts as that state pays higher wages.

Public hearings also attracted many volunteers to attend. Maplewood boasts a robust number of volunteers – we have 75 and in 2015, they contributed a total of 4,161 volunteer hours. A seasoned long term care employee touring Maplewood some years ago while interviewing for a major leadership position remarked how many staff we had. When it was pointed out that she was looking at the volunteer name badges, she was completely astounded and had never experienced anything similar to this in her 30+ years working in nursing homes around the country. The pros to both A1 and A2 include retaining staff and volunteers in a picturesque farming/mountain/river location.

The Cons to this location include its' remoteness. Many argue it's not that far. I charge each of you to experience being older/more frail and traveling 3x/week to dialysis in Keene on roads that are quite bumpy in the spring – all while sitting in the back of a w/c accessible vehicle. Anyone who traveled to school in a bus will recall the lift-off experienced in the very back going over bumps. Another con remains that the main route in is over a red-lined bridge. While an elected official indicated there was nothing wrong with the bridge, it is under a weight limit and can be found red listed on an official municipalities listing. With few exceptions, each year's snow melt has run the banks of the brook over Partridge Brook road, closing access for many successive days each spring. On more than 2 occasions, I recall River Road in Chesterfield overcome with water at a specific bridge near the boat launch. Both of these roads were closed the day after Hurricane Irene hit our area. While each situation described cleared up within days to no more than a week, operating a safe healthcare facility that requires 24/7 emergency access and planning for all hazards operations demanded by Federal Regulations. A strong message to Westmoreland is urged – if so many people are supporting Maplewood's' operations to remain here, then I should think the town will be most supportive of correcting this aged infrastructure that is under their jurisdiction.

One last consideration in the A1 and A2 options is the Assisted Living Facility (ALF). Assisted

living occupancy trends are projected to take a breather throughout 2017, then spike later as the baby boomers reach their peak entry dates in 2026. Maplewood has a long waiting list upwards of 50 – while many are not immediately ready, the current ALF administrator reports that 14 want immediate placement as of her ¼ report due July 2016. We won't know before it's time to have the elected officials take a vote on the future of Maplewood what the final outcome of the new Federal Regulations affecting the ability of ALF's to receive Federal funding after 2019. I urge that the ALF be a priority in our decision making for the future of Maplewood. I have cited reasons including the wait list, few if any Medicaid ALF beds are offered in our county, and for those that are Medicaid, taxpayers pay one third the cost as compared to the same resident in a nursing home. Based on the resident mix today, if the county gets out of the ALF business, then tax payers will immediately pay 3 times the rate for 15 residents to be in nursing homes.

Option 5; B1 Green House® (GH®). Not recommended. In contrast to opinions I have heard from others, I do believe this operation can work for our residents. It is a radical change from our current operations, however with proper training and support, I believe this operation does work and achieves a better home environment as compared to all other options on the table. The main reasons I don't recommend this include that it is a franchise and I see the controversy over tax payers having to pay the franchise fee. I could predict that were this option chosen, that the lawmakers would absolutely reject this fee and thus, set us up for a more challenging journey to prepare for the model. The fee includes training. Without adequate training, we would be ill prepared to move from a completely institutional setting that we work to make home-like into a home that we would need to completely alter how we staff, approach and ensure a smooth operation is achieved. I understand not wanting to have the franchise fee, but I have grave doubts over achieving the education without the support of that enterprise. I disagree with some of the limits GH® puts on buildings including not allowing connections between buildings. Public hearings echoed this concern and the ridiculousness of transporting residents via van to a community gathering in inclement weather.

I spoke with several GH® administrators during this journey including a county owned/operated 135 bed home in Tennessee. I also spoke with a GH® in Alaska, Chicago and NY, then visited 2 GH® operations in Mass and one in New York. Each administrator spoke of the improvements to the residents and none would "go back" to the original style of operation.

The operation in Alaska did serve residents with some challenging behaviors, but we realized that while it wasn't as though we were comparing apples to oranges, we were comparing 2 different apple types relative to our challenging resident behaviors. One thing that surprised me was that while she reported a big decrease in resident to resident altercations due to each resident having their own room and toilet/shower, she still reports resident to resident altercations as they still occur in the group areas.

