Center for Hospice Care
choices to make the most of life

Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
November 18, 2020
7:15 a.m.

BOARD BRIEFING BOOK

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Center for Hospice Care
choices to make the most of life

CHAPTER ONE

AGENDA

Center for Hospice Care

BOARD OF DIRECTORS MEETING

Via ZOOM Only

November 18, 2020

7:15 a.m.

A G E N D A

1. **Welcome** – Mary Newbold (5 Minutes)

2. **Consent Agenda** – Mary Newbold (10 minutes)
   A. Approval of August 19, 2020 Board Meeting Minutes *(action)*
   B. Patient Care Policies and Exposure Control Plan *(action)* – Included in your board packet. Angie Fox, available to answer questions.
   C. QI Committee Meeting Minutes included in your packet *(information)* – Jennifer Ewing is available for questions

3. **President's Report** *(information)* - Mark Murray (20 minutes)

4. **Finance Committee** *(action)* – Mark Wobbe (13 minutes)
   A. 2021 Flex Spending Account Limit
   B. 2020 Retirement Plan Audit
   C. Year to Date October 2020 Financial Statements
   D. 2021 Budget

5. **Hospice Foundation Report** *(information)* – Wendell Walsh (15 minutes)

6. **Nominating Committee** *(action)* – Mary Newbold (7 minutes)

7. **Chair's Report** – Mary Newbold (5 minutes)
   A. Board Member Recognition
   B. Board Self-Evaluation Survey

Next meeting February 17, 2021

# # #

1-800-HOSPICE ♦ cfhcare.org

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Center for Hospice Care
choices to make the most of life

CHAPTER TWO

CONSENT AGENDA

Center for Hospice Care
Board of Directors Meeting Minutes
August 19, 2020

Members Present:	Amy Kuhar Mauro, Jennifer Ewing, Jennifer Houin, Jesse Hsieh, Kurt Janowsky, Mark Wobbe, Mary Newbold, Roland Chamblee, Wendell Walsh
Absent:	Andy Murray, Ann Firth, Suzie Weirick
CHC Staff:	Mark Murray, Craig Harrell, Karl Holderman, Mike Wargo, Sue Morgan, Becky Kizer

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 7:20 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 06/17/20 meeting as presented. The motion was accepted unanimously.	A. Mauro motioned M. Wobbe seconded
3. Policies	• A motion was made to accept the new and revised policies as presented. The motion was accepted unanimously. • A motion was made to accept the revised "Policy Concerning the Position of President/ CEO of the Center for Hospice Care (and all Affiliates)" as presented. The motion was accepted unanimously.	A. Mauro motioned M. Wobbe seconded
4. President's Report	• The ADC has recovered from a loss in March and April. Through the end of July, it is 4% higher than a year ago. So far August ADC is 444 and YTD 431; breakeven is 398. Census is recovering especially in residential homes compared to ECFs. We have also had very late referrals. Patients/families are nervous about going to a facility. Our staff is still not allowed in some nursing homes. Some are opening to our nurses only, but not chaplains and social workers. Through April, referrals were down 14% from a year ago, and as of July they are down 1%. YTD July conversion rate is 76%--an all-time high. ADC hit 451 on 08/07, which is the first time on a single day it has been over 450 since February. ECF census is slowly beginning to recover. Both IPUs occupancy rate has been down 23-24%. • The new VP/COO, Lance Mayberry, starts 09/14. • We are hoping to have a new DON soon so Sue M. can mentor her before she retires this year. Mark received an email from HR during the meeting that the new DON has accepted the position and a start date will be determined.	

Topic	Discussion	Action
	• Pediatric Palliative Care – A QAPI started in October 2019 to look at our overall care of pediatric patients. The group focused specifically from the time the call comes in until after the patient's death. This included social work, nurses, chaplains, and the bereavement team. Overall education is planned for staff and we created a pediatric resource manual for them to follow. We did a mock walk through of the procedures and it was very successful. Today we are educating staff on their roles in the program. So far this year we have served more pediatric patients than in all of last year. • MADS and all adult day centers were closed for two months by the Indiana Division of Aging first in April and then by the Governor in May. It reopened June 1st. Their census is at about 50% of what it had been prior to closing. We received almost $40,000 from the State to make up for the difference of being closed for two months. • Raclin House is still not open due to CMS telling all state agencies to not do any non-emergency surveys of any kind. ISDH has said we need a facility survey before we can see patients there. On Monday, CMS lifted that suspension, so Mark M. emailed ISDH that we are looking forward to having our survey so we can open the facility. He had not heard back from them yet. • 25% of NHERT executive members are retiring this year. We think much of this may be due to COVID-19, staffing issues, stress levels, etc. It is taking its toll on some around executives around the country. • The "2019 Year in Review" is being edited. Due to competing priorities and COVID-19, it will be out later than originally planned. It should be in mailboxes soon. • HHS Stimulus money – We received almost $1.4M. We documented expenses related to COVID-19 and came up with $268,000 over the $1.4M received, so we can claim the entire amount. The thinking is HHS may settle up something in the future and fund the overages since those that didn't have enough expense will have to pay it back. Rybar Group consultants recommended to us by Kruggel Lawton have been very good to work with on this. • New Medicare rates go into effect 10/01/20. In the 4th quarter this will be an additional $305,000 in gross per diem revenue. If the 2021 rates were in effect the entire year, annualized it would have been $1.2M of additional revenue. This is the first time in years we received over a 5% increase, but that is only in two of our nine counties.	

Topic	Discussion	Action
	• On Monday, NHPCO released figures for the number of hospice programs in the country. For-profits now make up 69.65%, non-for-profit 26.94%, and government providers 3.41%. For-profits are up 25% in just the last five years and make up nearly 70% of all hospice providers. Locally, in our service area, we see nearly the same percentages. • Wendell W. asked about the educational focus we are doing with RNs from our Press Ganey surveys on the areas we want to improve such as communication and respect. Sue M. reported these areas score 92-93%, but we want to continue to improve upon them. Our scores in these areas are higher than the national average. • Wendell W. asked about staff morale during COVID-19. Sue M. said overall as an agency we have done a lot to keep morale up with day-to-day communications. Staff have had opportunities to be here every day and do the work they like to do. We have done a lot of individual thank you's to staff.	
5. Finance Committee	• The July YTD financial statements were reviewed and approved by the Finance Committee on 08/14/20. Mark W. commented when he joined the board, Receivables management was an area of concern and our attempts to improve that. The good news it has improved immensely. CHC's AR is now below the average of the program members in the National Hospice Executive Roundtable. • YTD, we served 1,417 patients compared to 1,390 a year ago. Budget is for 1,430. July ADC was 430 compared to 415 a year ago. Budget for 424. Breakeven is 398. YTD operating revenue $13.8M and budget is $14.2M. Most of that difference is in revenue from private commercial insurance. Total revenue was $13.6M, total expenses $12.9M and budget was $13.8M. Overall net gain was $678,656. Net without beneficial interest was $954,722 and the budget was $614,642. • A motion was made to accept the YTD July 2020 financial statements as presented. The motion carried unanimously.	K. Janowsky motioned J. Ewing seconded
6. Hospice Foundation Update	• Mike W. reviewed the Hospice Foundation fundraising since its inception in 2007. In 2007-2008 we were in the middle of the Elkhart campaign and raised nearly $3M. Annual giving increase in 2014 when we began the "Cornerstones for Living: The Crossroads Campaign." That campaign raised $14M. Through 06/30/20 we have raised $677,000 this year, $616,000 of which is in annual giving compared to $1.2M in annual giving last year. If we continue on this trend, annual giving should be close to where we were last year. We won't have revenue from the Helping Hands Award	

Topic	Discussion	Action
	event this year, which last year raised $404,000. Due to COVID-19, this event has been rescheduled for 2021. We have raised some money for the event his year before we decided to push it off until next year. Overall, we feel good about fundraising this year given the current situation. • We are working with Dan Reagan to identify post-campaign initiatives. We have identified six key areas: (1) Expand unrestricted giving; (2) Endow key mission support programs; (3) Identify annual fundraising priorities; (4) Base of support for GPIC; (5) The Cornerstone Society; and, (6) Next generation. One challenge for us is our donor base continues to age, so we need to work on cultivating the next generation of donors. We've added a 7th area – Care Connections at Milton Village fundraising initiative. • Center for Education and Advance Care Planning – During COVID-19, we have continued to keep engaged with our education initiatives. Most of this has been online and virtually. We continue to work with the family medicine residency programs at Memorial and SJRMC. We have done some Facebook live events. Elleah Tooker, Community Education Coordinator, is working on outreach to legislators. She was able to arrange a Zoom meeting with the health policy director for Senator Todd Young. We have held three virtual panel discussions, which have gone very well. • Honoring Choices Indiana-North Central – The new HCI-NC website went live in June. Steve Chupp, Honoring Choices Coordinator, and Dr. Mark Sandock did an online series on end of life care, especially in ECFs and the importance of having advance directives in place. We are developing refresher course for certified facilitators to help them learn how to deliver this education and facilitate those conversations online. • GPIC – We continue to work with PCAU, Road to Hope, PCAU interns, the mHealth project, and the Advanced Diploma in Palliative Care Nursing programs. In response to COVID-19, we sent nearly $50,000 to various partners in Sub-Saharan Africa. This included $10,000 in GPIC matching funds in concert with donations from U.S. partners. We still have 37 partners and continue to support them as much as possible right now. We currently have three GPIC interns working on projects. Please refer to the President's Report for more details. • In April we provided one-year AAHPM membership opportunities to selected GPIC members and collaborators.	

Topic	Discussion	Action
	• Mishawaka Campus projects – We are working on lighting and landscaping for the campus. The new maintenance building is completed and fully operational. We hope to be able to move South Bend staff to Raclin House soon so we can begin to transform the Roseland facility into a new home for Milton Adult Day Services. We have an architect's rendering of Milton Village. Once we get approval from ISDH to relocate the IPU to Mishawaka, we could begin demolishing the Roseland building in October-November and construction could begin in December. It will take about nine months to complete the remodel, so the building should be able to open in the third quarter 2021. We are working on firming budget prices for DJ Construction. • The 36th Helping Hands Award Dinner has been rescheduled for May 5, 2021. This will be the first time we ever had two-year recipients. Jennifer Ewing is chairing the event along with Tom Housand.	
7. Board Education	• Dr. Karissa Misner, CMO and Medical Director, did a presentation on "Challenges of providing hospice and palliative care during the COVID-19 pandemic." She has been at CHC one year as of today and became Chief Medical Officer on January 1. The medical staff has done an excellent job keeping receivables down to a more reasonable level. Dr. Misner reviewed how the pandemic has affected CHC medical staff, patients/families, and her personally.	
Adjournment	• The meeting adjourned at 8:20 a.m.	Next meeting 11/18

Prepared by Becky Kizer for approval by the Board of Directors on November 18, 2020.

Jennifer Houin, Secretary

Becky Kizer, Recording Secretary

PURPOSE: To establish an Agency protocol when using a CADD Pump for symptom control that provides safe and accurate use of the pump while providing good symptom management.

POLICY: Agency nurses will go to the patient location, verify the order, confirm pump setting, provide patient and caregiver teaching, and start the CADD Pump according to designated settings and route.

PROCEDURE:

Initiating the Pump

1. Scope of Practice - RNs
2. After the order is received, verify by repeating the order to the physician. Fax a copy of the order to the infusion pharmacy and call the pharmacy.
3. Confirm that the medication and pump has arrived at the patient's home before your arrival. Upon arrival, identify your patient and review the order with a second licensed professional in person or via ~~phone~~ Zoom. Check the pump settings against the order. Follow protocol for correct route, IV, port, SQ, and update the care plan.
4. Document in EMR verification of settings and name of licensed professional settings verified with.
5. Document in EMR MAR pump settings
6. Nurse initiating the pump will take picture of settings on CADD and upload to EMR under patient documents
7. Start the pump according to CADD Quick Reference Card for Clinicians. Confirm that the pump is running and locked prior to leaving the patient's location.
8. Be mindful of inputting codes to unlock the pump in front of patient or family/caregivers.
9. Complete the Ambulatory Home Infusion Pump Programing paper supplied by St Joseph Infusion and fax back to them with the number provided. Fold the paper and place in the bag with the pump. (Attachment A)

Cassette Change

1. Scope of Practice – RN/LPN
2. When the reservoir volume has less than a 24 hour supply, consider changing the cassette depending on availability of the medication. Notify the pharmacy that you are starting the new cassette.
3. Verify current order with a second licensed professional via ~~phone~~ via Zoom/face time
4. Check cassette against that order with second licensed professional either in person or via Zoom/face time. Review pump settings. Change cassette according to instructions in "Quick Reference Card for Clinicians."
5. Document in EMR verification of settings and name of licensed professional settings verified with.
6. Change site if indicated by site appearance or protocol.

Cassette Change (continued)

7. Confirm that pump is locked and running before leaving the patient location.
8. Dispose of any unused medication per agency policy.
9. When adding volume to cassette RN/LPN will verify settings and document in EMR MAR what the settings on the CADD pump are.

Changing the Settings

1. Scope of Practice – RN/LPN
2. Verify new order by repeating it back to the physician. Fax a copy to the infusion pharmacy.
3. Make any changes according to the instructions in "Quick Reference Card for Clinicians." Verify the new setting with a second nurse ~~phone~~ either in person or via Zoom/face time. Start the medication as ordered.
4. Document in EMR verification of settings and name of licensed professional settings verified with.
5. Nurse making changes will take picture of settings on CADD and upload to EMR under patient documents
6. Document in EMR MAR pump settings
7. Verify that the pump is locked before leaving the patient location.

With any nurse visit the nurse will chart in the EMR MAR the pump settings, including the volume left and if St Joe Infusion was notified to send new cassette.

Discontinuing the Pump

1. Scope of Practice – RN/LPN
2. Verify the discontinuation order.
3. Notify the infusion pharmacy of the discontinued order. Fax the order.
4. Discontinue site per protocol.
5. Dispose of unused medication per protocol (see medication disposal policy).
6. Return pump to the triage area for pick up, Document CADD pump on log and notify Infusion Clinic of CADD pump pick up.

CADD Pump Keys

1. Each office will have a spare key kept:
   - South Bend IPU medication room
   - Elkhart IPU medication room
   - Plymouth medication refrigerator
   - La Porte medication refrigerator
2. CADD pump keys must be picked up and returned to the office the same day.
3. CADD pump keys must be signed out and in (see attachment A).
4. Lost keys will be reported immediately to coordinator and an incident report completed.

REGULATION: 42 CFR 418.106 – Drugs and biologicals, medical supplies, and durable medical equipment.

PURPOSE: To establish procedure within the Inpatient Units (IPUs) where medications are secured in accordance with federal, state, and local laws.

POLICY: Medications shall be stored in a secure manner to protect public health and safety, and to promote patient care.

SCOPE OF PRACTICE: Registered Nurse (RN) and Licensed Practical Nurse (LPN).

PROCEDURE:

1. All medications will be secured in the medication room in the IPU.
   (a) Medication room will have either proximity card access or keypad access.
   - If keypad access, the access code will be changed twice yearly in April and November by the IPU Manager.
   - Code for keypad should never be communicated via email or written down anywhere in the IPU.
   - Only RN/LPNs may have access with their proximity card to the Medication Room.

   (b) Medications will be stored in either locked cabinet, locked refrigerator, or Omnicell.
2. Keys to patient medication cabinet and refrigerated must remain on the RN/LPN at all times.
3. IPU RN/LPN must remain in the medication room when access is granted to any unauthorized personnel, i.e., housekeeping, maintenance.
4. Medication room door must remain closed at all times.
5. If the door does not secure or medication cabinet or refrigerator does not lock, the RN/LPN is to immediately notify:
   (a) ~~PCC~~IPU Clinical Leader/Nurse Leadership on call
   (b) Maintenance
6. When unit is closed, they keys to the medication cabinet/refrigerator should be kept:
   (a) Esther House – Lock box in IPU Manager's~~PCC's~~ office—call the IPU Manager/IPU Clinical Leader ~~PCC/Maintenance~~ for code.
   (b) Raclin House – Lock box in Volunteer closet—call the IPU Manager/IPU Clinical Leader~~PCC/Maintenance~~ for code.

Signature: President/CEO

(c) Codes for lockbox will be changed after each use.
- Only the IPU Manager/IPU Clinical Leader should know the code between use.

Effective Date: 05/2020	Revised Date: 10/20	Board Approved: 06/17/20
Reviewed Date:		Signature Date: 06/17/20

Signature: President/CEO

REGULATION: 42 CFR 418.108(b) - Short-term Inpatient Care

PURPOSE: ~~To ensure patients who need respite care are cared for in the same manner as at home.~~ Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home.

PROCEDURE: ~~Patients will go to the Inpatient Unit (IPU) of their choice. If the IPU cannot accommodate them, they will be given the option of going to the other IPU or if they choose not to go to the other IPU, they may be given the choice of delaying respite stay.~~ After discussion with the Inpatient Unit (IPU) Manager on capacity at both IPUs, the patient will go to the IPU with the available capacity. Another Medicare contracted facility may only be used if both IPUs are full.

Before a patient is scheduled for Respite stay:
Determine if the patient qualifies for Respite stay:

- Respite care may not be provided in the following circumstances:
  - There is no identified caregiver
  - Patient resides in a nursing facility or a facility that provides 24/7 care
  - There is no clear reason for caregiver relief

- Case Manager/Visit nurse will complete the Communicable Disease form before transfer.
  - Emergency respites are defined as:
    - Caregiver illness/injury and cannot physically care for patient
    - Loss of utilities or sudden unsafe home condition
    - Other as determined by administration

- As soon as the family has made the request for respite, the Social Worker will enter all respites on the public calendar labeled IPU Respite Reservations.

- On the date the patient/caregiver is requesting to start respite, the social worker will add the following:
  - Under Subject:
    - Patient name
    - Date entered into calendar
    - Length of stay
  - Under Location:
    - Preferred location
  - Under the body:
    - Diagnosis
    - Anything that would be pertinent to the stay

Signature: President/CEO

- IPU staff member will complete the CHC Respite Stay Questionnaire profile before arrival to the IPU.
  - If family is requesting same day respite and there is no time for IPU staff to complete the questionnaire, Social Work will complete it with the family.

- An IDT will be scheduled within 24 hours of start of Respite by the Social Worker.
  - Respites that will begin on Sunday or Monday may be IDT'd on Friday in order to include the patient care team.

- The Case Manager will be included in the IDT to ensure all needed information is shared with IPU staff.

Day of Respite:

- Social Work will call the IPU and verify with the IPU Coordinator that a bed is available bed before scheduling transportation.
- If there are any changes to the patient since the IDT, the Case Manager will call the IPU with an update.

Admission to IPU:

- Upon arrival the patient and the caregiver, if present, will be oriented to the IPU including the following:
  - Inventory of patient belongings
  - Copy of questionnaire will be kept in CNA book for reference.
- Questionnaire will be utilized for the patient plan of care while in the IPU
  - Family preference on who to call first if there is more then one family member
- Home medications will be reconciled with family upon arrival to IPU. If the family does not accompany the patient, the RN will call the family to discuss.

Daily Care while in the IPU:

- Any changes in the patient's condition will immediately be reported to the family.
  - If patient becomes combative or increasingly agitated, the family will be notified.
- Any changes in medications from what the patient normally takes at home will be discussed with the family before initiating.
  - The nurse will document the reason for any medication changes or additions.
- If the patient does not have a Foley, the nurse will discuss with the family BEFORE anchoring.
  - The nurse will document the need for a Foley and family approval.

- The plan of care will follow the home routine to the best of the IPU's ability. This includes:
  - Dressing
  - Bathing
  - Activity
  - Meals
  - Medication schedule

Transfer from Respite Back to Home:

- Social Work will coordinate transfer time and transportation.
- IPU nurse will call the Case Manager with an update on the patient.
- Medications and belongings will be packed and made ready for transportation.
  - Belongings will be double checked against the inventory sheet to make sure all of the patient's belongings are returned with the patient.
- IPU Patient Discharge Instructions (Attachment A) will be completed and accompany medications home.
  - Dosages will be written in mg and # tablets or mL.
- If the family is not present at the discharge from the IPU, the IPU nurse will call the family with an update and to educate on any medication changes during on the patient's respite stay.

REGULATION: 42 CFR Part 418.56 – Interdisciplinary Team (IDT) or Interdisciplinary Group (IDG), care planning, and coordination of services

PURPOSE: The agency will use an interdisciplinary approach to assessing the medical, physical, social, emotional, and spiritual initial and ongoing needs of the patient and family.

POLICY: The Agency will have an Interdisciplinary Team (IDT) that includes at least the following persons:

- Doctor of Medicine or Osteopathy
- Registered Nurse
- Social Worker
- Spiritual Care~~Pastoral or other Counselor~~

Center for Hospice Care (CHC) is not held responsible to have all disciplines coordinate until after hospice has been elected and initiated.

There is not an expectation for an IDT prior to admission.

Each member of the Interdisciplinary Team will be qualified to fulfill their individual position's job description and hospice licensure.

No member of the IDT shall be a family member, or related to a family member, of the patient.

Participation of team members will be reflected in documentation.

The Interdisciplinary Team will fulfill the following functions

- Establish the patient plan of care with the attending physician and/or the Medical Director/Hospice Physician, prior to the provision of care, and review and update the plan of care at intervals specified in the plan.

- Provide or supervise care and services consistent with the established plan of care. Supervision of this care will be reflected in summaries of patient care conferences in which problems are reviewed by the Interdisciplinary Team and interventions are recommended.

- Report changes in condition/situation from the patient visit/contacts, and update the plan of care. At any time, an IDT member may initiate any form of communication or meeting to facilitate this exchange of information.

- Decide which services are considered reasonable and necessary for the palliation or management of the terminal illness and related conditions. The following questions may be asked to determine this:

- What is the financial classification?
- What is the patient's diagnosis?
- What are the patient's options?
- What are the expected outcomes for this particular patient?
- To what extent is the proposed service life-limiting/prolonging?
- Is there evidence that what is requested works and is used for that reason?
- Is the patient able to make an informed consent?
- Is this in the patient's plan of care? If not, should it be?
- What symptoms are we palliating?
- Are the symptoms related to the terminal illness?
- What are the potential burdens?
- What follow up is needed?