A more concerning issue I see with this operation is the staffing patterns. We have navigated through staffing challenges over the past year that have included being down 25% of our nurses

and 25% of our LNA's. We did close beds, however there was one point in time when I calculated that we would need 50 more LNA's than currently existed in our county in order for us to open and run this style of home. Given the current and future predictions of healthcare personnel challenges, I do not recommend this model. I would have loved to have been the first GH® Administrator in our state, but I don't want to set myself up nor the county for failure due to the issues I've identified above. In a recent poll of 9 local healthcare facilities, the total of open positions for nurses, LNA's and therapists is 128 openings in the 1st quarter of 2016.

Option 6; "B2 Neighborhood". This option is recommended as the best option for a site to be determined. I believe this option gives the best of the small house concept, but keeps it all under 1 roof to achieve some efficiency of scale and use of centralized processing. This model's environment looks most like a home, second only to the small house. You would enter a unit and see a kitchen and living room space. Each person would have their own room/BR/shower for privacy and infection prevention. This conceptual drawing has 6 double rooms that still have a toilet for each resident – this compromise is acceptable and can generally meet the infection prevention issue and possibly could be designed in such a way as to enable the wall to be completely separating the 2 rooms or only a privacy wall to allow for flexibility for sharing.

Even if this could not be designed with such flexibility, this limits bed loss to 6 total if we encounter incompatibilities or different genders requiring each their own room, and compared to 100 room changes done in 2015 alone in the current Maplewood, such a compromise has less of an impact in this style of operation.

We predict we need more unit managers due to this configuration and one more unit assistant. We predict we would need more dietary servers as we have more units to serve to. While we worked out numbers for each scenario with the EGA operational study, once a model is chosen, we can begin work with the architect to move from conceptual designs into true designs and have departments work with the architects and study more in depth the operational changes and better determine expected staffing numbers to truly operate the actual design chosen. In all models, the same approach was taken, so any "errors" in staffing predictions are equal in all models for the purpose of the EGA directed study.

This model still embraces parts of the traditional nursing home in that we can standardize certain elements ensuring that staff trained for one unit, can easily function on any unit. While this is achieved, the residents and families still get homier spaces and individual rooms for more personal and private visits. Another option is the flexibility of moving towards more of the small house operational model, however that is unlikely as without the trademarked franchise, we wouldn't have the education or support to proceed unless there were significant moneys found for development and ongoing training of the staff.

Option 7; "B3 Traditional". This option is not recommended. This returns to the current institutional model with little to no family spaces, and has smaller rooms as well as the smallest

square footage. I would differ in opinion to anyone wishing to argue that this would be the easiest to move into as it would be simply the same operation. With a move, it would still be disruptive to all including staff, and getting to know a new space would negate any benefits gained from re-creating the same operational style just with less of the lengthy corridors. If the decision is to move this operation and build new, it would be inadvisable to build an antiquated 40-year-old model that was never well suited to a long term living situation for human beings. I will choose not to spend much time or energy discussing this option, I doubt there is significant support.

Option 8; "B4 Hybrid". This model is not recommended. While it brings all elements discussed and would allow some small house design to be incorporated, for reasons already stated, I would not recommend considering this model. In addition to the missing element of the significant staff development and training that is not part of this, the major downside to such an operation is that there is no standardization. This model would require staff to be trained for small house, some to be trained for neighborhood and others to learn the new layout of an old institutional design.

This is the least effective and efficient system for a 150 bed nursing home. There are few operational efficiencies, and staff cannot easily be moved from one part of the home to another without support and training. All other models are at least homogeneous and share the element that once staff know the environment, they are able to function in any smaller component. Even laundry and maintenance staff would not have the elements and benefits of standardization. We would need additional vehicles to transport food, laundry and supplies to the small homes. Food and clothing transports inside the main building would need to be different and would require more and differing equipment styles that create operational inefficiencies on such a large scale.

In summary, the best design and operational option in my opinion for Westmoreland is A2, whereas the best design and operational option for a move is B2. I think the decision comes down to do we stay in Westmoreland or if we chose to bond a major construction project, do we start new and move it closer to the center of the county.

Kindopp concluded her report and a lengthy discussion ensued. Each of the options were discussed and reviewed and re-examined in light of the recommendations made by the Administrator. Kindopp and the staff answered many background questions concerning the current operations in Westmoreland and the impact of the recommended A2 and B2 options and the possible impacts on residents, staff, costs, operations, etc.

At 12:40PM there being no further business to discuss, Commissioner Graves moved to adjourn the meeting and was seconded by Commissioner Weed. Upon vote the motion passed with unanimously.

Respectfully Submitted,
P. Graves, Clerk