- Review patient's eligibility for his/her specific program every recertification period.

- IDTs are completed for:
  - Certification
  - Recertification
  - Plan of care initiation (after comprehensive assessment)
  - Changes to plan of care
  - Discharge alive for not meeting eligibility
  - Transfers

- ~~1.~~ IDTs are not required for DME; only a physician's order.

- IDTs are required for:
  - Discharge for Cause
  - Revocations

REGULATION: 42 CFR 418.28 – Revoking the election of hospice care

PURPOSE: To comply with state and federal regulations in the revocation process.

POLICY:

1. Revocation is a patient choice. The Agency should neither request revocation nor ~~pressure~~ determine revocation for the patient.~~/family or representative in any way to revoke his/her election~~. Education to the patient/family includes the choice to revoke service or the choice to continue hospice services and not seek curative treatment.

2. The Medicare and Medicaid Revocation form will be signed the day the Agency is informed or made aware of the patient/primary caregiver (PCG) decision to revoke. The revocation forms for both Hospice Medicare and Medicaid benefit~~HMB and MHB~~ will be placed in all admission packets in order to be available for immediate signing.

3. Revocation forms will not be accepted if completed verbally (over the phone). A signature from the patient or patient's representative must be obtained in person or fax. Signature must be dated the same day as the revocation. Verbal revocations are not acceptable.

4. Patients and families should be educated that hospice entails certain limits for coverage including: ~~in the way care will be provided, including restrictions on obtaining care outside the care arranged for or provided by the hospice, and the patient's liability for care received without the hospice's involvement. pursue treatment not present in the patient plan of care.~~
   - Seeking treatment without notifying hospice.
   - Pursuing treatment not present in the patient plan of care.

~~4. Patients who remain eligible and desire care are not pressured to revoke due to the expense of the care requested.~~

5. Hospitalized patients being discharged to a Skilled Nursing Facility (SNF) Medicare A skilled bed must be educated on their options related to revocation in order for regular *Medicare to cover their SNF days. They should not be discharged.*

~~7. The following questions should be answered at the IDT meeting regarding the reason for revocation:~~
   - ~~Patient's name~~
   - ~~Financial class~~
   - ~~Hospice diagnosis~~

~~• Description of incident that has led up to this meeting~~
~~• Options~~
~~• Expected outcomes~~
~~• Is this in their plan of care~~
~~• Related to pain and symptom management of hospice diagnosis~~
~~• Did the patient/primary caregiver contact the Agency first~~

~~Document the above in the patient record.~~

6. In any certification period, a revocation on the part of the patient/family causes all days remaining in that benefit period to be permanently lost; however, the patient may sign back into the Hospice Medicare or Hospice Medicaid Benefit ~~HMB/MHB~~ program. This will automatically begin with the next certification period.

PROCEDURE:

1. ~~The nurse/social worker will discuss with the patient/PCG their decision to revoke the Medicare/Medicaid Hospice Benefit and the financial implications of their decision.~~ If a patient is seeking treatment for a procedure, obtain details of the treatment and notify a Patient Care Coordinator (PCC) with the following information:
   - Patient's Name
   - Financial Class
   - Hospice Diagnosis
   - Description of incident that has led up to this meeting
   - Options
   - Expected Outcomes
   - Is this in the plan of care
   - Related to pain and symptom management of hospice diagnosis
   - Did the patient/primary caregiver contact the Agency first

2. The PCC will coordinate with the Billing Coordinator for further details of the procedure. If the procedure is outside of business hours, obtain signed revocation forms. The patient will not be discharged until a determination has been made regarding procedure coverage. The nursing leadership team will coordinate with the Medical Director, Billing Coordinator, the Director of Nursing, and the Chief Operating Officer to determine coverage.

3. ~~Document all pertinent information on the IDT note. Notify the physician and record the response.~~ A visit will be created in the medical record by the person presenting the patient with the revocation paperwork and education provided. The discharge visit and discharge documentation will be completed by a registered nurse monitoring the contact. Depending on the patient's specific situation, documentation may include any of the following:
   - Patient/PCG decided to seek treatment on their own without notifying the Agency of their intentions.

- Treatment was not a part of the hospice plan of care.
- Explained to patient/PCG their right to revoke at this time and the financial implications of the revocation.
- Patient chose~~wants to sign revocation papers today~~ to revoke hospice services.
- Reason for revocation (if provided voluntarily by patient or caregiver.)~~.~~

4. Obtain the Revocation Forms, review the reason for revocation (if a reason was provided), and make sure the signatures of patient or health care representative is obtained. Retrieve ~~this~~ these forms the same day of the revocation.

4. Enter "Hospice Medicare/Hospice Medicaid~~HMB/MHB~~ Revocation" with date and patient name via Secure Messaging.

5. Provide a copy of revocation form to the patient/PCG/POA regarding the change in status.

6. Complete plan of care, Secure Messaging, and/or discharge summary as necessary. Notify via email of revocation.

FORMS:
Revocation of Hospice Benefits Information Sheet
Medicaid Hospice Revocation
Revocation of Hospice Medicare Benefit

Center for Hospice Care

SCHOOL OF NURSING/MEDICINE CLINICAL EXPERIENCE - DRAFT

Section: Patient Care Policies Category: Hospice Page: 1 of 1

PURPOSE: CHC, in conjunction with contracted schools of nursing/medicine, will provide clinical experience in the home and inpatient units for students/Fellows during their community rotation.

POLICY: CHC will assign appropriate staff to mentor students/Fellows during their community clinical rotation at CHC under the guidance of the school.

PROCEDURE: Students/Fellows who wish to rotate through CHC for clinical experience must have the following on file at CHC:

- Schools must have a contract with CHC.
- Students must sign the CHC Confidentiality Agreement before their first clinical day with staff.
- Schools must send a letter stating all students are current on vaccinations, yearly TB test, and CPR.

Schools of nursing will send their student schedules to the ADON/Clinical Staff Educator before the first scheduled clinical day.

Medical schools will work through the Hospice Foundation and the CHC Medical Director.

During any pandemic, students will need to follow CHC's Pandemic Policy or the school's pandemic policy for visits or PPE use, whichever is stricter:

- If masks are required, schools of nursing will be notified before the first day.
  - If students do not have a mask, CHC will provide one.
- Visits to homes will be cleared with the family before the visit.
- Visits to ECFs/ALF/Group Homes will be cleared through the facility's Executive Director/Director of Nursing.

FORMS: CHC Confidentiality Agreement

Effective Date: 09/20	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

Signature:  President/CEO

REGULATION: 42 CFR 418.104(e) – Clinical Record

PURPOSE: To provide for continuity of care for patients leaving or entering CHC's ~~our~~ service area for short trips of 14 days or less. If the patient wishes to leave their original hospice for longer than 14 days, the patient will need to be discharged for leaving the service area.

POLICY: The Medicare Modernization Act of 2003 allows hospices to contract for care of patients who are receiving care under the Medicare Hospice Benefit (HMB) when they travel outside the hospice's service area. For non-HMB patients, hospice staff would need to talk with the specific insurance company to determine how they support the patient during travel. Medicaid does not allow for Temporary Service Agreements (TSAs).

PROCEDURE: The TSA Letter of Agreement will be signed by the designee of each organization prior to the patient leaving for his/her trip. For CHC, the designee is the Vice-President/COO. In the absence of the Vice-President/COO, the Director of Nursing will sign the agreement. In the absence of the Director of Nursing, the Director of Support Services will sign the agreement.

The Letter of Agreement will be specific to the patient leaving or entering the service area, the dates of leaving and returning, in addition to the location of where the patient will be staying.

For patients traveling outside the CHC service area:

1. CHC will provide the contracted hospice with a copy of the patient's face sheet, current plan of care, and medication profile in advance of the patient leaving.

2. If a visit is made by the contracted hospice, a copy of the visit or progress notes will be provided to the contracted hospice and sent to the attention of the Director of Nursing.

3. If needed, the contracted hospice will call CHC to arrange a visit and report back the findings of their visit.

For patients traveling to the CHC service area:

1. The contracted hospice will provide CHC with a copy of the patient's face sheet, current plan of care, and medication profile in advance of the patient traveling to CHC's service area.

2. If needed, CHC will call the contracted hospice to arrange a visit. If a visit is made by CHC, then CHC will provide a copy of the visit or progress notes to the contracted hospice, sent to the attention of the Director of Nursing.

~~1~~3. The patient must be seen and assessed as defined by his/her Plan of Care including during times of travel. Review the patient's visit frequency and adapt to the patient's needs both during travel and upon his/her return home. Adjust visit frequency as ordered by physician as required by the needs of the patient. Check with the Patient Care Coordinator when the patient is due for the review of the Plan of Care, as the patient will need to be home in order for that assessment to be completed.

~~2. The Temporary Services Letter of Agreement will be signed by the designees of each organization prior to the patient leaving for his/her trip.~~

~~3. The Letter of Agreement will be specific to the patient leaving the area, the dates of leaving and returning, in addition to the location of where the patient will be staying.~~

~~1.~~4. Document in the patient record the instructions that were given to the patient or primary caregiver regarding contacting CHC or the contracted hospice for all questions and concerns. ~~If needed, CHC will call the contracted agency to arrange a visit. They in return will report back to CHC the findings of their visit.~~

~~2.~~5. The price per visit and cost per mile will be established by both agencies in advance and will be designated on the agreement. CHC or the contracted hospice will submit an invoice summarizing the number of visits made and the number of miles traveled if applicable.

~~3. CHC will provide the following for the contracted agency in advance of the patient leaving:~~
~~a. patient face sheet~~
~~b. current plan of care~~
~~c. medication profile~~

~~4. If a visit is made by the contracted agency, they will provide CHC with a copy of their visit or progress note and send to the attention of the Director of Nursing.~~

6. CHC or the contracted hospice will ~~E~~ensure that the patient has the necessary medications and supplies for the trip until returning home.

~~5.~~7. If the patient's condition changes sufficiently to warrant a change in the level of care or a significant change in their Plan of Care, ~~transfer~~ the patient will be transferred to CHC or the contracted ~~the~~ hospice ~~of the patient's destination~~ in order for the patient~~m~~ to obtain the necessary medical services.

~~4.~~3. ~~Send an~~An unsigned HMB Revocation form will be sent with the patient. If the patient should require emergent care during travel, they should go to the nearest emergency room. If the patient should die enroute, the original hospice would be responsible, in conjunction with the family, to determine the patient's final destination. If the patient should die ~~while~~ at the travel destination, that hospice will facilitate arrangements to transfer the body to the mortuary designated by the family.

~~6.~~8. All transmission and maintenance of patient health information will be completed in a HIPAA compliant manner.

~~7. The contracted hospice agency will submit an invoice summarizing the number of visits made and number of miles traveled if applicable.~~

REGULATION: 42 CFR 418.104(e) – Clinical Record; Discharge or transfer of care

PURPOSE: To provide for continuity of care for patients transferring to or from our Agency. This will apply for Hospice Medicare Benefit (HMB) patients, and Medicaid Hospice Benefit (MHB) patients who have Medicare/Medicaid in the state of Indiana.

PROCEDURE:

1. An IDT meeting will be held to coordinate patient care when transferring to or from another hospice.
2. Case manager will contact his/her PCC regarding request to transfer hospices.
   - PCC will review information from case manager to make sure everything is completed.
   - PCC to follow up with family, if it is a care issue, to see if CHC can meet their needs before transfer.
3. Determine the patient's present insurance coverage. If the patient has Medicare~~they are HMB~~, determine if the hospice they are transferring to is certified to provide the Hospice Medicare Benefit. This also applies to Medicaid~~MHB~~ if the patient has Indiana Medicaid and transferring within the state of Indiana.
4. If the patient resides in a nursing home and has Medicaid, complete the Medicaid form "Hospice Provider Change Request Between Indiana Hospice Providers." Complete Sections A, B and C and send to the new hospice.
5. Contact and provide the transferring hospice the following:
   - Transfer/Discharge Summary
   - Patient Profile
   - Medication Profile
   - Certification of Terminal Illness
   - Copy of Advance Directives (if applicable)
   - Plan of Care
6. The patient will be informed of financial implications. If the patient is not enrolled in either the Medicare/Medicaid systems, it will be considered a discharge from the Agency.
7. The Discharge Summary would be completed as usual and sent to the physician.
8. Documentation in the IDT note must include:
   - Reason for the transfer or discharge
   - The name and phone number of the receiving hospice
9. Document transfer or discharge in the admissions/discharge section of the computer.

EXPOSURE CONTROL PLAN

Revised September 2020

TABLE OF CONTENTS

PROGRAM ADMINISTRATION

The Quality Assurance (QA)/Medical Records Coordinator is responsible for the implementation of the Exposure Control Program. The QI Committee will review and update the Exposure Control Plan at least annually, and whenever necessary to include new or modified tasks and procedures.

All Center for Hospice Care (CHC) employees who have the risk of occupational exposure to blood or other potentially infectious materials must comply with the procedures and work practices outlined in this Exposure Control Plan.

CHC will maintain and provide all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers), labels, and red bags as required by the standard. Nursing Education will ensure that adequate supplies of personal protective equipment are available in the appropriate sizes.

QA will be responsible for ensuring that all medical actions required are performed if an exposure should occur and that appropriate employee health and OSHA records are maintained.

QA will make the written Exposure Control Plan available to employees, OSHA, and NIOSH representatives. The Clinical Staff Educator will be responsible for the training/education on the Exposure Control Plan, appropriate use of PPE and will document training and education, these records will be maintained by the QA department.

METHODS OF IMPLEMENTATION AND CONTROL

Universal Precautions

All employees will utilize universal standard precautions.

Exposure Control Plan

Employees and volunteers will receive an explanation of this Exposure Control Plan during their orientation. All employees have an opportunity to review this plan at any time; it is available on the staff website.

All patient care procedures performed by CHC employees, including volunteers, are classified as Category I, II, or III depending on their potential for occupational exposure. (See addendum A)

The QA Coordinator will evaluate and classify each patient care procedure performed by CHC staff to:

a. Identify parts of the body that might be contaminated;
b. Determine the probability of the employee being exposed to contaminated body fluids as a result of performing the procedure;
c. Identify the personal protective equipment that should be used while performing the procedure; and
d. Identify the work practices that are necessary to perform the procedure safely.

Once the patient care procedure is classified, the proper procedures are initiated.

Classification categories are reviewed annually, by the QA Coordinator and as needed, should a procedure need to be re-classified to a higher or lower risk category.

Work Practices

Standard workplace practices will be used to prevent or minimize exposure to blood borne pathogens.

Sharps disposal containers are inspected and maintained or replaced by the Nursing Department whenever necessary to prevent overfilling.

Identification of any needed workplace practice changes will be through observation and monitoring for any trends

Personal Protective Equipment (PPE)

PPE is provided to CHC employees. Training/education is provided by the Clinical Staff Educator in the use of the appropriate PPE for the tasks or procedures employees will perform.

The types of PPE available to employees are as follows: gowns, masks, gloves, shoe covers, and eye protection.

PPE is located in the supply room and may be accessed as needed to ensure adequate supplies are available for patient care

All employees using PPE must observe the following precautions:

- Wash hands immediately after removal of gloves or other PPE.
- Remove PPE after it becomes contaminated, and before leaving the work area.
- Sharps containers may be disposed of in an Inpatient Unit (IPU) Dirty Utility Room into the corrugated labeled biohazard disposal container
- Lab specimens should be placed in zip lock bags with the biohazard label. Specimens should be transported in temperature controlled soft or hard sided cooler designed for lab specimen transport
- Wear appropriate gloves when it can be reasonably anticipated that there may be hand contact with blood or other potentially infectious materials
- Wear appropriate gloves when handling or touching contaminated items or surfaces; replace gloves if torn, punctured, contaminated, or if their ability to function as a barrier is compromised.
- Wear appropriate face and eye protection when splashes, sprays, spatters, or droplets of blood or OPIM pose a hazard to the eye, nose, or mouth.
- Remove immediately any garment contaminated by blood or other potentially infectious material in such a way as to avoid contact with the outer surface

Housekeeping

Regulated waste is placed in containers which are closable, constructed to contain all contents and prevent leakage, appropriately labeled, and closed prior to removal to prevent spillage or protrusion of contents during handling.

The procedure for handling **sharps disposal containers** is to place in regulated waste container

The procedure for handling **other regulated waste** is to place in biohazard bag and dispose of in regulated waste container.

Contaminated sharps are discarded in containers that are closable, puncture-resistant, leakproof on sides and bottoms, and labeled appropriately. Sharps disposal containers are available in the supply room.

Broken glassware which may be contaminated is picked up using mechanical means, such as a brush and dustpan.

Regulated Waste Safety

Warning labels shall be affixed to regulated waste containers and red bags are to be used if regulated waste or contaminated equipment is brought into the facility. Employees are to notify the IPU Manager or IPU Clinical Leader or if the Coordinator is unavailable, contact on call nursing leadership to notify that regulated waste containers (located in IPU rooms) need to be picked up.

HEPATITIS B VACCINE

Employees and volunteers will receive training and education on Hepatitis B vaccinations, addressing the safety, benefits, efficacy, methods of administration, and availability.

The Hepatitis B vaccination series is available at no cost after education and within 10 days of initial assignment to employees identified in the exposure determination section if this plan. Vaccination is encouraged unless: (1) documentation exists that the employee has previously received the series, (2) antibody testing reveals that the employee is immune, or (3) medical evaluation shows that vaccination is contraindicated.

However, if an employee chooses to decline vaccination, the employee must sign a declination form. Employees who decline may request and obtain the vaccination at a later date.

All documentation regarding Hep B vaccination or declination is kept in the employee or volunteer's medical file.

EMPLOYEE TRAINING

All employees who have occupational risk of exposure to blood borne pathogens will receive training/education at the time of orientation and annually.

Training/education shall include, but not be limited to:

- A copy of the Exposure Control Plan or education as to its location on the staff website
- Appropriate use of PPE and engineering controls; including indications for use and disposal
- Information on the Hepatitis B vaccine, its benefits and vaccination schedule
- Information on follow-up procedure, if an exposure incident should occur
- An opportunity for interactive questions and answers with the person conducting the training session
- Epidemic/Pandemic guidelines and procedures

RECORDKEEPING

Training Records

Training records shall be maintained by QA after completion of initial (and updated) Exposure Control Plan training and education

Employee training records are provided upon request to the employee or the employee's authorized representative within 15 working days. Such requests should be addressed to QA.

Medical Records

Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.20, "Access to Employee Exposure and Medical Records."

Human Resource is responsible for maintenance of the required medical records. These confidential records are kept in Human Resource with the exception of exposure-related laboratory results. Exposure-related results will be stored with the Director of Nursing. All other medical records will be stored with Human Resources. All medical records will be stored in a locked file during employment then stored for the duration of seven years.

Employee medical records are provided upon request of the employee or to anyone having written consent of the employee within 15 working days. Such requests should be sent to QA.

OSHA Recordkeeping

An exposure incident is evaluated to determine if the case meets OSHA's Recordkeeping Requirements (29 CFR 1904). This determination and the recording activities are done by QA.

OCCUPATIONAL EXPOSURE CLASSIFICATION CATEGORIES

CATEGORY I PROCEDURES

All job-related tasks that involve an inherent potential for mucous membrane or skin contact with blood, body fluids, tissues, or have a potential for spills or splashes. Use of the appropriate personal protective equipment is required for every employee who performs Category I procedures.

Category I procedures include:

- Bladder irrigation
- Cleaning of blood/body fluids spill
- Catheter care
- Catheterization
- ChemStick/AccuCheck (blood sugar testing)
- Collecting blood specimen
- Collecting sputum specimen
- Collecting stool/urine specimen
- Colostomy/ileostomy care (including irrigation)
- Cultures, obtaining
- Diabetic urine testing
- Disposal of contaminated articles (including trash)
- Dressing change, IV
- Dressing changes, wound
- Enema-giving and/or suppository insertion
- Fecal impaction, removal of
- Incontinent care
- IV, administering (including insertion of)
- Laundry/linen, handling of soiled
- NG tube (including insertion, removal, feeding, giving meds via, & dressing change)
- Nasal/oral/tracheal suctioning
- Oral hygiene
- Output, measuring of
- Rectal/oral temperature, measuring of
- Perineal care
- Postmortem care
- Topical medication, application of
- Tracheotomy care
- Vaginal douching
- Cleaning, body fluids spill and/or splash
- Cleaning, toilets (including bedside commodes)
- Cleaning, rooms (including patient rooms)
- Dishes and utensils, handling soiled
- Feeding syringes, handling soiled
- Laundry/linen, handling soiled (including sorting & pre-soaking)

Procedure Precautions/Category I

PROCEDURE	Category	Gloves	Face Mask/ Shield/ Goggles	Gown/ Apron	Potential Contaminate	Duration of Precautions	Staff Member Code*
Cleaning, body fluids spill and/or splash	**I**	**Yes**, utility-type	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F S/C/V M/H
Cleaning, toilets (including bedside commodes)	**I**	**Yes**, utility-type	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F S/C/V M/H
Cleaning, rooms (including patient bathrooms)	**I**	**Yes**, utility-type	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F S/C/V M/H
Dishes & utensils, handling soiled	**I**	**Yes**, utility-type	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F S/C/V M/H
Feeding syringes, handling soiled	**I**	**Yes**, utility-type	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F
Laundry/linen, handling soiled (including sorting & pre-soaking	**I**	**Yes**, utility-type	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F S/C/V M/H

***Staff Member Code**

N = Nursing staff (RN, LPN, HHA, Homemaker)
S = Social work staff
C = Chaplains
B = Bereavement staff
V = Volunteers
P = Physicians
O = Office & clerical staff
M= Maintenance
H = Housekeeping
F = Family members/caregivers/visitors

CATEGORY II

The normal work routine involves no exposure to blood, body fluids, or tissues, but exposure or potential exposure may occur. Employees performing Category II procedures need not wear personal protective equipment, but they should be prepared to utilize it on short notice.

Category II procedures include:

- Bedside/table/over-bed table, cleaning
- Compress, applying (cold / warm)
- Dressing/undressing the patient
- Ear or ear care
- Eye drops/ointments, administration
- Oral medications, administration
- Vital signs, measuring
- Cleaning baseboards, bathrooms, or furniture
- Cleaning laundry equipment
- Cleaning wheelchairs & other medical equipment
- Floor care
- Maintenance procedures
- Washing windows
- Accidents & incidents
- Ace bandage, application and/or removal of
- Back rub
- Bath (including bed bath & skin care)
- Bed-making (occupied)
- Bed-making (unoccupied)
- Bedpan/urinal/bedside commode/kidney basin, patient assistance with (including emptying & cleaning)
- Feeding (including syringe feeding)
- Hair care
- Injections
- Intake, measuring of
- Nebulizer/IPPB treatments
- Nursing/physical assessments
- Nose drops, instillation of
- Oxygen administration of
- Protective devices/restraints (including application & removal of)
- Range of motion
- Shaving
- Transfer of patient, assisting with
- Turning/repositioning patient, assisting with
- Weighing the patient

Procedure Precautions/Category II

PROCEDURE	Category	Gloves	Face Mask/ Shield/ Goggles	Gown/ Apron	Potential Contaminate	Duration of Precautions	Staff Member Code*
Accidents & incidents	**II**	**Yes**	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F S/C/V M/H
Ace bandage, application and/or removal of	**II**	**No**, unless contact with blood/ body fluid likely	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F
Back rub	**II**	**No**, unless contact with blood/ body fluid likely	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F S/C/V
Bath (including bed bath & skin care)	**II**	**Yes**	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F/V
Bed-making (occupied)	**II**	**No**	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F/V
Bed-making (unoccupied)	**II**	**No**	**No**, unless splashing likely	**No**, unless soiling likely	N/A	During procedure	N/F
Bedpan/urinal/bed side commode/kidney basin, patient assistance with (including emptying & cleaning)	**II**	**Yes**	**No**, unless splashing likely	**No**, unless soiling likely	Urine/feces/ vomitus; blood/body fluids	During procedure	N/F S/C/V
Bedside/table/over - bed table, cleaning	**II**	**Yes,** utility-type	**No**	**No**	Blood/body fluids	During procedure	N/F S/C/V M/H
Cleaning baseboards	**II**	**Yes,** utility-type	**No**	**No**	Blood/body fluids	During procedure	N/F S/C/V M/H
Cleaning bathrooms	**II**	**Yes,** utility-type	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F S/C/V M/H

PROCEDURE	Categor y	Gloves	Face Mask/ Shield/ Goggles	Gown/ Apron	Potential Contaminate	Duration of Precaution s	Staff Member Code*
Cleaning furniture	**II**	**Yes,** utility-type	**No**	**No**	Blood/body fluids	During procedure	N/F S/C/V M/H
Cleaning laundry equipment	**II**	**Yes,** utility-type	**No**	**No**	Blood/body fluids	During procedure	N/F S/C/V M/H
Cleaning wheelchairs & other medical equipment	**II**	**Yes,** utility-type	**No**	**No**	Blood/body fluids	During procedure	N/F S/C/V M/H
Compress, applying (cold / warm)	**II**	**No**, unless contact with blood/ body fluid likely	**No**	**No**	Blood/body fluids	During procedure	N/F

PROCEDURE	Category	Gloves	Face Mask/ Shield/ Goggles	Gown/ Apron	Potential Contaminate	Duration of Precautions	Staff Member Code*
Dressing/ undressing the patient	**II**	**No**, unless contact with blood/ body fluid likely	**No**	**No**	Blood/body fluids	During procedure	N/F/V
Ear care	**II**	**No**, unless contact with blood/ body fluid likely	**No**	**No**	Secretions/ blood/ body fluids	During procedure	N/F
Eye care	**II**	**No**, unless contact with blood/ body fluid likely	**No**	**No**	Secretions/ blood/ body fluids	During procedure	N/F
Eye drops/ointments administration	**II**	**Yes**	**No**	**No**	Secretions/ blood/ body fluids	During procedure	N/F
Feeding	**II**	**No**	**No**, unless splashing likely	**No**, unless soiling likely	Saliva/ secretions/ exudate	During procedure	N/F/V

PROCEDURE	Category	Gloves	Face Mask/ Shield/ Goggles	Gown/ Apron	Potential Contaminate	Duration of Precautions	Staff Member Code*
Feeding - by syringe	**II**	**Yes**	**No**	**No**	Secretions, exudates	During procedure	N
Floor care	**II**	**Yes,** utility-type	**No**	**No**	Blood/body fluids	During procedure	N/F
Hair care	**II**	**No**, unless contact with blood/ body fluid likely	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F S/C/V
Injections	**II**	**Yes**	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F
Maintenance Procedures	**II**	**No,** unless contact with biohazard material likely	**No,** unless required for protection from flying debris	**No**	Blood/body fluids	During procedure	N/F S/C/V M/H
Nail care	**II**	**Yes**	**No, unless splashing likely**	**No, unless soiling likely**	Blood/body fluids	During procedure	N/F S/C/V
Nursing/physical assessments	**II**	**No**	**No, unless splashing likely**	**No, unless soiling likely**	Blood/body fluids	During procedure	N/F
Nose drops, installation of	**II**	**Yes**	**No, unless splashing likely**	**No, unless soiling likely**	Nasal secretions	During procedure	N/F
Oral medications, administration	**II**	**No, unless contact with blood/ body fluid likely**	**No**	**No**	Saliva/ secretions/ blood/body fluids	During procedure	N/F
Oxygen, administration of	**II**	**No**	**No, unless splashing likely**	**No, unless soiling likely**	Nasal secretions	During procedure	N/F

PROCEDURE	Category	Gloves	Face Mask/ Shield/ Goggles	Gown/ Apron	Potential Contaminate	Duration of Precautions	Staff Member Code*
Oxygen, administration of	**II**	**No**	**No**, unless splashing likely	**No**, unless soiling likely	Nasal secretions	During procedure	N/F
Range of motion	**II**	**No**, unless contact with blood/ body fluid likely	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F
Respiratory treatments	**II**	**Yes**	**No**, unless splashing likely	**No**, unless soiling likely	Saliva/secretions	During procedure	N/F
Shaving	**II**	**Yes**	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F
Transfer of patient, assisting with	**II**	**No**, unless contact with blood/ body fluid likely	**No**, unless splashing likely	**No**, unless soiling likely	Blood/body fluids	During procedure	N/F/V
Turning/ repositioning patient, assisting with	**II**	**No**	**No, unless splashing likely**	**No, unless soiling likely**	Blood/body fluids	During procedure	N/F/V
Vital signs, measuring	**II**	**No, unless contact with blood/ body fluid likely**	**No**	**No**	Blood/body fluids	During procedure	N/F
Washing windows	**II**	**Yes, utility-type**	**No**	**No**	Blood/body fluids	During procedure	N/F S/C/V M/H
Weighing the patient	**II**	**No, unless contact with blood/ body fluid likely**	**No, unless splashing likely**	**No, unless soiling likely**	Blood/body fluids	During procedure	N/F

***Staff Member Code**
N = Nursing staff (RN, LPN, HHA, Homemaker)
S = Social work staff
C = Chaplains
B = Bereavement staff
V = Volunteers
P = Physicians
M = Maintenance
H = Housekeeping
O = Office & clerical staff
F = Family members/caregivers/visitors

CATEGORY III

Category III procedures – The normal work routine involves no exposure to blood, body fluids, or tissues. Persons who perform these duties are not called to perform or assist in emergency medical care or first aid, or to be potentially exposed in some other way. Activities that involve handling of implements or utensils, use of public or shared bathroom facilities or telephones, and personal contacts such as handshaking are Category III procedures. These procedures do not involve any exposure to blood and body fluids. No protective equipment or precautionary measures are needed.

Category III procedures include:
- Administrative tasks, all departments
- Beverages, serving
- Charting and record-keeping tasks
- Cleaning office areas
- Kitchen, routine cleaning procedure
- Medications delivered orally
- Medications, destroying
- Medication orders
- Storage of medications
- Storing clean equipment

EXPOSURE CONTROL

PROCESS AND FORMS

EXPOSURE EVALUATION AND FOLLOW-UP.

A confidential medical evaluation and follow-up will be conducted by CHC and our prescribed community partners. If the exposure occurs after normal business hours, present to any hospital or urgent care center.

The following exposure protocols will be followed:

- Initiate first aid (clean the wound, flush eyes or other mucous membrane, etc.)
- Notify your supervisor of the incident immediately. Notify QA and HR of the incident as well (next business day, if after hours)
- Follow post Exposure Control Instruction sheets
- Complete incident report and send to QA Coordinator and employee's Supervisor.

Documentation on the exposure incident report will include:

- Route of exposure
- How the exposure occurred.
- Identify source individual
- Any other pertinent information

Medical follow-up may include:

- Source identification if feasible and not prohibited by state or local law:
- Obtain source consent and make arrangements to have the individual tested as soon as possible to determine HIV, HCV, and HBV infectivity.
    - The source patient will be notified of the incident and a consent will be obtained for approval or denial to collect and test the source's blood. If during regular business hours, notify the QA Coordinator to initiate. If during non-business hours, it is the on-call supervisor's responsibility to initiate this process.
    - Notify the South Bend Medical Foundation at (574) 234-4176 to run testing on the patient's specimen. Utilize blood draw order from Medical Director for testing for HIV, HBV, HBC and RPR. Instruct the laboratory that patient can only be identified as Hospice male/female. Instruct laboratory that the Center for Hospice Care is to be billed and the results are to be sent to the CHC Medical Director at 501 Comfort Place, Mishawaka, IN 46545. These results will be made available to the employee by the Medical Director.
- Document that the source individual's test results were conveyed to the employee's health care provider.
- If source is known to be HIV, HCV and/or HBV positive, new testing need not be performed.
- Providing exposed employee with the source individual's test results and information about applicable disclosure laws and regulations concerning the identity and infectious status of the source individual (e.g., laws protecting confidentiality).
- Obtain employee consent, collect exposed employee's blood as soon as feasible after exposure incident, and test blood for HBV, HIV, HCV serological status.
    - If the employee does not give consent for HIV serological testing during collection of blood for baseline testing, preserve the baseline blood sample for at least 90 days; if the exposed employee elects to have the baseline sample tested during this waiting period, perform testing as soon as feasible.
    - CHC will offer repeat HIV testing to exposed employee at 6 weeks, after 12 weeks, and 6 months after exposure.

- Follow-up of the exposed employee will include counseling, medical evaluation of any acute febrile illness that occurs within 12 weeks post-exposure and use of safe and effective post- exposure measures according to recommendations for standard medical practices by QA Coordinator.
- If the employee declines testing, a declination form needs to be completed

ADMINISTRATION OF POST-EXPOSURE EVALUATION AND FOLLOW-UP

QA ensures that health care professional(s) responsible for employee's Hepatitis B vaccination and post-exposure evaluation and follow-up are given a copy of OSHA's bloodborne pathogens standard.

QA helps to ensure that the health care professional evaluating an employee after an exposure incident receives the following:

- a description of the employee's job duties relevant to the exposure incident
- route(s) of exposure
- circumstances of exposure
- if possible, results of the source individual's blood test
- relevant employee medical records, including vaccination status

PROCEDURES FOR EVALUATING THE CIRCUMSTANCES SURROUNDING AN EXPOSURE INCIDENT

QA Coordinator will review the circumstances of all exposure incidents to determine:

- engineering controls in use at the time
- work practices are being followed
- a description of the device being used
- protective equipment or clothing that was used at the time of the exposure incident
- location of the incident
- procedure being performed when the incident occurred
- employee's training and understanding of OSHA's blood borne pathogen standard

If after a thorough review of exposure incidents, it is determined that revisions need to be made, QA will ensure that appropriate changes are made to this Exposure Control Plan.

Center for Hospice Care

EXPOSURE CONTROL LOCATIONS

Call Human Resources first at Extension 8107 or 574-243-3103.

If unavailable, send employee to the following for evaluation during normal business hours:

Mishawaka Staff

Beacon Occupational Health 2301 N. Bendix
Drive, Suite 500 South Bend, IN 46628
Phone 574-647-1675
Fax 574-232-5595

Elkhart Staff

Beacon Occupational Health 22818 Old
US 20
Elkhart, In 46516
Phone 574-389-1231
Fax 574-389-1232

Plymouth Staff

LifePlex Urgent Care
2855 Miller Drive, Suite 119
Plymouth, In 46563
Phone 574-941-1000
Fax 574-941-1075

After hours

Urgent Care Facility (example Med Point) Hospital
Emergency Room

Revised 06/20 HR/Exposure Control Locations

1-800-HOSPICE ♦ cfhcare.org

501 Comfort Place
Mishawaka, IN 46545
(574) 243-3100
Fax: (574) 243-3134

Center for Hospice Care

Employee's Declination of Follow Up to Occupational Exposure

(Occupational Exposure of Bloodborne Pathogens
or Other Potentially Infectious Material)

The undersigned, _____, experienced an occupational exposure in the course of my duties. I acknowledge that I may be examined by a physician and be tested for Hepatitis B virus (HBV), human immunodeficiency virus (HIV), Hepatitis C virus (HBC), and Rapid Plasma Reagin (RPR) at no charge.

The physician, who is authorizing the testing, should be informed of the latest CDC guidelines regarding the testing frequencies which are six weeks, twelve weeks, and six months subsequent to the exposure. A baseline sample may be requested for testing, which will be drawn after the exposure.

The results will be forwarded to the Medical Director in a confidential manner, and will be communicated to the employee.

_____ I do not authorize the examination and testing for the presence of HBV, HIV, HBC, and RPR.

_____
Print Employee's Name

_____ _____
Employee's signature Date

_____ _____
Director of Nursing's signature Date

_____ _____
QA Coordinator's signature Date

Revised 06/20
HR/Employee Declination of Follow Up

1-800-HOSPICE ♦ cfhcare.org
501 Comfort Place
Mishawaka, IN 46545
(574) 243-3100
Fax: (574) 243-3134

Center for Hospice Care

Patient Antibody Testing Consent

Patient:_____

Date of Birth:_____

We are requesting to obtain a blood specimen from you for laboratory analysis because of an occupational exposure to one of our employees. The Occupational Safety and Health Administration requires us to test the specimen for Hepatitis B virus (HBV), human immunodeficiency virus (HIV), and Hepatitis C virus (HBC) to investigate all occupational exposures to bloodborne pathogens and other potentially-infectious materials. Your consent is required to perform this analysis. You will be notified of your results by your personal physician.

_____I do consent to the antibody testing.

_____I do not consent to the antibody testing.

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

_____
Patient's Physician's Printed Name

_____ _____
Director of Nursing Signature Date

_____ _____
QA Coordinator Signature Date

Revised 06/20
HR/Patient Antibody Testing

501 Comfort Place
Mishawaka IN 46545
(574) 243-3100
Fax: (574) 243-3134

Center for Hospice Care

REPORT OF BLOODBORNE PATHOGENS EXPOSURE

Name: _____

Address: _____

_____

Birthdate: _____

Phone: _____

Tetanus: (date) _____

Hep. B Vaccine (date): _____ _____

Date of Incident: _____ Time: _____ AM / PM

Type of Exposure: ____ Needlestick ____Laceration _____Splash _____Other:

To: ____ Intact Skin _____ Non-intact Skin _____Mucous Membrane ____Other:_____

Description of Incident:

_____

_____

_____

PPE in place at time of incident [circle all that apply] (gloves, mask, goggles, gowns): ____Yes ____No

_____Other: _____

Serum drawn on: _____

Notification of expiration of 90 days for storage: _____

Comments:

_____

_____

Revised 06/20
HR/Report of Bloodborne Pathogen Exposure

MANAGEMENT OF BLOODBORNE PATHOGENS

	Initial	6 Weeks	12 Weeks	26 Weeks
HIV				
Antigen Hep B				
Antigen				
Antigen				
Antibody Hep C				
RPR				
HCG (females only)				

SOURCE INFORMATION

Source Name: _____

Source Birth:_____ ID#:_____

Admitting Diagnosis: _____

Additional Diagnosis: _____

Risk Factors: _____

Transfusions:_____ Surgeries:_____

Tests results given to employee by Medical Director.

Employee signature: _____

QA Coordinator signature: _____

Director of Nursing signature: _____

Center for Hospice Care

Evaluation of Employee After Occupational Exposure

Dear Physician:_____

An employee of the Center for Hospice Care experienced an occupational exposure on (date) _____. This employee has presented him/herself for medical evaluation regarding antibody testing for the presence of Hepatitis B Virus (HBV) and human immunodeficiency virus (HIV). CDC guidelines indicate antibody testing for HBV and HIV should be performed at six weeks, 12 weeks, and six months following the date of exposure. A blood sample has been drawn by the _____(medical facility) from the employee after the exposure. The specimen will be tested at your discretion.

The source specimen status is as follows:

_____The source specimen and/or patient specimen can be identified.

_____The source specimen and/or patient specimen cannot be identified.

_____The medical facility can provide the name of the patient's physician to initiate testing authorization, if needed.

The following information has been provided for your information:

1. A copy of 29 CFR 1910.1030, Bloodborne Pathogens (attachment).
2. A copy of the employee's job description.
3. Documentation of the route(s) of exposure and the circumstances under which the exposure occurred on the Incident/Accident Report.
4. Results of the source individual's HIV and HBV testing, if available.
5. All medical records relevant to the appropriate treatment of the employee, as well as vaccination status.

501 Comfort Place
Mishawaka IN 46545
(574) 243-3100
Fax: (574) 243-3134

Occupational Exposure (continued)

A copy of your medical evaluation and a written opinion should be delivered to the employee within 15 working days of the injury.

The following areas should be addressed in your written opinion:

1. If the Hepatitis B Vaccination is indicated.

2. If the employee has received the Hepatitis B Vaccination.

3. Post-exposure evaluation results have been given to the employee.

4. Employee has been told of any medical conditions resulting from the exposure, which may require further evaluation or treatment.

5. All other findings or diagnoses will remain confidential and will not be included in this report.

Your assistance and cooperation is greatly appreciated.

Sincerely,

CHC Representative

Revised 06/20
HR/Eval of Employee After Exposure

Center for Hospice Care
INCIDENT REPORT
SHARPS INJURY
REPORT

Date: _____

Person(s) Involved: _____

_____

Type/Brand of Device involved:

_____

_____

_____

_____

Location of Incident:

_____

_____

Explanation of Occurrence:

_____

_____

_____

_____

_____

_____

_____

_____

Action Taken:

_____

_____

_____

☐ Incident report completed and sent to employee's supervisor.

QA Coordinator signature:_____ Date: _____

Director of Nursing signature: _____ Date:_____

Revised 06/20
HR/Sharps Injury Report

Center for Hospice Care
QI Committee Meeting Minutes
August 25, 2020

Members Present:	Carol Walker, Carolyn Burke, Craig Harrell, Deb Daus, Holly Farmer, Karissa Misner, Larry Rice, Mark Murray, Natalie Barnes, Sue Morgan, Tammy Huyvaert, Becky Kizer
Guests:	Jeannie Geissler, Maryjanet Swain
Absent:	Jennifer Ewing, Kim Geese

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 05/19/20 meeting. The motion was accepted unanimously.	T. Huyvaert motioned C. Harrell seconded
3. HQRP Reporting	• Hospice Conditions of Participation 418.58 address the development, implementation, and maintaining of a quality assessment and performance improvement (QAPI) program. The program includes several quality indicators. In the future we will be reviewing patient rights and administrative services. • Hospice Compare Website – From 2017-2019 we met or exceeded the national scores for timely help, emotional/spiritual support, rating of hospice, and, willing to recommend. There was a small decrease in the timely help score in our latest report. We are using this information to guide our education as an organization. Recently staff was educated on communication, training to care, help for pain and symptoms, and respect. We focused education on these areas at the nursing meetings in June, July, and August. This data is for 2017-2019. It takes about six months after the training for changes to be reflected on the Press Ganey reports. Our help with symptoms score improved in January-February 2020. We can work with our Press Ganey account representative on suggestions on what to change to improve individual scores. • Hospice Item Set – For October 2017-September 2019, our scores exceeded the national average in all areas. Maryjanet S. reviews this data daily and guides the nurses to make sure these areas are assessed at the time of admission.	

Topic	Discussion	Action
4. QAPI Projects	• Pediatric QAPI – This QAPI started in October 2019 and concluded this month. We will continue to monitor the outcomes. Education was completed for all disciplines including the admissions department and patient care coordinators. We don't admit a lot of pediatric patients, but the number has been increasing this year. The majority of the referrals come from Riley. We have created a Pediatric Palliative Care brochure and education materials for staff. Sarah Youngs, Community Relations and Engagement Liaison was added to the pediatric committee. She will be our link to Riley and the Peyton Manning Children's Hospital. We have a dedicated pediatric team that will continue to review pediatric patients and the pediatric program. Thank you to Mark M. for doing the introduction on the training video and for sending a thank you to the members of the pediatric committee. • HeartWize and BreatheEazy – In the second quarter 2020, no HeartWize patients went to the ER or were hospitalized for cardiac-related symptoms. BreatheEazy had one patient go to the ER in April, two in May, and five in June. • Non-Hospitalizations – From January to June 2020, 30 patients went to the ER but were not admitted to the hospital. One-third (10 patients) were for falls, five for bleeding, three for feeding tube replacements or adjustments, four for trouble breathing, three for swelling/redness, and five for Other. • Triage Calls – Since February we have been monitoring the number of incoming calls to triage to see if there are any areas for improvement and the reason for the call. The highest volume days were around the time the pandemic was starting to hit in March. One day in August had 104 incoming calls. For every incoming call there is at least one out going call. These numbers do not include death calls. We pulled out ECFs calls, because they never let us know they are out of a med until they are completely out. Home patients call in because they need a local refill called in to a pharmacy. We educate nurses to not just ask if the patient needs refills, but to actually look at the bottles. Most med refill calls come in on Fridays and Mondays. HAV/SNV are calls asking when the nurse/aide is coming. We investigated these calls and found that staff are making the calls, but either no one answered, forgot we called and then called again in the afternoon asking when the nurse is coming, or the family calls and says "someone called me from this number."	

Topic	Discussion	Action
5. Hospice Quality Indicators	• Inpatient Unit Updates – Education was done with the medical staff in January on IPU documentation, history and physical, progress notes, and the billing component as well. April through June there were 111 IPU patients. Of those 88 were visited by the medical staff and there were 122 medical entries. 23 were not visited. Of those, five were weekend stays and 18 died within one day. Essentially everyone who was supposed to be documented on was. • Extubations – The numbers have increased 33% in 2020 from the prior year. From April to June, eight were done in the IPU and one was a pediatric extubation by Riley in the patient's home. Jeannie G. is tracking that the consents and forms are signed. We don't have set times when extubations are scheduled, we created a policy will allow the nurse practitioners to be trained to do them if they want to be trained. We are in the process of doing that training now. Carol W. said Lou and Mike are making rounds with the intensivists and encouraging them to make to plan to do these earlier in the day rather than the afternoon or evening so the patient can be transitioned earlier to the IPU. Dr. Misner has met with the intensivists to discuss protocols. We are looking at ten hours so we can get those patients into the IPU in the late evening, get the patient settled and the in to visit, and then do the extubation in the morning. This will be a big project and will take a lot of education, so we are looking at 2021 for this. • Live Discharges – The latest data from NHPCO is 2018. At that time, 17% of discharges were live discharges. 83% of all discharges were deaths in 2018, CHC was 88% for January-July 2019 and 88.4% in 2020. Live discharges nationally were 17% in 2018, CHC was 12% in 2019 and 11.6% in 2020. Revocations were 6.6% nationally, CHC 7.5% in 2019 and 6.4% in 2020. Moved out of area was 1.6% nationally, CHC 1.9% in 2019 and 2.3% in 2020. We average 140 discharges a month. We are reviewing revocations specifically by procedure, which aided in the decrease in the number of revocations this year. We paid for two G-tube replacements and a paracentesis. Moved out of service area – We are doing chart reviews to make sure we have the proper documentation. This includes discharges to non-contracted hospitals, usually Goshen Hospital and Franciscan Hospital in Michigan City. 30% of "moved out of service area" actually moved, and 70% went to a hospital where we don't have a contract.	

Topic	Discussion	Action
	• Support Services – All staff are monitoring assessments and doing periodic peer reviews. Chaplains 99% compliance, Social Workers 96% compliance. There were 14 Respite stays and documentation compliance was 100% regarding the availability of respite beds. Bereavement 100% compliance in all areas. • Volunteers – During COVID-19 the CMS requirement for volunteers has been waived. We are tracking tuck-in calls. No calls were made in April and May. We will continue to look at the number of calls and the type of calls that go to triage. Volunteers are asking about supplies and med refills. We are also looking at what the needs are. At the next meeting, we will have a QAPI with volunteers and nurses to look at tuck-in calls on how we can improve the program. • Patient Safety – In the second quarter 2020 we had 138 falls and 59 non-falls. We had two vendor events. In April, the DME vendor damaged the floor of a patient's home during an oxygen delivery and they paid to have the floor repaired. In May, the laboratory disposed of a urine specimen, so it had to be collected again. Customer service with St. Joseph Home Infusion has improved. They have a new director and he reviews any errors immediately and works with Chrissy M. on them. Fall rates – Currently there are no standards for comparison for hospices, so we look at hospital rates. So far, the fall rate in 2020 is lower than 2019. This includes ECFs. Anytime we see more than one fall in an ECF, we make sure we get with the DON to look at it and education takes place. • Raclin House – The Life Safety Code Inspection was done. We had a few areas that needed changed, which we have done, and the plan of correction was approved. Yesterday we had a focused survey by the Indiana Department of Health, and the surveyor found us to be in compliance. We are waiting for the final letter of approval so we can open the facility for patients. The surveyor was very impressed with the facility	
6. Home Health Quality Programs	• Quality Updates and Monitoring – Conditions of Participation 484.65. • Home Health Compare Website – 2019 ADC was 29.8 and YTD 2020 ADC is 40.6, an increase of 36.2%. Due to the increase, we are now eligible to participate in the home health patient surveys through Press Ganey. It uses a Star Ratings of 1 to 5 in areas of process of care and outcome of care. • OASIS assessments are completed at the time of admission, transfer to an inpatient facility, resumption of care from a facility stay, and at discharge. Looking at the	

Topic	Discussion	Action
	discharges for January-July 2020, 39% the patient improved or other, 50% decline in function, 11% died. Most of the patients that declined went into the hospice program. Some staff attended the IAHHC conference in January, and education was done at the February nursing meeting. We know we will not be a five-star home health because patients are not coming to us for rehab. We hope our care will be reflected through the Press Ganey survey to offset the quality Star Ratings. • Patient Safety – For January to June 2020, there were six non-hospitalizations. We are looking at contracted therapy services and quality of outcomes related to that. We have used two contracted vendors—Triune handles LaPorte County and Rochester, and St. Joseph VNA covers the rest of our service area. We are looking at why a referral was initiated. Maryjanet S. drives this program and makes sure we have the right therapy services, signed orders, etc. We are looking at the time of care, communication, and average number of days from referral until services were initiated. Currently the written notes are sent to us and scanned into the computer. This will change with the new EMR. • Adverse Events – We had one in June where the patient went to the hospital due to symptoms and then went to rehab. June had no falls.	
7. ISDH Follow Up	• We continue to monitor these areas from the complaint survey a year ago. Wound documentation 98% compliance in June compared to 68% a year ago. Social Work initial assessment within five days of admission 94% compliance, and respite stays bed availability 100%. Chaplain assessment 99%. IPU medication reconciliation 100% compliance. Separate home health and hospice IDTs 100% compliance. Carolyn B. is doing some performance improvement plans and reminders to social workers and monitors this daily. We have openings for three social workers. Larry R. continue to monitor chaplains. We will review IPU GIP documentation and the patient orientation checklist.	
8. Other Business	• We are inviting QA staff to attend these meetings as education and see the results of their efforts in monitoring these areas.	
Adjournment	• The meeting adjourned at 9:00 a.m.	Next meeting 11/17

Center for Hospice Care
choices to make the most of life

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
President / CEO Report

November 18, 2020

(Report posted to Secure Board Website on November 12, 2020)

This meeting takes place exclusively on Zoom with no in-person option on Wednesday, August 19, 2020. **Zoom call-in and/or computer connect information will be sent in a separate email.** The Hospice Foundation and GPIC Board meetings will follow exclusively via Zoom with the same connection information after a very short break.

CENSUS

Despite the pandemic and the dips from roughly March through June, census has continued to recover nicely. Year-to-date (YTD) referrals are still down 3.7% primarily due to lack of activity in the early pandemic months with many physician and clinic offices closed and nursing homes and assisted living facilities whose censuses were/are down. However, the conversion rate of turning a referral into an admission is 74.35%, the highest in history, and well above the industry standard benchmark of 70% being considered about as good as it can get. Speed to care is also evident as 55% of all admissions are taking place the same or next day YTD compared to 47% at the same time last year.

October 2020	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Patients Served	572	1,839	1,785	3.03%
Original Admissions	146	1,416	1,418	-0.14%
ADC Hospice	386.45	391.89	389.07	0.72%
ADC Home Health	42.10	40.04	29.76	34.53%
ADC CHC Total	428.55	431.92	418.83	3.13%

CHC HOSPICE INPATIENT UNITS

October 2020	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Raclin House Pts Served	37	284	300	-5.33%
RH House ALOS	5.14	4.39	5.10	-13.97%
RH House Occupancy ***	51.08%	54.41%	71.90%	-24.33%
Esther's House Pts Served	34	231	236	-2.12%
EH House ALOS	4.03	5.85	5.24	11.69%
EH House Occupancy	63.13%	63.33%	58.08%	9.04%

*** *Raclin House 1/1-9/14 = 7 beds; 9/15 – 10/31 12 beds*

MONTHLY AVERAGE DAILY CENSUS BY OFFICE AND INPATIENT UNITS

	2020 Jan	**2020** Feb	**2020** Mar	**2020** Apr	**2020** May	**2020** June	**2020** July	**2020** Aug	**2020** Sept	**2020** Oct	***2019*** Nov	***2019*** Dec
S.B.:	220	226	217	221	220	223	224	228	224		230	225
Ply:	70	70	70	73	76	75	76	81	82		65	71
Elk:	120	113	115	114	106	106	107	109	104		107	114
Lap:	14	17	15	16	17	18	19	21	20		13	12
RH:	4	5	5	2	3	4	4	4	4		6	5
EH:	4	5	4	4	2	3	3	3	3		4	4
Total:	431	436	426	431	423	428	433	445	437	429	424	432

Due to going LIVE with a new EMR on 10/1/20, census information by office for October was not available at the time of this writing.

PATIENTS IN FACILITIES

Of the 514 patients served in October 2020, 151 resided in facilities. The average daily census of patients served in nursing homes, assisted living facilities and group homes in October 2020 and YTD thru October 30 was not available at the time of this writing.

FINANCES

Karl Holderman, CFO, reports the year-to-date October 2020 financials will be presented and voted on at the Finance Committee meeting to be held via Zoom on Friday, November 13th and then posted to the secure board website later that morning. For informational purposes, the un-approved September YTD Financials are presented below.

On 9/30/20, at the HF, intermediate investments totaled $4,998,576. Long term investments totaled $23,386,612. The combined total assets of all organizations, including GPIC, on September 30, 2020 totaled $71,567,065 an increase of $7,320,880 from September 2019. Year-to-date investments as of 9/30/20 showed a gain of $1,250,451.

From a year-to-date budget standpoint at 9/30/20, CHC alone was under budget on operating revenue by $541,753, and under budget on operating expenses by $1,100,219.

Year to Date September 2020 Unapproved Financials

September 2020 Year to Date Summary	Center for Hospice Care	Hospice Foundation	GPIC	Combined
CHC Operating Income	17,811,114			**17,811,114**
MADS Revenue	140,328			**140,328**
Development Income		783,576		**783,576**
Partnership Grants			287,105	**287,105**
Investment Income (Net)		1,250,451		**1,250,451**
Interest & Other	46,727	131,090	50,173	**227,990**
Beneficial Interest in Affiliate	(104,954)	(25,336)		
Total Revenue	**17,893,215**	**2,139,781**	**337,278**	**20,500,564**
Total Expenses	**16,748,730**	**2,244,735**	**362,614**	**19,356,079**
Net Gain	**1,144,485**	**(104,954)**	**(25,336)**	**1,144,485**
Net w/o Beneficial Interest	*1,249,439*	*(79,618)*		
Net w/o Investments				***(105,966)***

2021 CHC BUDGET ON THE AGENDA FOR NOVEMBER MEETING

The Finance Committee was expected to review and approve the 2021 CHC Budget at their meeting on November 13th. The 2021 DRAFT budget is included as an attachment to this report. CHC's budget alone is over $27.5 million dollars for next year. To continue business into the new year, it is very important that we have a quorum at our next board meeting. Please plan to attend the board meeting via Zoom on Wednesday, November 18th.

CHC VP/COO UPDATE

Lance Mayberry, CHC VP/COO reports…

I'm happy to have joined the Center for Hospice Care Family and to build upon the excellent service the community and our health partners have grown to trust over the years. Over the next two quarters, I will be focusing on leading the clinical team through this pandemic while continuously moving the organization forward in the following areas:

1. Leveraging our new EMR technology to improve every patient's healthcare journey while enhancing our quality assurance processes.
2. Strengthening our relationship and process with our health care partners.
3. Collaborating and developing recruiting and retention tools.

We have completed the due diligence on selecting an accrediting body for our hospice program and will go through the accrediting process in 2021. We have chosen the Accreditation Commission for Health Care (ACHC), which is a nonprofit accreditation organization that has stood as a symbol of quality and excellence since 1986.

We have partnered with OPTUM to integrate and launch the HospiTrac reporting suite, which identifies opportunities to improve patient care and cost-effectiveness. Layered with robust analytic and dynamic filtering for CHC clinical and administrative managers, the enhanced reporting platform will now enable our team members to access our critical data easily. This new platform will serve as a foundation for innovation.

On an annual basis, our bereavement team supports thousands of families through counseling and education. In addition to the team's daily support of patients, our team provides three distinct CHC community events that the community has come to recognize and appreciate annually. In the spring, we had to cancel our Camp Evergreen, but in September, we were able to host our Camp Evergreen Family Workshop for youths here at the Mishawaka Campus. During the weekend workshop, we had 29 participants consisting of campers, volunteers, and CHC team members. In November, we will be leveraging technology to host our Annual Memorial Service for our patients who have died in the previous 13 months.

CHC DIRECTOR OF NURSING UPDATE

Angie Fox, DON, reports…

During September, the education began for the implementation of MatrixCare the electronic medical record replacing Cerner. On October 1, we went live with MatrixCare. The platform is much easier for the staff to utilize for the documentation of patient care. There continues to be a learning curve on the documentation and available reports. Cerner utilized laptops; MatrixCare utilizes iPads which is easier for taking into the patient's home.

Currently we have 14 RN's with their Certification in Hospice and Palliative Nursing and four Certified Nurses Assistants have their CHPNA. There is a study guide and test which CHC reimburses if they pass and confirms their knowledge base to care for terminally ill patients. They also receive an annual stipend for keeping theses certifications up to date. This certificate is awarded by the Advanced Expert Care by the Hospice & Palliative Nurses Credentialing Center. A requirement for nurses to maintain their certification is to develop and present a lecture. Due to COVID, examinations have not been offered since March 2020, and will start again in October 2020. We presently have two RN's who will take their exam in November.

A program for Certification of Dementia Care took place in September with 25 clinical employees attending. It will be offered in December and January 2021 for all clinical staff. Our goal is to have all clinical staff certified in Dementia Care by 2/2021.

On August 17, the Indiana Department of Health conducted a survey at Raclin House for approval of the building, patient safety, staffing and level of care. There were no deficiencies or recommendations. Raclin House opened and admitted their first patient on Tuesday September 15, 2020. All Clinical Staff received education on the durable medical equipment, safety, and environment prior to opening Raclin House.

On October 20th, a Mock Survey was conducted at Raclin House in preparation of a possible survey soon. Several opportunities for improvement were identified. The areas identified will be corrected with another mock survey scheduled for November 2020.

A Pediatric QAPI (Quality Assessment Performance Improvement) Team has been in place since October 2019. The goal of the Team was to follow the flow of a pediatric patient from the referral until after death. The team has completed the review of processes to improve the continuity of care. There is a designated Pediatric Team for any patient from perinatal until 20 years of age. The first patient under this program was admitted in September and the process will be reviewed at the Pediatric Committee to identify areas of improvement. 2020 has seen more pediatric patients than we have in our history.

HOSPICE FOUNDATION VP / COO UPDATE

Mike Wargo, VP/COO, for our two separate 501(c)3 organization, Hospice Foundation (HF), and Global Partners in Care (GPIC) presents this update for informational purposes to the CHC Board…

Fund Raising Comparative Summary

Through October 2020, the Development Department recorded the following calendar year cash gifts as compared with the same period during the previous four years:

	2016	**2017**	**2018**	**2019**	**2020**
January	65,460.71	46,552.99	37,015.96	62,707.48	79,642.06
February	101,643.17	199,939.17	93,912.90	113,771.80	222,116.20
March	178,212.01	282,326.61	220,485.17	369,862.26	295,882.74
April	341,637.10	431,871.55	310,093.61	565,568.94	414,128.88
May	579,888.08	574,854.27	505,075.65	663,483.70	565,824.55
June	710,175.32	1,066,118.11	633,102.69	850,496.19	608,907.96
July	1,072,579.84	1,277,609.56	767,397.15	918,451.53	676,956.69
August	1,205,050.76	1,346,219.26	868,232.25	1,018,532.22	818,805.78
September	1,297.009.78	1,466,460.27	994,301.35	1,122,498.94	901,877.85
October	1,421,110.26	1,593,668.39	1,074,820.86	1,778,379.29	984,590.41
November	1,494,702.09	2,443,869.12	1,173,928.93	1,841,457.95	
December	2,018,630.54	2,730,551.86	1,635,368.33	2,946,889.74	

Year-to-Date Monthly Revenue
(less major campaigns, bequests, and significant one-time major gifts)

	2016	2017	2018	2019	2020
January	52,156.98	31,552.99	37,015.96	51,082.36	52,550.56
February	36,182.46	35,125.58	56,896.94	45,621.02	140,985.12
March	73,667.84	79,387.44	113,969.42	254,547.16	70,044.19
April	163,425.09	149,569.94	87,978.18	194,857.93	118,092.10
May	93,318.98	142,982.72	182,601.92	97,864.76	149,945.67
June	127,315.24	146,200.17	46,947.92	69,026.39	42,369.40
July	52,394.52	61,505.45	64,243.53	67,591.20	42,034.72
August	97,470.92	63,593.03	61,803.98	54,739.37	40,023.54
September	92,459.02	120,261.01	117,984.73	68,812.68	71,574.73
October	71,323.54	127,208.12	79,852.69	50,019.27	68,718.24
November	66,490.16	75,809.56	94,053.07	57,214.65	
December	138,328.11	286,687.74	191,211.72	225,547.36	
Total	**1,064,532.86**	**1,319,883.75**	**1,134,560.06**	**1,236,924.15**	**796,338.27**

Strategic Planning/Fund Raising Initiatives

Hospice Foundation's planning meetings, coordinated by our fundraising consultant, Dan Reagan, resulted in the creation of previously reported core goals. We are now implementing action plans and specific tasks to achieve the six core goals described below in greater detail.

For reference, the planning process generated the following six core planning goals:

1) Expand unrestricted giving through existing annual giving programs while identifying and evaluating new programs to bolster this area.
2) Endow key mission support programs (Camp Evergreen, After Images, We Honor Veterans, etc.)
3) Establish a process of yearly fundraising priority setting.
4) Determine, and then pursue, a realistic base of support for GPIC.
5) Establish, announce, and immediately begin to promote a planned giving society – name to be determined.
6) Work towards the identification, education, cultivation, and eventual solicitation of the next generation of hospice donors.

We initiated Core Goal 3 – establishing a process of yearly fundraising priority setting –through a meeting on September 17. Tier 1 fundraising priorities identified at that meeting are:

- Milton Adult Day Services (Roseland facility Rehab)
- Annual Giving
- Sister Carmel Helping Hands Fund (charity care)
- GPIC/International
- Honoring Choices Indiana – North Central

We continue to work around COVID-19 related restrictions and have adjusted our targeted donor communication accordingly the use of technology, i.e. Zoom calls, email newsletters and social media. We're evaluating the impact of digital fundraising efforts by utilizing Federated Digital Services (FDS) to target online messaging to donors.

Annual Giving

Response to our 2020 Friends of Hospice appeal through 10/31/20 totals $17,931.65. This appeal is focused on Pet Peace of Mind. Unrestricted annual giving to HF from 1/1/20 through 10/31/20 totals $90,345.02.

Special Events & Projects

Coast to Coast for Hospice in Memory of Tania Coddington Deren raised a total of $25,288.68 of its $25,000 goal. Dale Coddington, a 73-year-old cycling enthusiast, rode his bicycle from the East Coast to the West Coast in memory of his daughter, Tania Coddington Deren. Tania's daughter Abby selected Center for Hospice Care's Life Transition Center as the benefactor of funds generated by Dale's cross-country journey after the center helped her following her mother's death. The ride began on the morning of February 8th with the wheels of Dale's bike touching the Atlantic Ocean at Crescent Beach in St. Augustine, Fla. Dale faced several challenges on his ride, the greatest being the COVID-19 pandemic. Thanks to the nature of Dale's riding route, coupled with the fact that he and his wife were able to social distance in their RV, Dale was able to finish his ride on April 20th as his wheels splashed into the Pacific Ocean at Coronado Beach near San Diego. Every dollar donated to Center for Hospice Care as a result of Dale's coast-to-coast ride is being directed to support our grief counseling programs that serve participants at no charge.

Signature Event Changes due to COVID-19

Based upon guidance from the CDC and Indiana State Department of Health regarding mass gatherings and an assessment on the pandemic's impact on events, we made the decision in mid-July to carry over this year's *Helping Hands Award Dinner* from its previously postponed date of September 30, 2020 to May 5, 2021. HF staff recently consulted with the dinner co-chairs and are moving forward with plans for May 5, 2021. We will continue to monitor and review pandemic restrictions and revisit the viability of the May 5 date in February 2021.

Due to the ongoing COVID-19 gathering restrictions, we conducted this year's *Elkhart Campus Gardens of Remembrance and Renewal Memorial Dedication Ceremony* virtually on Tuesday October 20, 2020 at 6:00 p.m. It can be viewed at https://foundationforhospice.org/gardens/

Our annual *Veterans Tribute Ceremony* took place virtually, debuting on November 11th, Veteran's Day, at 6:45 p.m. Our 2020 featured speaker was Indiana Senator Todd Young. It is available to view at https://foundationforhospice.org/veteran-tribute/

Education and Collaborative Partnerships

The Center for Education & Advance Care Planning (CEACP) continues to be a community hub for end-of-life planning and education. One of the challenges of our work has been tracking and coordinating our outreach with other departments of CHC and our collaborators. We began mapping our organization's community network through Google Maps over the summer and are working out how this prototype can be integrated into the new, separate CRM add-on within MatrixCare called ReferralConnect. Our points of contact are currently separated into organizations, trusted advisors, stakeholders, major donors, and colleges/universities. This will help

us to execute an effective, sustainable outreach program as well as develop priorities for outreach throughout the organization.

Health System/Professional Education Collaborations

As you can imagine, how we collaborate with our community partners in professional education has changed dramatically in the past five months. While our collaborations look different, they continue to be fruitful. Cyndy continues to present virtually and in person with Dr. Bunmi Okanlami, the Endowed Bicentennial Chair of Palliative Care at the Vera Z. Dwyer College of Health Sciences, on palliative care, end-of-life planning/conversations, and hospice care.

Through early November, we have had five family medicine residents from Saint Joseph Hospital rotate through CHC, with another 19 to come. We have had two Health Services Management fellows from Memorial Hospital do rotations here as well. The first, Dr. Kimberly Azleton, completed her rotation in July. Dr. Kate Callaghan just completed her rotation.

We are also working with the IU School of Medicine to offer virtual versions of IU Talk to Memorial and Saint Joseph residency programs. Like the in-person workshops, these versions will offer CMEs for those who attend. If timing permits, we will also offer a virtual workshop for area clinicians.

These rotations and workshops are an opportunity to recruit fellows for the Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine. We received an inquiry during August about the fellowship from a trauma surgeon in Fort Wayne who would like to move into hospice and palliative care.

Cyndy and Elleah Tooker completed a second webinar with Advocacy Links on October 12th. This webinar was a deep-dive into supported decision making, designed to help the organization's case managers better understand how this process can be used to help navigate end-of-life planning with their clients. The webinar was live and received multiple questions ranging from advance care directives to guardianship and power of attorney. CEACP was asked to present two more times in the coming year.

Outreach to Legislators

NHPCO's grassroots campaign, MyHospice, continues to be part of Elleah's responsibilities. Elleah was able to virtually meet with Representative Jackie Walorski and Todd Young's staffer during a 'Virtual Hill Week.' COVID-19 was discussed as well as the Rural Access to Hospice Act and other bills pertaining to education in hospice/palliative care (PCHETA).

Community Education

Like much of the world, our community education initiatives have moved online. We hosted another virtual panel discussion on August 13th which was featured on the Center for Education & Advance Care Planning's Facebook page. Wendell Walsh and Steve Chupp discussed advance care directives as well as what to expect when using an attorney for end-of-life legal documents. On August 20th CEACP held another virtual panel with Ashlie Collier who practices in Elkhart County. We will end the year with an additional three virtual events via Facebook Live.

Social media continues to play an important role as a source of information during the pandemic; we have increased our online messaging to take advantage of this. If you're on Facebook, be sure to visit – and like – our page:
https://www.facebook.com/CenterForEducationAndAdvanceCarePlanning

Honoring Choices Indiana® – North Central

Honoring Choices Indiana – North Central has also moved to promoting advance care planning digitally. We continue to provide updated information on the importance of having advance directives in place during the COVID-19 pandemic on the organization's new website. Steve Chupp, Honoring Choices coordinator, and Dr. Mark Sandock, chair of the organization's advisory board, have given a series of online presentations to extended care facility staff members to explain how advance directives work and promote the use of HCI-NC's certified facilitators to help complete the directives via Zoom or FaceTime. Steve has created some refresher courses for certified facilitators with the assistance of Michael White, a certified "First Steps" instructor who is also a former advisory council member. We will be holding our first virtual certification workshop virtually in December to train the next cohort of facilitators.

Palliative Care Association of Uganda (PCAU)

PCAU's role in creating awareness of and advocating for palliative care continues as Uganda, like other countries around the globe, continues to deal with the COVID-19 pandemic. The organization's leadership role in ensuring those in need still receive palliative care during the lockdown also continues with advocacy work in collaboration with the Ministry of Health and other palliative care stakeholders. When it became apparent the pandemic's impact would be long-standing, PCAU developed an overarching strategy with five focus areas:

- TECHNOLOGY: Supporting continued operations of the PCAU staff working remotely.

- ADVOCACY: PCAU has advocated for integration of palliative care into the national COVID-19 response. This includes participation in the national pandemic committees.

- CONTINUITY OF CARE: Palliative care as an essential health service was not initially recognized. Because of PCAU's advocacy, the President of Uganda issued directives to District Health Officers to support palliative care and ensure hospice and palliative care organizations obtained travel waivers during the lockdown.

- RESOURCE MOBILIZATION: COVID-19 has impacted donor funding for palliative care in Uganda. In addition, the country does not have a budget line item for palliative care. Hospices are in dire need of support. Most have scaled down operations, with some at below 50%. PCAU offered grants to member organizations for PPE, food relief, medicines and communication needs to help ensure minimal disruption in their services. They are also working on collaborative funding appeals to support palliative care services and have appealed to the government to support palliative care services through the National COVID-19 Fund.

- TRAINING: The rapidly evolving COVID-19 situation necessitated an urgent need for continuous clinical education, especially for frontline health workers. With support of a Zoom license provided by Global Partners in Care, PCAU has hosted weekly virtual discussions with the palliative care fraternity to share knowledge and resources. PCAU has also worked with the Ministry of Health (MOH) to develop standard operating procedures for hospices during a pandemic.

As noted earlier in the year, this activity was indefinitely postponed. Likely, there will be no exchange visits until the second half of 2021.

Road to Hope (RTH)

Since schools shut down in March, PCAU has stayed in touch with each child. An estimated 15 million children are currently staying home – including the 56 children on our Road to Hope (RTH) program. This comes with its own risks as children lose focus on school. For vulnerable children there are more serious concerns of domestic violence, sexual abuse, and early pregnancy. Hunger is a major issue. Many of the RTH children come from impoverished households and their biggest struggle during the lockdown is access to food. As is sometimes the case in the US, families rely on children receiving nutritious meals from school. PCAU is helping find ways for them to access at least one meal a day while at home.

PCAU pivoted their focus to supporting the children at home and making sure they continue with their studies. The Ministry of Education and Sports publishes curriculum and lessons in local newspapers and on the radio and TV. PCAU's community of volunteers help deliver learning materials to each child as well as food and basic needs for the RTH families. PCAU is also creating ways to engage the children further with additional books to read and identifying tutors in the communities where the children live.

During the lockdown, most RTH children are helping around the home and garden with chores. Some have also resumed their caregiving roles for sick parents or guardians. PCAU continues to help them balance these activities.

PCAU Interns

While Ainur Kagarmanova, a Master of Science in Global Health student from the University of Notre Dame, has completed her capstone project, she continues work on bringing her work to publication. Her project assessed the status of palliative care in Uganda by analyzing data from the mHealth project along with other national data on morphine and palliative care services.

Notre Dame senior Kat Kostolansky continues to work with us on the Road to Hope program. Kat is working closely with the PCAU team to develop frameworks, documentation and tracking of the children in the program. She has helped structure and organize aspects of the program as well as researching grants to support it.

Advanced Diploma in Palliative Care Nursing (ADPCN)

Because interviews for the next cohort of ADPCN students continues to be on hold, we have worked with PCAU to determine how some of the funding budgeted for this program could be reallocated to support this program. As the overriding objective of the ADPCN program was to provide palliative care support in districts throughout the country, funds have been re-allocated to help reach this goal in other ways. For example, PCAU will be holding sensitization meetings districts throughout the country to increase awareness of the ADPCN program in districts without palliative care services. The funds will also be used to support continuing ADPCN students, recruit new students and hold COVID-19 management training session at five regional private hospices to help facilitate the continuity of palliative care.

mHealth Project

PCAU continues to work with the Ministry of Health (MOH) on the integration of data collection into the national data collection (District Health Information System 2). The new palliative care registers were printed and tested successfully in a select number of districts and facilities. Cynthia Kabagambe, PCAU's ICT and data quality officer, has been traveling throughout the country to provide training. While the pandemic has caused some delays, there has been good progress on better palliative care data collection in Uganda.

Mishawaka Campus

Finishing touches are complete on building lighting as well as landscaping at the Cedar Street main entrance and along the Comfort Place corridor and Maintenance Building.

Roseland Office

Mike has been working closely with Helman Sechrist Architecture, Jones Petrie Rafiniski, DJ Construction, Office Interiors and VISTA AV Integration on design concepts to remodel the Roseland facility. Once completed, the facility will house CHC's Milton Village Adult Day Center as well as Alzheimer's & Dementia Services of Northern Indiana's Caregiver Resource Center and Institute for Excellence in Memory Care.

GLOBAL PARTNERS IN CARE UPDATE

For informational purposes for the CHC board, GPIC presents this update…

GPIC Response to the COVID-19 Pandemic

As of October 11th, we ended the sole redirection of Disaster Response Funds (DRF) funds to COVID-19 response for our partners. Partners can still request COVID-19 response funds, but we also want these funds to be available for other disasters which may occur. In total, GPIC and GPIC partners have sent over $50,000 to partners – including the African Palliative Care Association (APCA) and national associations – in Africa for COVID-19 response efforts. This includes donations we have received and GPIC matching funds. Many of our US partners have been supportive of our COVID-19 response efforts and are becoming more engaged with us. Our

relationships with our international partners have deepened during the pandemic and many of them have expressed their gratitude for our solidarity during this difficult time. They are sharing stories and challenges along with good wishes for our well-being in the US.

We are in discussion with APCA on establishing a COVID-19 response fund, based at APCA, to support resiliency of hospices and national associations and organizations during this pandemic. This could be structured like our joint scholarship fund. Discussions are ongoing.

Current Partnerships

We continue supporting our 37 partnerships. Much of our engagement has centered around COVID-19 and fundraising support. We have been holding group country calls (i.e., Tanzania, Malawi, and South Africa) for US partners to share and brainstorm ideas. Some have found this helpful and continue regular communication. We hope to expand this to each of the countries with multiple partners in 2021 as well as initiate networking for our African partners. This could include unpartnered national associations as well.

Potential Partnerships

We are beginning to explore participation in virtual conferences as an option for outreach to potential partner organizations in the US. We are currently exhibiting at the virtual Midwest Regional Conference on Palliative Care.

We sent outreach mailings to all past GPIC/FHSSA partner organizations and some organizations where the CEO came from a past partner.

International organizations who have applied for partnership are now highlighted on our website in hopes that this may help draw interest of potential partners who visit our website for other reasons. In addition, we will promote this portion of our website via social media and in our e-newsletter.

We have also had one organization, Cornerstone Hospice, contact us about potential partnership in Tanzania which we are currently exploring.

Global Collaboration

The collaborative Palliative Care Leadership Project between Bluegrass Care Navigators in Lexington, KY (BCN), APCA and GPIC, which has been shifted from the research section as it is no longer specifically research focused, has been valuable for all thus far. We are holding monthly meetings to systematically discuss APCA's strategic plan. This involves some structured coaching and support from BCN to help APCA stay on track with their strategic plan goals, identify challenges and strategies to address them, to brainstorm details of activities in the plan and facilitate helpful connections.

We are currently collecting the initial round of feedback from those to whom we gave a one-year membership to the American Academy of Hospice and Palliative Medicine (AAHPM). This includes basic information on how they have used the connections and resources from AAHPM for themselves and their organization. Once we have this feedback, we will work with AAHPM over

the upcoming months to address any issues raised in an effort to make this membership even more valuable for our partners.

Feed the Hungry (https://www.feedthehungry.org/) is located in South Bend. We have had numerous discussions with them in recent years regarding possible areas of collaboration. One of our partners, Umodzi Children's Palliative Care – part of Palliative Care Support Trust (PCST) in Malawi – has a support group for guardians and carers of children with disabilities. One of the biggest challenges faced by members of the group is malnutrition among their children. After several discussions with the different partners, GPIC, FTH and PCST agreed to do a small trial of food support for these families. In August, every member of the group was given a supply of Mana Packs™ from the Malawian team of FTH. We collected feedback from the mothers in the group and will be meeting soon to discuss whether or not to pursue a larger project of nutrition support for our partners.

COMMUNICATIONS, MARKETING, AND ACCESS

Craig Harrell, Director of Marketing and Access, reports on marketing and access activities for August – October 2020…

Referral, Professional, & Community Outreach

Our Professional Community Liaisons continue to contact doctor's offices, clinics, hospitals, group homes and extended care facilities to build relationships and generate referrals. Although the COVID-19 pandemic continues to limit the ability of the liaisons entering many facilities, they continued to reach out via phone and email. Most of the extended care continue to discourage visitors.

We're in the process of converting from our Customer Relations Management software to Referral Connect which is a product of MatrixCare/Brightree. Since it is a product of and by our new EMR vendor we're confident it will integrate better than our previous vendor with whom we had ongoing issues. However, we don't have accurate numbers to report in the interim.

Access

Certainly, the impact of the pandemic has had a tremendous effect on our referrals, and to a lesser extent our admissions. However, during the period of August-October of 2020, the hospital and ECF referrals have steadily increased over the previous three months which occurred at the height of the pandemic. Since the beginning of the year our Admissions Department has been able to increase our conversion rate to an outstanding 74.35%, which has helped to maintain our monthly average daily census (ADC) of 445, 428 and 437 August-October, respectively. On August 25th we set an agency record with a census high 453.

Recently, our biggest challenge has been staffing due to the loss of a few long-term employees. Our HR has been very responsive in finding replacements, but it's going to take some time to complete orientation. We are currently the most adequately staffed in admissions since Craig joined CHC in February of 2017.

The percentage of non-admits due to "Death Before Admission" (DBA) has remained the same as last year.

Website

We continue to fine-tune our new website that was recently launched. We recently converted an existing tab to "The CHC Difference". Some of the topics easily viewed are: Experience, HeartWize, BreatheEazy, and We Honor Veterans. We wanted these differences to be differentiators between CHC and other hospice programs.

Social Media

Center for Hospice Care's social media presence is increasing steadily. We continue to use Facebook to communicate information and events. CHC reached 73,825 people for the period of August-October and had 6,023 reactions, comments, and shares. Our leading post was on August 10th, "Sharing tales of those we've lost is how we keep from really losing them". It reached 4,946 people and generated 1,546 reactions, comments, and shares. The second most viewed posting was on August 3rd: "Your stories-and the memories of you-are what really mean the most to your loved ones". It reached 4,714 people and generated 658 reactions, comments, and shares. CHC currently have 4,604 Facebook followers. CHC continues to have social media presence on Twitter, Instagram, YouTube, and LinkedIn as well.

Digital Overview

The digital campaign focuses on delivering our ad to the proper audience at the proper time. For the months of August - October it generated 56 telephone calls. As competition for digital visibility increases, the cost per click also increases. In 2021 we've allocated additional funds to offset this factor and continue our high online visibility. Google industry benchmarks show an average click-through rate in the Health & Medical field of 3.27 % and we continue to be very high at 9.47%.

POLICIES ON THE AGENDA FOR APPROVAL

There are seven revised and one new clinical policy on the agenda for board approval along with CHC's Exposure Control Plan.

"CADD Pump Procedure" has been revised primarily to insure we have received a pump with the correct settings from the pharmacy.

"Inpatient Unit – Medication Room" has been revised to reflect current practice and security.

"Inpatient Unit – Respite Patient Care" has been revised to put into policy the education staff has recently received.

"Revocation" has been updated to provide further education for staff.

"Interdisciplinary Team" has been revised to reflect an effort to reduce the number of unnecessary interdisciplinary team meetings.

"Temporary Service Agreement" has been revised to reflect enhanced communication between hospice agencies. TSAs are not that common but temporary travel is allowed under Medicare and each program pays whoever the visiting hospice program is from their Medicare Hospice reimbursement.

"Transfer of a Hospice Patient" simply addresses clarity and what to send to the new hospice.

"School of Nursing/Medicine Clinical Experience" is a new policy to reflect that rotating clinical students and their schedules are now being handled by the education department at the Hospice Foundation and our Chief Medical Officer.

The Exposure Control Plan is reviewed annually. It has been revised to reflect current practice, staff changes, and changes of outside agencies we send staff to for potential exposures.

Angie Fox, DON will be available to respond to any questions on anything within this section.

CHC CONTINUES TO RESPOND TO COVID-19

The Administrative Team continues to stay current on issues related to COVID-19 and are proactive in our responses to mandates and information supplied by local and state government. This includes review of policies and procedures, patient staffing, employee safety, supplies, environmental factors, telehealth, admission information, communications, and updates from our contact sources. The most recent CHC and affiliates Back on Track Plan was distributed on 10/29/2020. Staffing has been a challenge during this time. Besides the scheduled retirements, people moving out of the area, going back to school, going into other lines of work, and elsewhere, just from November 1 - 11, we have had 30 staff either test positive or quarantine due to potential exposure. Recruiting clinical care positions had been challenging for most health care organizations and the pandemic has strained limited staff resources nearly everywhere. Some of the measures CHC has implemented include sign-on bonuses for new nurses and aides; re-hire bonuses for (eligible) staff who have left our employ and are willing to return; referral bonuses for existing staff who refer new nurses or aides; enhanced per-visit pay (enhanced COVID specific pay was implemented in March); additional shift pay for IPU staff; across the board wage increases for aides (originally slated for January but implemented now in November); and a new recognition and retention plan which will be announced to staff later this month. In addition, our HR Manager is working her network of contacts, and we are working on enhancing our recruiting presence on social media and will be hitting traditional television media as well with spots of interviews of happy staff who love working at CHC. The B roll for this has already been shot and interviews are taking place soon.

Due to guidance from the St. Joseph County Health Department, Milton Adult Day Services was closed on November 10th due to a positive COVID test result of a client and a staff member. We are slated to re-open November 23rd.

$1.4 MILLION IN HHS STIMULUS FUNDING UPDATE

As you recall from our last meeting, we have engaged The Rybar Group to assist us with the necessary documentation to be able to keep the HHS Stimulus funds of nearly $1.4MM received without asking on April 10, 2020 related to COVID-19 expenses. Rybar is an accounting firm in Michigan that was recommended to us by Kruggel Lawton through their common alliance with BDO. Their practice is ensuring Medicare providers are paid appropriately and stay out of trouble with the False Claims Act, Medicare audit prevention, etc. Karl and I have been meeting with them by phone regularly as we have been collecting expenses and accounting for a variety of COVID-19 expenses and passing them along to Rybar. Currently, the calculation indicates that lost revenues and additional expenses incurred by CHC due to COVID-19 exceed $1.4MM funding received by $276,432. There continues to be speculation by Rybar that there may be a "settle up" in the future for providers whose expenses exceeded their stimulus grants, just as it will be for providers whose stimulus grant was more than their expenses and who will be required to return the funding. We continue to track expenses and expect the overage to grow. On an unfortunate note, HHS finally released their "instructions" on COVID-19 expenses and decided that lost fundraising revenues cannot be counted, meaning our events and the 2020 Helping Hands Dinner will not be able to be included in our calculations.

NEW ELECTRONIC MEDICAL RECORD SOFTWARE WENT "LIVE" ON 10/1

As you may remember, we were informed by Cerner in October 2019 that they would be abandoning their HomeWorks/RoadNotes product on 12/31/20 and no longer providing support. Cerner has been CHC'S EMR since November 2010. We began seeking a new EMR vendor and started scheduling demos a year ago. We looked at four major vendors and each demo lasted about five to six hours, starting with in-person demos in November until the pandemic caused them to move entirely to virtual demos. We followed up with each of them and called back one vendor for another look and then decided. We chose MatixCare (formerly Brightree) as our new EMR vendor. This was also the company that Cerner recommended last year. Earlier this year, MatrixCare's Home Health and Hospice EMR solution earned Best in KLAS honors, receiving a top-ranked score of 87.1 in this year's "Best in KLAS: Software & Services" report. The software offering surpassed the average for home health and hospice EMR vendors by more than 6 points. Best in KLAS winners are determined annually through extensive surveys and interviews with healthcare providers on the efficiency and quality of health IT products. KLAS research methodology rates and ranks vendors according to their ability to meet certain current and future expectations. Training on the new software has continued these past several months and the reviews we are receiving from our clinical and accounting staff is near universally positive. We have had a few glitches and user error problems, but most of the installation seems to be going fairly well. Certainly, much better than 11/10/2009 when we originally went LIVE with Cerner.

VIRTUAL ANNUAL EVENTS

Due to COVID-19, we are had a virtual Annual Report and Volunteer Recognition. Each volunteer received a Panera gift card for lunch on their own at their convenience (since the luncheon could not be held and because Panera is readily available throughout our service area) along with an invitation to watch the recognition at their convenience. A virtual Elkhart Gardens of Renewal and

Remembrance Dedication event to dedicate benches, trees, and bricks, etc., and our annual Veteran's Memorial event to dedicate plaques, bricks, etc. began to be available on the CHC Facebook page on 10/20. A virtual Robert J. Hiler Veteran's Memorial Dedication began to be available on Veteran's Day, Wednesday, November 11th featuring special Marines Veteran, Senator Todd Young.

ELECTION OF NEW BOARD MEMBERS; RECOGNITION OF MEMBERS GOING OFF

We will be electing three new board members. There is a short bio statement on each potential new board members Kevin Murphy, Jeff Bernel, and Brian Huber, MD attached to this report. We will also be thanking Jesse Hsieh, MD, Ann Firth, and Suzie Weirick for their six years of service to the CHC board. Please see the attached "2021 CHC Board of Directors Elections" for additional information.

2020 BOARD OF DIRECTORS SELF-EVALUATION

Every other year, at the last meeting prior to the seating of new officers and board members, we take an opportunity to complete a Board of Directors self-evaluation. At the 11/18/20 board meeting, we will be distributing hard copies of the bi-annual Board of Directors Self Evaluation along with a postage page return envelope. For those participating by Zoom, we will mail the form that day. We ask that you complete the evaluation and return the form by December 31, 2020. Aggregate results will be included in the February 2021 board meeting packet. **Please remember this is a Board Self-Evaluation requesting *your opinion regarding the operations of the Board of Directors itself*. This is not an evaluation of Center for Hospice Care, its programming, or its Administration.**

BOARD COMMITTEE SERVICE OPPORTUNITIES

Committee service by all board members is encouraged by the Executive Committee. A listing of the Committees of the Board and a brief description of each is attached to this report for your review. Also, please note the "Specialty Committees" section which are open to all board members.

BOARD EDUCATION SECTION

Due to this being exclusively a virtual meeting on Zoom with no in-person option and the sheer amount of agenda items, there will be no board education section at the 11/18/20 meeting.

OUT AND ABOUT

I have continued to meet with the National Hospice Executive Roundtable CEOs regarding COVID-19 and other issues in our respective programs, gaining insights and best practices. Our scheduled in-person meeting was rescheduled for Zoom over seven hours on October 5th and 6th.

I participated in the Hospice Action Network Board meeting and the NHPCO combined issues sessions via Zoom on October 12th and 15th.

I attended an Indiana Hospice and Palliative Care Organization (IHPCO) Board Meeting via Zoom on November 6th and did not miss the roundtrip drive to Indianapolis.

ATTACHMENTS TO THIS PRESIDENT'S REPORT IMMEDIATELY FOLLOWING THIS SECTION OF THE .PDF

Becky Kizer's Census Charts

Karl Holderman's Monthly dashboard summaries.

CHC Volunteer Newsletters for September, October, and November.

Board Committee Opportunity Sheet

2021 Board Meeting Dates

NEXT REGULAR BOARD MEETING

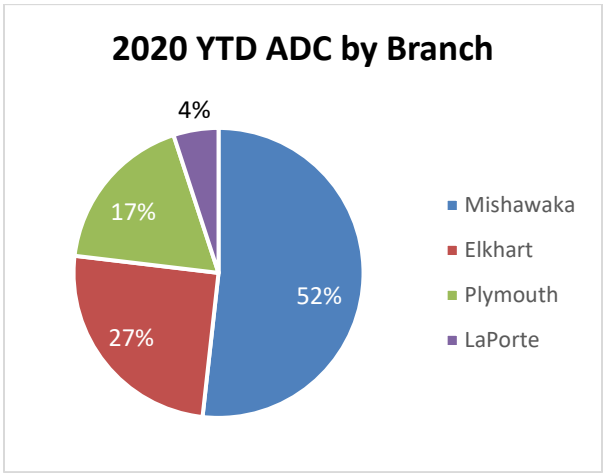
Our next regular Board Meeting will be **Wednesday, February 17, 2021 at 7:15 AM**. We will decide well in advance if it will be Zoom only, an in-person meeting with a Zoom option, or something else. In the meantime, if you have any questions, concerns, suggestions or comments, please contact me directly at 574-243-3117 or email mmurray@cfhcare.org .

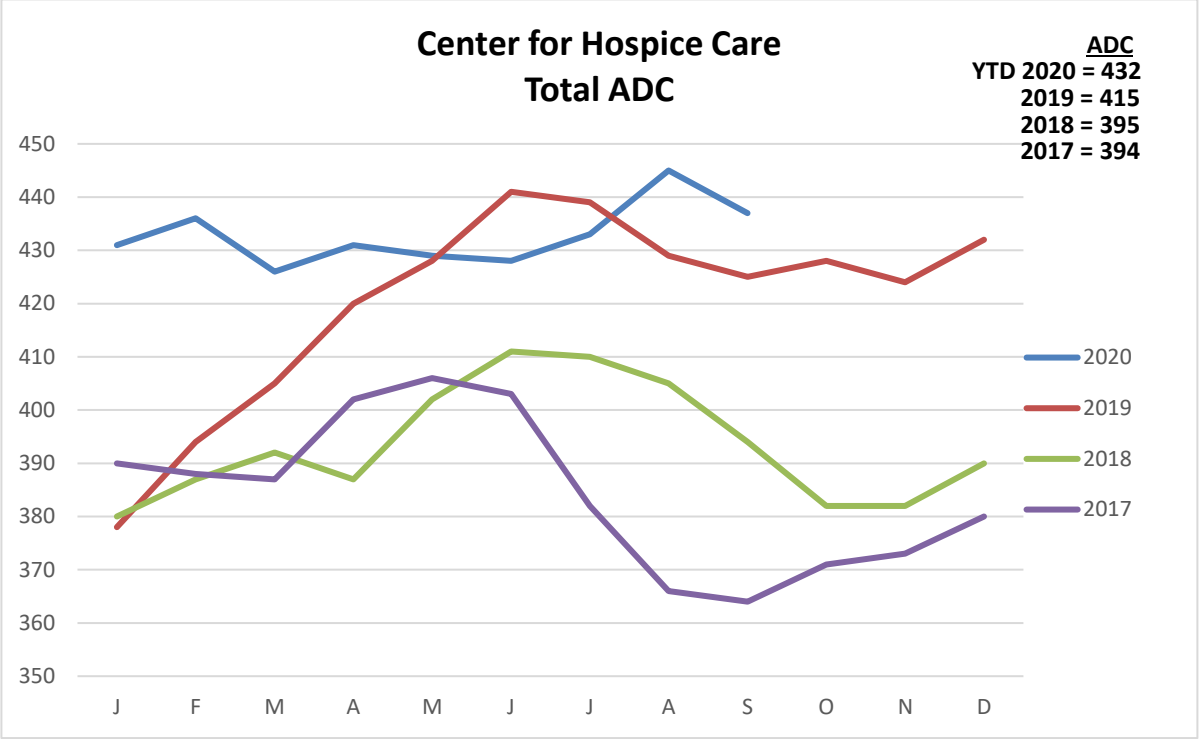
# # #

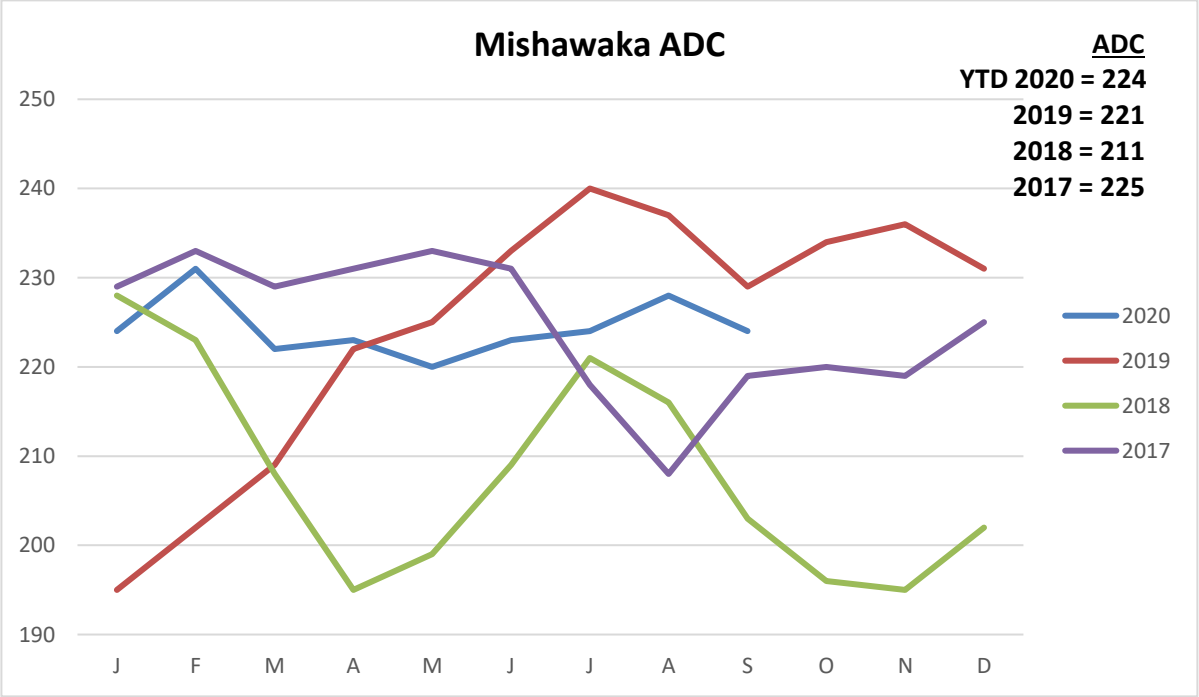
2020 YTD Average Daily Census (ADC)

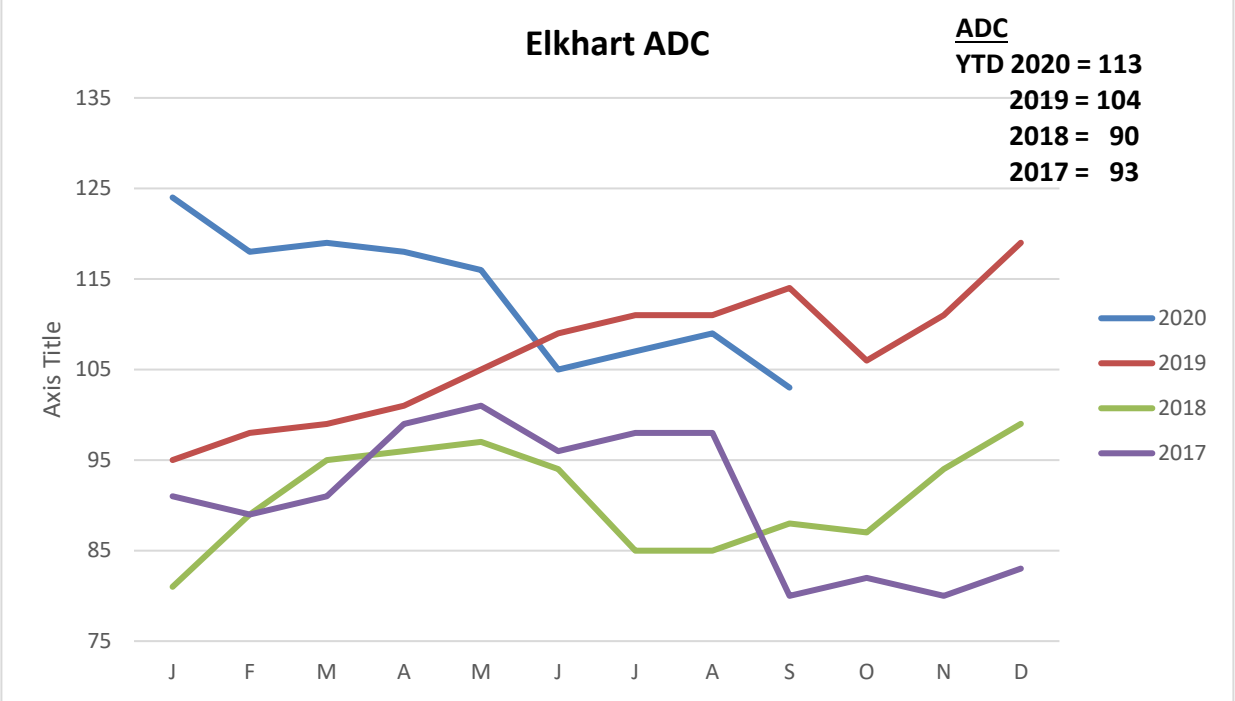
(includes Inpatient Units and Home Health)

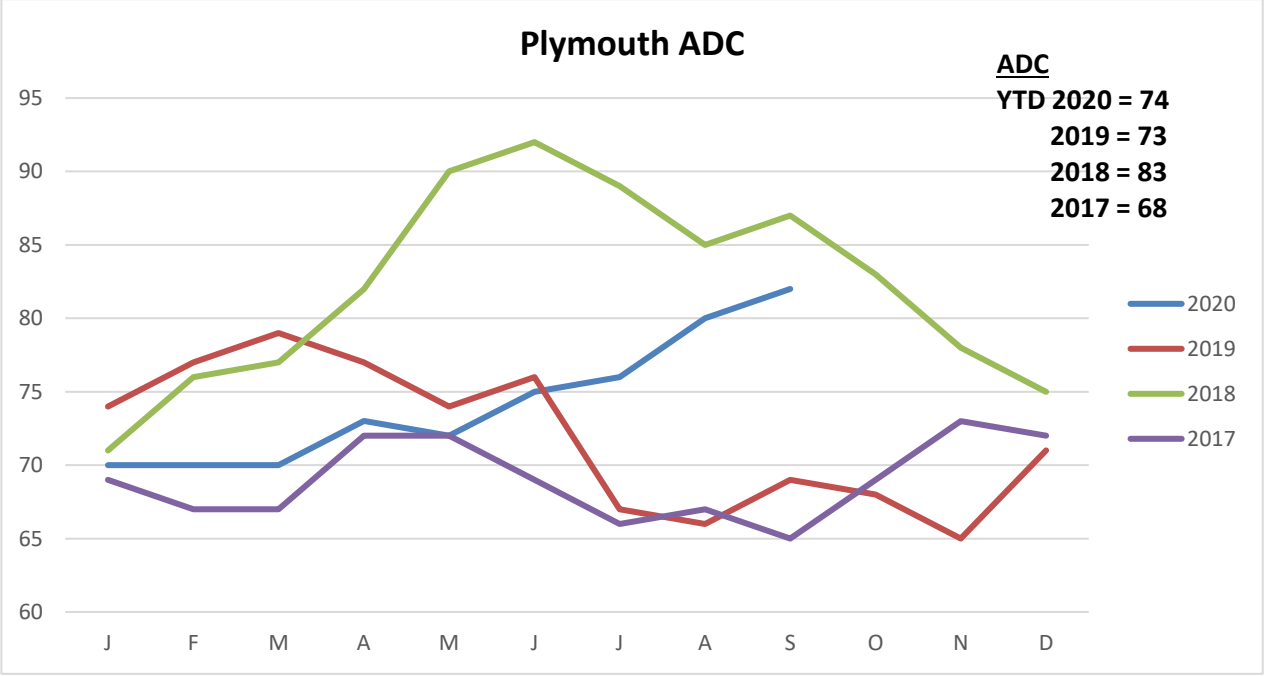
	All	Mishawaka	Elkhart	Plymouth	LaPorte
J	431	224	124	70	14
F	436	231	118	70	17
M	426	222	119	70	15
A	431	223	118	73	16
M	429	220	116	72	15
J	429	221	112	72	16
J	429	221	111	73	16
A	445	228	109	80	20
S	432	222	110	74	17
O					
N					
D					
2020 YTD Totals	3888	2012	1037	654	146
2020 YTD ADC	**432**	**223**	**115**	**72**	**16**
2019 YTD ADC	416	221	104	73	18
YTD Change 2019 to 2020	16	2	11	-1	-2
YTD % Change 2019 to 2020	**3.7%**	**0.8%**	**9.5%**	**-1.3%**	**-12.5%**

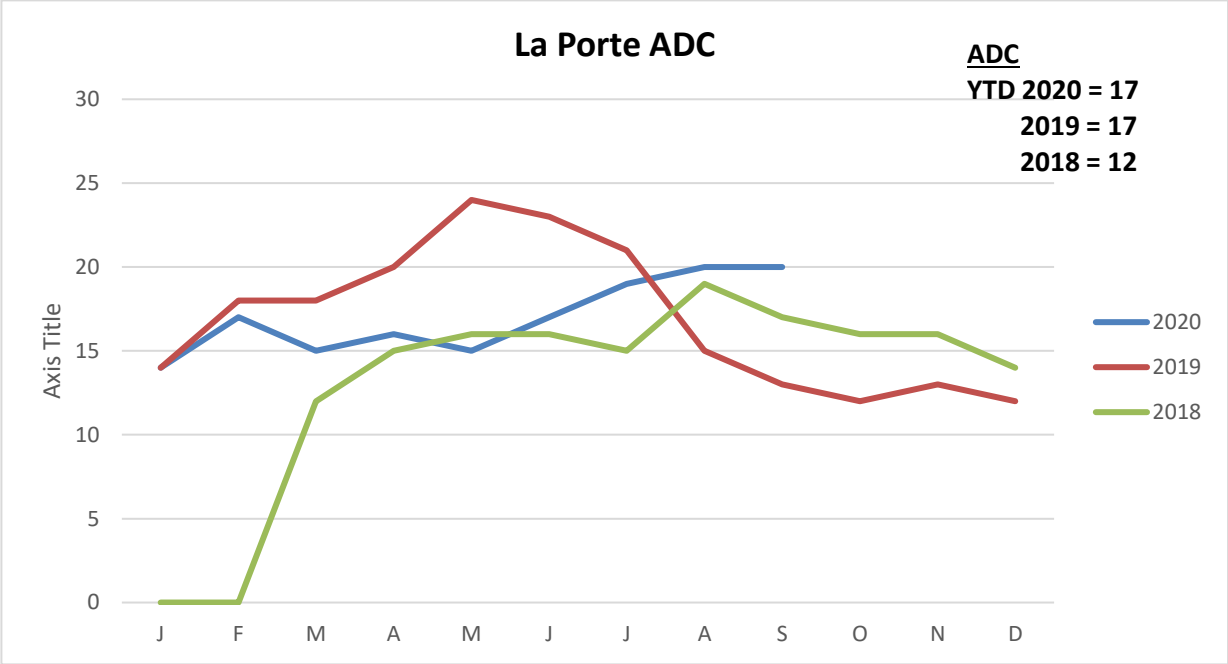



Center for Hospice Care
Total ADC
ADC
YTD 2020 = 432
2019 = 415
2018 = 395
2017 = 394
450
440
430
420
410
400
390
380
370
360
350
J F M A M J J A S O N D
2020
2019
2018
2017


Mishawaka ADC
ADC
YTD 2020 = 224
2019 = 221
2018 = 211
2017 = 225
250
240
230
220
210
200
190
J F M A M J J A S O N D
2020
2019
2018
2017

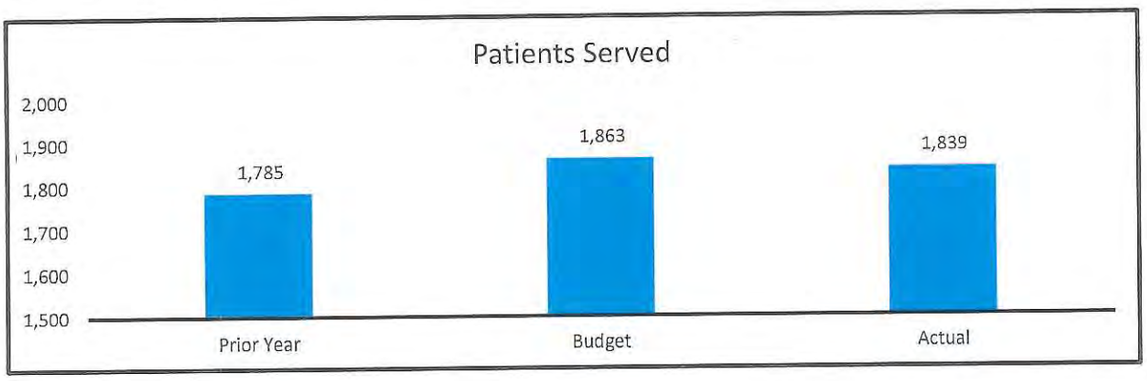

Elkhart ADC
ADC
YTD 2020 = 113
2019 = 104
2018 = 90
2017 = 93
135
125
115
105
95
85
75
Axis Title
J F M A M J J A S O N D
2020
2019
2018
2017


Plymouth ADC
ADC
YTD 2020 = 74
2019 = 73
2018 = 83
2017 = 68
95
90
85
80
75
70
65
60
J F M A M J J A S O N D
2020
2019
2018
2017

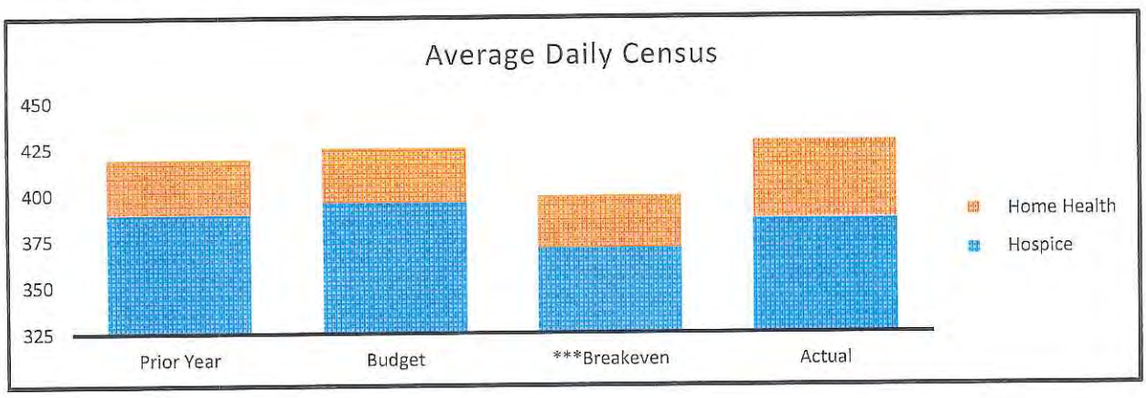

La Porte ADC
ADC
YTD 2020 = 17
2019 = 17
2018 = 12
Axis Title
30
25
20
15
10
5
0
J
F
M
A
M
J
J
A
S
O
N
D
2020
2019
2018

Center for Hospice Care
October 31, 2020

	Prior Year	Budget	Actual
Patients Served	**1,785**	**1,863**	**1,839**

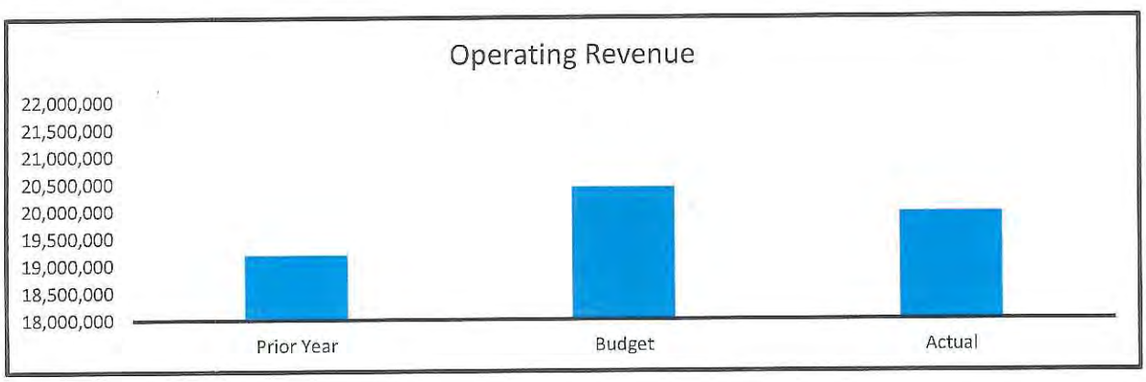


Average Daily Census	**Prior Year**	**Budget**	*****Breakeven**	**Actual**
Hospice	389.07	395.42	370.80	386.45
Home Health	29.76	29.49	27.66	42.10
Total Average Daily Census	**418.83**	**424.91**	**398.46**	**428.55**

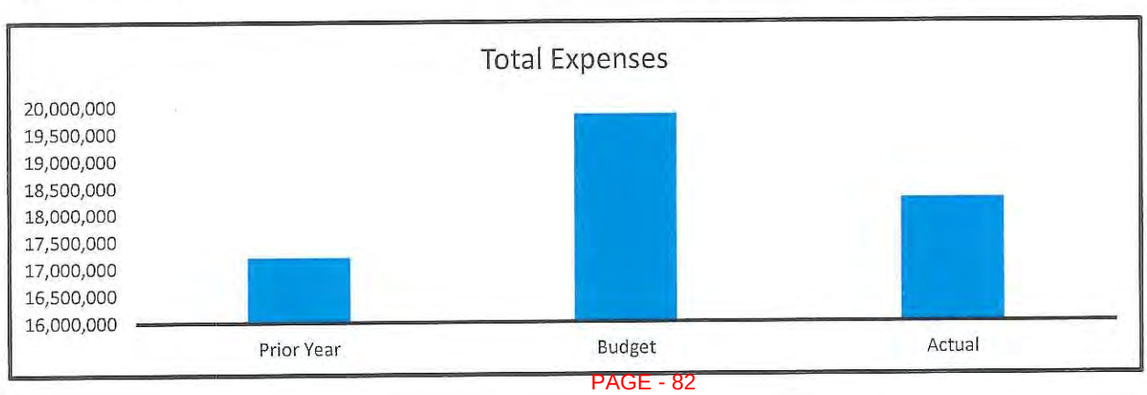


**** Budgeted Breakeven*

	Prior Year	Budget	Actual
Operating Revenue	**19,188,147**	**20,425,258**	**19,971,891**



	Prior Year	Budget	Actual
Total Expenses	**17,205,441**	**19,857,062**	**18,307,054**



September 2020
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

The Hardest Lesson: Nolan's Precious Journey

By Kristiana Donahue

Parenthood is one of the most complex mysteries of humanity. It can bring so much joy and satisfaction, but also frustration and grief. Parents love deeply and sacrificially. When a child is diagnosed with a critical medical condition, this love is tossed into an emotional blender with fear, insecurities, isolation and pure exhaustion. Simply going to the park, sledding in the backyard, or just getting together with friends becomes nearly impossible as a result of the difficulties caring for a child who needs so much day-to-day care. Sheena Zent, a parent of one of Center for Hospice Care's pediatric patients, shared her family's story of their journey with their precious son, Nolan.

Sheena and her husband, Stephen, are both dentists and work together in their busy practice. Like many of us, they wanted to grow their family. About four years ago they welcomed their daughter, Naya, and then two years later Nolan was born. After a brief stay in the neonatal intensive care unit, everything seemed to be great with him. However, after a few months they noticed that Nolan wasn't meeting age-appropriate milestones. When they brought these concerns up with their physicians, they reassured them that each child progresses at his or her own pace. But Sheena felt that something "just wasn't right."

Nolan lost all of his black hair, which can be common in early infancy, but the new growth came in white. "No child of mine is going to have blond or white hair," Sheena said. "I'm Indian and my husband has really dark hair too. We knew something wasn't right." At five months old, Nolan still wasn't holding his head up. They had started First Steps, an Indiana early intervention program, but they continued to dig for answers, a

Continued on page 4

Inside this issue:

Welcome to the Team

Michael DeArmond
Raclin House Maintenance Assistant

Melanie Grimble
Elkhart IPU PRN RN

Renee Kanagy
Elkhart Chaplain

Cari Medford
South Bend IPU RN

Zachary Pryor
Mishawaka RN Case Manager

Michelle Smith
Referral Specialist

In Loving Memory

Our condolences and heartfelt sympathies go out to the following CHC volunteers who lost a loved one recently.

Kathy Fuchs, Mishawaka
Mother, Catherine Ocskasy
Sunday, May 17, 2020

Birthdays

9/7	9/12	9/21
Mary Perron	Nancy Whipple	Judith Atkinson
9/8	9/14	9/22
Mary Adams	Cheryl Barker	Jim Rahilly
9/8	9/16	9/23
Barbara Adcock	Sharon Leamon	Lino Rodriguez
9/11	9/16	9/24
Kathleen Hojnacki	Max Rarick	Sylvia Ford
9/12	9/17	
Becky Donahue	Matthew Huyvaert	

Resuming Volunteer Services

We have resumed volunteer services in the home! As we continue to move along with this plan, it is subject to change, given any updates regarding COVID-19.

We also understand that while some volunteers are able to return to active volunteering with CHC, some may not be able to. Please know that we encourage everyone to make decisions that are in the best interest of their own health. We want to keep everyone healthy and safe.

New protocol for home visits:

- Each request for volunteer home visits must be approved on a case by case basis at an IDT meeting. Once a volunteer is contacted by the volunteer coordinator, this process will have already been completed.
- Prior to the volunteer making the patient home visit, they must complete a short education course regarding competency on personal protective equipment (including a CHC-issued N-95 mask), hand washing and social distancing.
- Volunteers will need to social distance during visits. This will mean that hand holding, personal care, feeding or any other close contact activity will not be allowed at this time. Social distancing of at least 6 feet apart must be practiced during patient visits.
- Volunteers must wear CHC-issued N-95 masks during visits. These masks may be reused at visits. No sharing of masks is allowed.

Please feel free to reach out to your volunteer coordinator if you have additional questions. Please let them know if you plan on resuming your volunteer services at this time.

Volunteer Spotlight
Hugh O'Donnell, Mishawaka

What volunteer work do you do with CHC? How long have you been a volunteer with CHC?
I am a patient home visit volunteer. At my last assignment, I would go to the patient's home and stay with him so the caregiver could take a break for a few hours. This was the most rewarding experience of the last year for me. I gained so much more than I gave.

I am also a veteran volunteer. I perform veteran pinning ceremonies for our patients who have been in the military. I present them with a certificate and a pin and thank them for their service to our country. I have been a CHC volunteer for 1 ½ years.

Why do you volunteer with CHC?
I retired from being a high school chemistry teacher and I was bored. I listened to the book *Living in a Mindful Universe* by Eben Alexander and the book said hospice work is most rewarding. Some of the most remarkable stories come from people in hospice care. They are the closest to God in their near-death spiritual experiences.

What is your favorite food and why?
I'm on a low carb diet for health reasons. I love fruit sprinkled with Splenda, particularly fresh cut strawberries.

What is your favorite quote?
Do unto others as you would have others do unto you.

Favorite movie and why?
Field of Dreams, I love baseball.

Favorite books?
Dying to be Me by Anita Moorjani and *The Universal Christ* by Father Richard Rohr.

Tell us a bit about your family.
I raised 5 children in Pittsburgh. All 5 said they would not attend college in Pittsburgh. All 5 graduated from Notre Dame. I also graduated from Notre Dame with a MA in Theology in 2009 after getting an MS in Chemical Engineering in 1968.

Where are you from originally?
Pittsburgh. I retired here as my children prefer this area to Pittsburgh. I now love Notre Dame and the Notre Dame community.

What talents/hobbies do you enjoy?
I love aviation. While in the Air Force I logged 3500 hours in a AF C-130 cargo plane. I am also a medic at Notre Dame games/events.

Favorite music/band?
Tom Petty, Merle Haggard, I love country music.

What do you like to do in your spare time?
Play golf at Burke Notre Dame course.

"Hugh loves people and has a special place in his heart for veterans. He is a vital part of our We Honor Veterans Program and brings a special joy to the veterans he meets through this work."

Debra Mayfield, Mishawaka Volunteer Coordinator

Continued from page 1

Sweet Nolan passed away in our (his parents) arms and surrounded by close family and his nanny on February 6, 2020 after a courageous battle with Menkes Disease. We miss him every minute of every day, but we take comfort in knowing that he changed our lives and touched so many others. Steve and I decided shortly after Nolan's diagnosis, that no matter what, we would have no regrets. We would do our best to take care of him and love him and be comfortable with that. With the help of our support system, doctors, nanny, nurses, and the Center for Hospice Care, we were able to stand by our goal of having no regrets to this day. As a family, we reminisce about Nolan through stories, pictures, and videos daily, and say a prayer for him every night led by his big sister. He may be gone, but his memory will live on forever.

task that can prove very difficult. They finally went to the Chicago Children's Hospital to begin genetics testing. Through interactions, discussions and clinical testing with specialists, they determined that Nolan had Menkes disease. The genetic testing would help them determine which mutation and whether it was severe or mild. "We were hoping to get a lot of information, such as which doctors or specialists we would need to see," Sheena explained. "We got no information, so it was very discouraging. We were told that we were going to have to be the experts at this. We've never even heard of this. How could we be the experts? It was so overwhelming just digesting the information and feeling very lonely, with no direction. How do we help ourselves and how do we help him? It was a rough year figuring it out."

Having a child with a rare medical condition often means that parents become the experts, which is an intimidating position for parents who find themselves suddenly thrust into the medical world. The Zents were thrown into the role of advocacy and research. "I became committed to setting aside time to look up as much as I could, and ask questions," Sheena shared. "You learn to become an advocate. I've become a stronger person in general because of Nolan, and I've learned so much. We have to be the voice for him."

According to Wikipedia, "Menkes disease (MNK), also known as Menkes syndrome, is an X-linked recessive disorder caused by mutations in genes coding for the copper-transport protein ATP7A, leading to copper deficiency. Characteristic findings include kinky hair, growth failure, and nervous system deterioration. Like all X-linked recessive conditions, Menkes disease is more common in males than in females. The disorder was first described by John Hans Menkes in 1962. Onset occurs during infancy, with incidence of about 1 in 100,000 to 250,000 newborns; affected infants often do not live past the age of three years, though there are rare cases in which less severe symptoms emerge later in childhood."

In Sheena's words, "Copper is responsible for everything. Your connective tissues, your muscles, veins, the makeup of your whole body and regular development. With Menkes, the copper transporter is defective." Nolan's mutation is severe and therefore nothing is getting to his brain. Even if he was injected with copper, it wouldn't cross the blood brain barrier, therefore it wouldn't be effective. "He is basically forever like a three-month-old cognitively," Sheena explained. "He can't hold his head up; he won't walk or talk. It affects his eating, so he was aspirating everything. We had to get a G-tube in his belly, and he can only get fed through his stomach, nothing by mouth. He has issues with the tissue in his bladder, so he cannot urinate and was having UTIs, so we have a little catheter. It affects everything." The typical life span is around three years; however, they have been seeing a lot of kids live a lot longer. A lot of that may be due in part to moms/parents talking and sharing information and seeking out doctors and having that support. Online forums have been a vital lifeline for Sheena and Stephen. Through the experiences of other families of children with Menkes, they've been able to learn from each other, better advocate for their children and realize they are far from alone on this journey. Because of these online groups, even doctors know more of what to expect. "I can see what the other children are having problems with at ages five or six and anticipate these issues. Then I bring it up with the doctors," Sheena said. "Even the doctors in Chicago ask, 'What did your mom's group say?'"

In February of 2019, little Nolan was having a rough time breathing and vomiting sporadically for six weeks. They were trying different medications, but to no avail. They needed to go to Chicago. One of the doctors mentioned Center for Hospice Care (CHC) and the day before he was transported to Chicago, Sheena and Stephen met with Kathy Eash, Nurse Practitioner at CHC. "We were initially closed off," Sheena said. "You think of hospice, you think of end of life. We felt if we chose hospice, we're giving up on him." The Zents learned they had misconceptions about hospice services and they learned that starting care with CHC was far from giving up on their beautiful son.

For many pediatric patients, families may be able to pursue any treatments for their child while receiving hospice and palliative care services. It's called concurrent care. When families learn that they don't have to stop pursuing

Continued on page 6

Pediatric Hospice & Pediatric Palliative Care

Pediatric Palliative Care

Palliative care is available for a child 20 years old or younger with a serious illness requiring skilled nursing care.

Skilled nursing care in the home includes:

Management of symptoms

Drains or feeding tubes

Lab draws, if needed

Management of port or PICC lines

Trach care

Education

Medication management

Pediatric Hospice Care

To qualify for pediatric hospice care, a patient must have an expected life span of six months or less. The goal of hospice care is to improve the quality of the child's life. Studies have shown that having hospice care prolongs life expectancy as symptoms are better managed.

CHC is one of the only hospices in Northwest Indiana that accepts pediatric patients.

Management of care will be provided by hospice while actively coordinating a plan with the child's care providers. Skilled nursing is available under hospice care.

Depending on the health care plan, a child may be eligible for concurrent care, which allows a child 20 years of age or younger to have hospice and curative treatment.

Where is care provided?

Homes

Hospitals

Extended care facilities

Our inpatient units

What payment options are accepted?

Commercial insurance

Medicaid

Self payment

Members of the team will depend on the program and can include:

Nurses

Social Workers

Chaplains

Nurse Practitioners

Volunteers

Home Health Aides

Physicians

Counselors

Why is it needed?

With our support, families can process each moment with compassionate professionals equipped to help them.

Because families are in the midst of grief, it can be difficult for them to focus on their own needs. They may need others to advocate for them and suggest things that they may never have thought of, for example, photography sessions.

Our goal is to give the child the best quality of life we possibly can, all while walking alongside the family for whatever needs they have as well.

If you know of a family who could benefit from our services, please have them call our admissions department at (574) 243-3100.

Comments from our Families

- My experience with hospice care at home was wonderful. The nurse and aide were more than wonderful and helpful.

- I didn't know much about hospice care until the doctor told us he wanted my husband to have hospice. It was such an experience I'll never forget. The best care you will never forget. Everyone worked so well with each other.

- The CHC team was a huge help in caring for my mother-in-law. I only wish we would have had them sooner. We had several family members who disagreed on our plan for her, and it was such a blessing to have the CHC team by my side in the challenge. In the end, the entire family agreed that it was the best decision, and were appreciative of their help. Thank you so much for helping me make her last month comfortable and painless.

Continued from page 4

the treatments that they desire, they start to listen to what hospice care can provide. "There was a mom out of state who mentioned that a nurse comes to her house a couple times a week from hospice to take her son's vitals," Sheena continued. "She still goes to doctors' appointments. It doesn't stop her. It's not one or the other. It's a nice mesh of both worlds. We knew we wanted to get involved 100%. When we were transported to Chicago, we met with their palliative care team and they communicated with CHC. Everything was just easy. We learned about all the options and support that would make our life so much easier. This was a no brainer."

Even within the first few days of starting to work with CHC, Sheena and Stephen felt the additional support. They added more advocates to their support network. "It has been such a stress relief for me and my husband and our nanny too," Sheena shared. Calling doctor's offices and pharmacies had easily eaten up a good chunk of their day. Balancing regular schedules at work and the needs of their daughter in addition to Nolan's medical needs, was increasing their stress and affecting their quality of life. She and her husband were stopping by the pharmacy every two days because of different medication due dates. "Now, if we're low on a medication, we just write it down on a sheet. On Tuesdays our nanny will talk with the CHC nurse and we'll get it the next day." With his frequent UTIs, the Zents would have to take him out of the house to get his urine samples tested. Now, with CHC, the nurse can bring those sample cups and then drop them off at the lab. "It cuts down on time and cost," Sheena continued. "Even things like a hospital bed. That was an amazing thing. We were talking about this bed that circulates air, since he can't move. I called our nurse in the morning and asked her more about it. By 8:00pm that same day it was delivered. It would have taken months if we tried to go through our doctors and insurance. We were so excited. It's been great." It isn't uncommon for CHC staff to hear that older patients wish they started care with us earlier. The same is true for pediatric patients. "It was nice to get another set of healthcare eyes on him. Now we have another person in the field that can help us advocate for him. That alone is a big deal. My husband and I realized, 'We should have done this earlier.'"

Making the decision to start with CHC seems so easy after the fact. However, the process of making the choice takes quite a bit of work. The reality is there are many other people that need to hear the message and knowing the story of someone who's been there can assist that person or family to move forward. "Even though it is very isolating, there are so many people going through similar things. It's just a matter of being mentally ready to seek it out," Sheena shared. "You should reach out and have other people to talk to, whether that is a therapist, a friend or even a stranger."

The conversations can get uncomfortable, and at times, even raw. To break down the walls of our society - where we put perfect pictures on social media - will require all of us to open up. Families walking a difficult journey need to find people who can sit with them and let them expose their vulnerabilities. "You really can't say some of the things that are real and raw or may be hard to hear. Many people can't fathom living with a child you know is going to die," Sheena said. "That is just my every minute of every day." While not every moment is fraught with tears and pain, having a place to unload those emotions when needed, helps families in these situations process better.

Families also have to process heavy realities while somehow maintaining routine and normal activities of their lives. It's such a confusing balance. "I just see so many parents that don't take care of themselves," she continued. "You have to set time aside and do something that makes you happy, because then you are energized, in a good mood and are able to be a good role model." Many parents simply find it hard to set aside space for themselves. The children will benefit when the parents take time out for self-care. Young siblings, like Naya, may not comprehend the gravity of their sibling's prognosis. Sheena was given a beautiful book, *The Story of the Ladybug,* by a woman whose son died from a rare disease. The book tells the story of a horse family which somehow had a ladybug for a baby. They loved the baby so much. But they soon realized she was different. They took her to the doctor and found out that while they were built to have long, hard-working lives, their little ladybug baby was born to have a sweet short life. After the ladybug dies, the mom and dad talk about their memories and what they learned. Naya loves this book. While she continues to color pictures, play with friends and live out a normal, young girl's life, her parents hold onto that with one hand and in the other they love her "ladybug" brother, Nolan. "It's like I'm living two different lives," she said. "I put her to bed and I'm really happy and reading her stories and doing the normal things, and then I put him to bed and I'm just bawling."

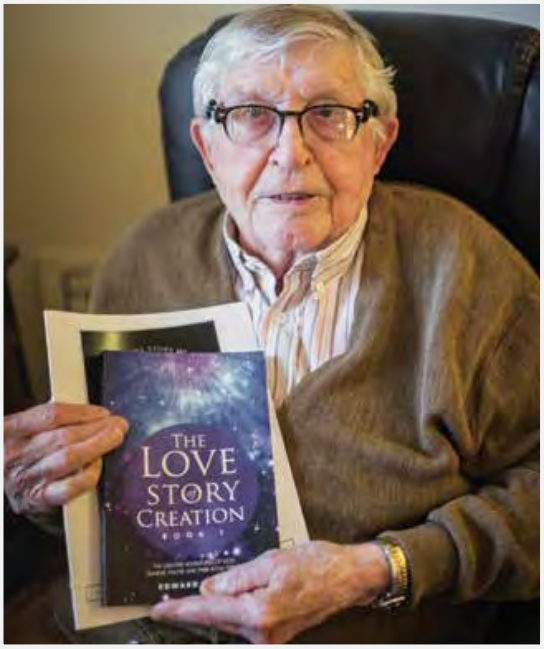
The great thing about the story of the ladybug, is that at the end of the book, the family not only remembers, but talks about what they learned. Sheena and Stephen have already learned so much. "The little stressors that I used to think were really stressful, are nothing anymore. It's not what matters in life. I'm really grateful. It's eye opening. It took this to learn that." Nolan's smile is absolutely contagious. It isn't hard at all to see what truly matters when you look into his little face. Supporting him and his family is the sincere privilege of CHC, and all the other loved ones on this journey with them. "He is very precious and happy," Sheena smiled. "And that is our number one goal."

October 2020
Volunteer Newsletter

Center for Hospice Care
choices to make the most of life™

The Grandest Love Story:

Father Ruetz's Legacy



"Surprise! I am still living! On January 10, 2019 Dr. Strzelecki, after a CT scan told me I had prostate bone cancer. I figured I would be dead in a few months. Four months later I wrote the enclosed letter dated, "Close to my death." When I visited my doctor four months later, I told him I thought I would be dead by now. At the end of our visit, he looked at me with a smile on his face and said, 'I will see you in four months!'"

– Christmas Letter written by Father Ed Ruetz on December 12, 2019

By: Kristiana Donahue

Father Ed is passionate about telling a story, *The Love Story of Creation*. His lifetime of discovery and curiosity birthed these published books (Book I and II) that creatively share his views of God, creation and love. When he was a kid and he prayed, he said that God was about 12-13 miles up in the sky. "It started with love. It's God's divine love that started it. The God that I thought was 12 miles up in the sky, has followed this long journey and is very intimate to it."

Father Ed designed this book to be an encouragement to others, especially those who have wrestled with the ideas of creation and evolution. "It is written especially for young people to help them understand that they can accept both belief in God and the 15 billion years of the scientific story of evolution," he shared in an introduction of Book II.

In 1988 he was one of seven founding members of an ecological community, EARTHWORKS INC., Donaldson, IN. He served nine years on its board and as head of the education committee which presented ecological programs for children and adults. That paved the path for his deep investigation of creation and evolution's relationship.

Early in his priesthood, Father Ed spent about eight years at Saint Mary's church, which was adjacent to the black community. "We were involved in the Civil Rights Movement," Father Ed shared. "We had the leading feminist in Fort Wayne. We were really helping in the neighborhood. We had a clinic for people that needed hospital care. We

Continued on page 6

Inside this issue:

Welcome to the Team

Kelli Breden
Elkhart RN

Angie Fox
Director of Nursing

Camille Kocsis
Professional Relations Liaison

Jan LaVine
Raclin House RN

Jill Lehman
Raclin House RN

Lance Mayberry
VP/COO

Lily Shroyer
Mishawaka Social Worker

Birthdays

10/1	10/14	10/25
Ann Baucus	Steven Madar	Janice Berger
10/2	10/15	10/26
Noreen Buczek	Cathy Schiff	Heidi Payton
10/2	10/15	10/27
Sue Ermeti	Carolyn Tihen	Cindy Ward
10/6	10/18	10/30
Martha Skrzeszewski	Hugh O'Donnell	Sharon Marshall
10/11	10/21	10/30
Don Zimlich	Peggy Cunningham	Kay Swett
10/13	10/21	10/31
Joan Hunt	Ted Stanley	Bob Putnam

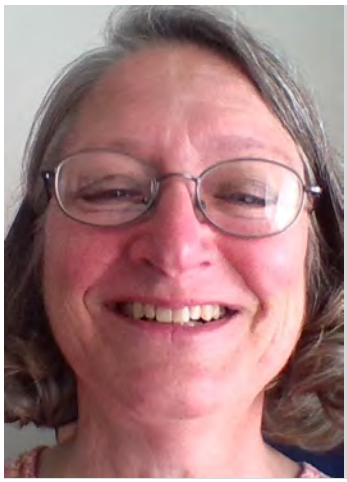
A Warm & Cozy Thank You

There are many volunteers throughout our service area who contribute their time and talents to provide blankets for Center for Hospice Care. Whether it be for our hospitality program, our Camp Evergreen campers or some of our bereaved family members, these blankets are a tangible love offering to those in hard times. Thank you for helping us spread this warm and cozy token of compassion to those that we care for.

- *Ann Baucus*
- *Bethel Assembly of God*
- *Natalie Busch*
- *Debra Clymer*
- *Janeen Ellis*
- *Extension Homemakers of Elkhart County*
- *God's Gals Group—Vineyard Church*
- *Jayne Hammontree*
- *Leah Beth Johnson*
- *Abigail Jones*
- *Donna Kooy*
- *Mary Jo Kubiak*
- *Jeanette McKew*
- *Christine Miley*
- *Madison Miley*
- *Joyce Minix*
- *Maria Moleski*
- *Erin Olson*
- *Kathy Orcelleto*
- *Nancy Riegle*
- *Annetta Russell and family*
- *Sandy Schuff*
- *Eileen Staal*
- *Trinity Lutheran Church and volunteers (organized by Chrystal Snow-Schmatz)*
- *Walnut Church of the Brethren*

Volunteer Spotlight

Lisa Melin, Mishawaka



What volunteer work do you do with CHC? How long have you been a volunteer with CHC?

I've been a Center for Hospice Care volunteer for maybe 10 years or more? I've lost track! I like to do a variety of hospice volunteer work. I've visited patients in nursing homes. I especially like going into homes to visit, clean, cook and give respite care. I have also volunteered at Camp Evergreen. That was a blast!

Why do you volunteer with CHC?

My mother had hospice care and I was so very impressed that I began volunteering sometime after that. Also, a favorite Bible verse of mine is from 1 Peter 4:10, "Each one should use whatever gift he has received to serve others, faithfully administering God's grace in its various forms." So that's why I volunteer!

Do you have a favorite hobby?

I like to say that my hobby is checking out cookbooks from the library and trying new recipes. If the recipe includes cheese you can be sure I'll give that recipe a try! I love to cook, especially for family.

Where would you most like to go in the world?

My husband and I have been blessed to travel to Mexico several times. Such great memories. The scenery, food, and relaxing atmosphere are fabulous.

Tell us a bit about your family.

We have 4 grown children and 2 grandchildren. Sometimes when we reminisce about raising our 4 kids in a small house we think, "How did we do that? How did we manage?" Then we smile because all 4 grew into wonderful adults, certainly only by God's grace. The 2 grandchildren are a blessing beyond belief.

It's all a matter of paying attention, being awake in the present moment, and not expecting a huge payoff. The magic in this world seems to work in whispers and small kindnesses.

Charles de Lint

PICTUREQUOTES.com

"Patients and families love the personal touch that Lisa brings to her visits. Whether she is providing respite, companionship, cleaning up around the house or preparing a warm meal for her patients, Lisa's personality shines. She is a true servant."

Debra Mayfield, Mishawaka Volunteer Coordinator

In Loving Memory

Our condolences and heartfelt sympathies go out to the following CHC volunteers who lost a loved one recently.

Paul Piller, Mishawaka

Mother, Mary Piller

Saturday, September 19, 2020

Similarities and Differences between Flu and COVID-19

What is the difference between Influenza (Flu) and COVID-19?

Influenza (Flu) and COVID-19 are both contagious respiratory illnesses, but they are caused by different viruses. COVID-19 is caused by infection with a new coronavirus (called SARS-CoV-2) and flu is caused by infection with influenza viruses. Because some of the symptoms of flu and COVID-19 are similar, it may be hard to tell the difference between them based on symptoms alone, and testing may be needed to help confirm a diagnosis. Flu and COVID-19 share many characteristics, but there are some key differences between the two.

While more is learned every day, there is still a lot that is unknown about COVID-19 and the virus that causes it. This page compares COVID-19 and flu, given the best available information to date.

Similarities

Both COVID-19 and flu can have varying degrees of signs and symptoms, ranging from no symptoms (asymptomatic) to severe symptoms. Common symptoms that COVID-19 and flu share include:

- Fever or feeling feverish/chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue (tiredness)
- Sore throat
- Runny or stuffy nose
- Muscle pain or body aches
- Headache

Some people may have vomiting and diarrhea, though this is more common in children than adults

Differences

Flu

Flu viruses can cause mild to severe illness, including common signs and symptoms listed above.

COVID-19

Other signs and symptoms of COVID-19, different from flu, may include change in or loss of taste or smell.

How it Spreads

Similarities

Both COVID-19 and flu can spread from person-to-person, between people who are in close contact with one another (within about 6 feet). Both are spread mainly by droplets made when people with the illness (COVID-19 or flu) cough, sneeze, or talk. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.

It may be possible that a person can get infected by physical human contact (e.g. shaking hands) or by touching a surface or object that has virus on it and then touching his or her own mouth, nose, or possibly their eyes.

Both flu virus and the virus that causes COVID-19 may be spread to others by people before they begin showing symptoms, with very mild symptoms or who never developed symptoms (asymptomatic).

Differences

While COVID-19 and flu viruses are thought to spread in similar ways, COVID-19 is more contagious among certain populations and age groups than flu. Also, COVID-19 has been observed to have more super-spreading events than flu. This means the virus that causes COVID-19 can quickly and easily spread to a lot of people and result in continuous spreading among people as time progresses.

Information taken from CDC website:

https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm

Listening with Empathy

As you listen with an open heart to those whose lives have been turned upside down by a terminal diagnosis, chances are you'll frequently hear the words, "I'm afraid…" What are the fears of hospice families? Understanding them can help you listen with empathy.

Realizing some of these fears can help you attempt to put yourself in their shoes.

The patient may fear:

- Loss of relationships
- Loss of control
- Being a burden
- Pain
- Progression of the disease
- Disfigurement
- Rejection
- Loss of identity
- Invasion of privacy
- Stigma of disease
- Not knowing the truth
- Alienation from important others
- The dying process

The family may fear:

- Unknown new role
- Poor performance
- Loss of physical relationship
- Outside interference in relationship
- Physical changes in patient
- Uncertainty
- That patient will "give up" when hospice becomes involved
- That patient may not be valued
- Economic loss
- The dying process

Comments from our Families

- Our nurse was exceptional. Our volunteer who came every week for three hours was exceptional. I am grateful for their care.
- Your volunteers who sat with my mom in her last days was so appreciated by me. She wrote me a note and it was so sweet. I have kept it still. She wrote "*it has been an honor to be with her today*" and more words that brought me peace. Thank you!
- All I can say is they are an awesome organization. Don't know what I'd have done. The regular nurse and my counselor were wonderful.
- Hospice of Elkhart did a wonderful job with my wife while she was there. Everybody that works there did an excellent job. Very professional. I can't say enough good things about your hospice program. Thank you all.

Continued from page 1

had doctors that donated services. We had a place where they could get soup every day. It was just an outgoing parish. That really formed my life."

In 1974 he got a job at Holy Cross Junior College. He taught five years there and was a chaplain to the brothers. "One of the brothers who was training to be an LPN and worked at Saint Joseph Hospital in Mishawaka under a Benedictine priest asked if I would come with him to start a pastoral care department there," he reminisced. "I said yes. We had a wonderful department. I spent 15 years there, dealing with death and dying every day as a chaplain." This is also where he met Dr. John Krueger, one of the pioneers who started the hospice movement in our area. Dr. Krueger, along with a group of individuals, established Hospice of St. Joseph County, Inc. in 1978, which today is Center for Hospice Care.

Father Ed's love for others, all of humankind, is evident in his message. "I have loved my identity as a priest," he shared in his final letter to his loved ones. "When people asked me, "What were your most important experiences as a priest?" I answered, "My relationship with the people I met in my ministry! The personal stories of the People of God, whom I met, taught me and honed my theology all the way through the years of my priesthood."

The culmination of his life's work has been to share the story of love that is shown throughout creation and the continual evolution of the world. "I've done this my whole life, but I didn't realize I was part of this evolutionary journey and trying to push the human race toward greater unity and realize it started with divine love and all of the energy forces in the universe are God's love."

That is what life is all about. It's love that is driving the universe and it's love that should be pulling the human race together. Fr. Ed Ruetz

As we all look forward towards the end of our life on this earth, it takes a leap of faith and Father Ed shared his ideas about this. "The bishop said, "What do you think heaven is like?" I said, "I don't know, but when I take that leap of faith, I'm going to find out." About six years ago, his brother-in-law was dying and during his visit with him, Father Ed encouraged him with words about faith. "We were sitting in the living room one day," he remembered. "He said, "Ed, I think I'm losing my faith. I wonder if there is a God." I said, "Don, you're not losing your faith. You're coming to understand what faith really is—a belief in something that you can't prove. So when I make the leap of death, I really believe and my faith tells me, God is on the other side. I can't prove that physically, but that is what faith is."

One of the most remarkable gifts Father Ed has given are the letters he has left for his friends and family. After he received his cancer diagnosis and started care with Center for Hospice Care, he realized that sharing what he's learned is one of his acts of love. "I am enclosing with this letter my Farewell Statement," his letter says. "This Final Testament is my gift to you! It expresses some of the wisdom and knowledge that I have come to understand through my long life on our blue, green, brown planet Earth!" And perhaps not surprisingly, Father Ed has surpassed his previously understood time. He had to write a second letter, in December 2019, sharing that he is still alive! He writes in the second letter, "So I live day by day, week by week, month by month. I am ready for death!"

He continues to share his love and wisdom to others. Currently residing in an assisted living community, he will often find new people every day to share meals with. Living life fully is engaging in the lives around him and sharing The Love Story of Creation. "When I was growing up I was taught that I have a conscience," he explained. "If I do an act that is against my conscience, I'm not loving myself. I'll take any sin, and I'll look at it and say—it is a failure to love. That is what life is all about. It's love that is driving the universe and it's love that should be pulling the human race together."

November 2020
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

More Than Comfort:

My Pediatric Palliative Care Journey

John Couri, University of Notre Dame, Junior, GPIC Intern, CHC Volunteer

Danny Thomas, the founder of St. Jude Children's Research Hospital, said, "No child should die in the dawn of life." Danny had a dream when he opened the doors of St. Jude in 1962, and it has lived on ever since. When I first reflected on the hopeful words of this Lebanese philanthropist, who also was an American nightclub comedian, it was difficult for me to come up with ways I would be able to contribute to the mission. Fortunately, the field of pediatric palliative care led me to my answer.

In summer 2019, I interned at St. Jude Children's Research Hospital in Memphis, TN. At the time, my career goal was to become a physician scientist, and enriching the lives of patients through breakthroughs in laboratory research was an area I thought I must be a part of. During my internship, I realized bench research was not something that I wanted to do for the rest of my life, but one aspect of the summer kept me resilient and deepened my interest in healthcare: the Lunch & Learn Lecture Series sponsored by St. Jude's Pediatric Oncology Education Program.

I participated in this one-hour lecture series every day during lunch, listening to professionals discuss topics ranging from the genetics of leukemia to ethical issues in pediatric research. A lot of lectures focused on the clinical side of healthcare and provided a platform for students to ask questions and talk with medical doctors and scientists, allowing me to connect with them on both a personal and professional level. One talk that truly opened my eyes was titled "Integrating Palliative Care into Pediatric Oncol-

Continued on page 6

Inside this issue:

Welcome to the Team

Stephanie Burkus
Bereavement Counselor

Vanessa DePue
Elkhart RN

Hannah Dreibelbeis
Raclin House RN

Todd Glenn
Esther's House RN

Ed Harris
Maintenance Coordinator

Diana LaBonne
Referral Specialist

Elizabeth Lung de Rodriguez
Admission RN

Jeffrey McClain
Mishawaka RN

Ashley Tucker
Mishawaka RN

Birthdays

11/1	11/10	11/23
Nancy DeMaegd	Kathleen Griffin	Katherine Fuchs
11/7	11/17	11/25
Martha Stein Jones	Jenny Cowsert	Jennifer Lutz
11/8	11/18	11/25
Susan Danielson	Nancy Jackson	Nellie Vels
11/8	11/20	11/29
Karen Goodnough	Karen McCormick	Phyllis Hong
11/10	11/22	
Ruth Anne Gray	William Singler	

Milton Adult Day Services

Did you know that Milton Adult Day Services is a Center for Hospice Care service? Milton Adult Day Services provides a structured setting to adults who need health, social, and support services during the day. This community-based service is designed to meet the needs of functionally impaired adults who require supervision during the day. Milton Adult Day Services promises to be respectful, offer opportunities for an enhanced quality of life and assures the safety of all those who use the services.

Some of the therapeutic services provided are:

- Pet therapy
- Art and music therapy
- Daily exercise
- Intergenerational programs
- Entertainment, parties and special events
- Crafts, ceramics and wood working
- Cooking club
- Manicures
- Table games and cards
- Ping-pong and indoor/outdoor physical games

Milton Adult Day Services also provides the following:

- Spiritual program
- Noon meal and nutritious snacks
- Assistance with personal care needs
- Health monitoring and medication administration supervised by a Registered Nurse

Milton Adult Day Services in conjunction with Alzheimer's and Dementia Services of Northern Indiana hosts a support group the second Thursday of every month at 10:00am. Free monthly classes are offered for families with a loved one diagnosed with Alzheimer's disease or related dementia.

For more information, check out the website

www.miltonads.org/_wp/

Volunteer Spotlight

Paul Piller, Mishawaka

What volunteer work do you do with CHC? How long have you been a volunteer with CHC?

I have been a volunteer for two years and have been to Camp Evergreen for two years, both the weekend and day camps. I have enjoyed interacting with the other volunteers, but mostly I enjoy working with the kids. They all have interesting stories and never cease to amaze me with their resilience.

I also do in-home respite visits and I have missed this part of the adventure during this virus shut down. I still get a bit of this tending to my mom's needs. I miss the interesting stories the older people have to share. I have attended two funerals for the people I have visited with. This is an opportunity to spend some time with their families in their time of grief.

The photo I am sharing will showcase the additional volunteer work I have done with your organization. This also taps my love for children. Santa is a special person in the lives of many of the younger generation and I love being a representative for this *Jolly Old Soul* for Center for Hospice Care. I am looking forward to the opportunity to share my time with your staff and their children again this coming Christmas season.

Do you have a favorite hobby?

During a 12 week period about a year and a half ago, I took on the role of caregiver on a family level. As my wife recuperated from a broken ankle, I became *Mister Mom*. It was good that I was retired and could commit full time to these duties. In the midst of this adventure, I learned that I can put together some pretty impressive meals. The trick was to get everything to be ready at the same time and hopefully that would align with mealtime! Since that time I have browsed cookbooks to get some variety into the dining experience at the Piller household. Because my mom spends much of her time in her chair, I have been able to share some of these treats with her. She has not thrown anything in the trash yet, at least to my knowledge. She and my Aunt Margaret did provide passing marks on my attempt at Hungarian goulash. Not bad when you can get the old Hungarians to approve of your meal!

What do you like to read?

My reading endeavors have been mostly of the scholarly bent. I am teaching part time at Holy Cross and Indian University South Bend. I am teaching economics, statistics, and marketing and sales management. This keeps me active during the school year and keeps me in touch with the younger generation. Moving classes on-line during the last half of this semester also taught me to be flexible in my presentation. I am looking forward to another active semester with two sections to teach at each university. My additional readings would include two daily papers and *Economist* magazine, to stay current for presentations to my students. I am also doing some reading this summer in the great books of the Western World series to further my liberal sciences education.

"Paul's compassion and sense of humor are evident in all he does. From children's camp to in-home respite visits, he can relate to any age group. Paul has a great personal manner and enjoys improving people's lives!"

Debra Mayfield, Mishawaka Volunteer Coordinator

In Loving Memory

Our condolences and heartfelt sympathies go out to the following CHC volunteers who lost a loved one recently.

Kathleen Hojnacki, Mishawaka

Stepson, Philip Hojnacki

Thursday, October 1, 2020

Helpful Hints for Dementia Patient Visits

Get Comfortable

Make sure your patient is comfortable, situated and relaxed. Eliminate distractions such as:

- Objects within reach. Your patient may be tempted to fidget with them.
- Noise from a radio or television or from other people talking nearby. It may be difficult for your patient to isolate sounds, instead hearing a jumbled stream of words. You want them to focus on you.
- Mirrors or large windows that might present confusing reflections.

Reflection of you

Dementia patients are very astute observers of your expressions and attitudes. They will often mirror your emotions, matching your smile with one of their own, or punctuate your laughter with a chuckle. Likewise, your patient may react negatively to signs of impatience or frustration. Your patient depends on you for reassurance that all is well, so smile, smile, smile!

Don't keep score

Create an atmosphere where there is no such thing as failure. Activities done with your patient are meant to make you and your patient feel good. If your patient gives you a wrong answer, you can still say "Yes, that is right!" or “Good Job!” Your patient was engaged and may have known the answer, but was unable to verbalize it correctly at that moment. Remember, the goal is participation and fun, not accuracy.

Attention grabbers

Try to get your patient's full attention when doing an activity. Rather than sit side by side, sit at a 45 degree to a 90 degree angle. Your patient will be better able to focus on you and see the nonverbal cues in your gestures and expressions.

If your patient's attention wanders, precede questions with your patient's name. For example, "John, did you know that Chicago is known as the Windy City?” If you are still having trouble, gently take your patient's hand in your own and say something like:

- "I’d like to hear more about you."
- "Tell me more about..."

Adjust your tempo

Be sure to give your patient plenty of time to respond to your questions. It may take awhile for your patient to

form the answers. If ample time elapses with no response, repeat or rephrase the question, or move on.

Be flexible

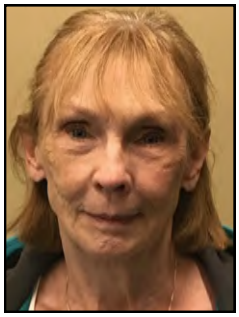
If the questions and answers digress into other topics, don't worry. It's a sign that your patient is responding and interested! Just let the conversation flow naturally. You can always resume the rest of an activity later.

Helpful Tips

- Say your name and their name every time you see them.
- Make eye contact every time you are speaking with them.
- Approach from the front, then move to the side.
- Speak slowly, clearly and simply in normal tones (to minimize communication barriers).
- Allow the patient time to respond.
- Be attentive. Keep nonverbal responses consistent to prevent excess stimulation.
- Hands should be seen at all times.
- Offer a word if they seem like they are struggling to find the correct word.
- Use short 1-3 words for direction with cueing each step.
- Do not ask "yes or no" questions.
- Don't use the word "no" as a correction to the patient.
- Say "tell me more" when the patient starts talking about a memory.
- REDIRECT, REFOCUS, RE-APPROACH
- Learn and recognize their body language.

Welcome New Volunteers

Help us welcome these new volunteers who finished their training this month. Please introduce yourself to these volunteers as they begin their service with CHC.



Ilene Crutchfield, Mishawaka

Michael Finn, Mishawaka

Bob Tyler, Mishawaka

Comments from our Families

- Mom only spent four days at hospice house before she expired. The care and compassion received in those four days was world class. We are so grateful for her final days of life under hospice care.
- All the nurses and aides were very caring and wonderful to work with while caring for my dad as he had his final days on earth. Many thanks to all of them.
- My son got the diagnosis of terminal cancer with only two months to live right at the beginning of the COVID -19 crisis. We had limited health options as a result and felt lost. Then CHC jumped in and guided us through the difficult days. You are miracle workers. God bless all of you!

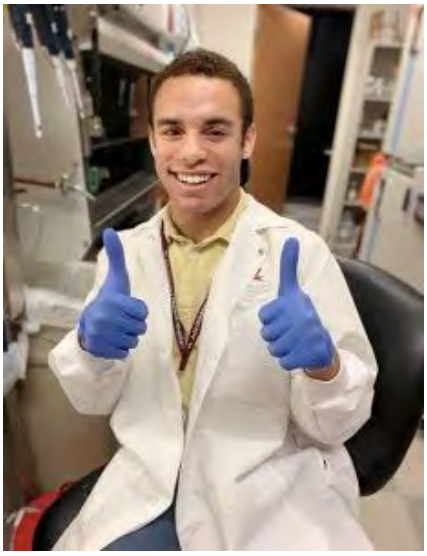
Continued from page 1

ogy Practice," as it seemed to ignite an inexplicable fire within me.

This lecture, presented by Dr. Justin Baker, inspired me not only because it highlighted the key components of understanding and integrating palliative care but also because it emphasized the importance of palliative care in pediatrics. Specifically, the talk underscored the complexity of childhood illness and how children are still developing as they progress through cancer, giving a reason as to why palliative care is essential. It provides that extra layer of support needed to tailor a child's medical care to his or her specific needs. This layer not only focuses on providing comfort but also involves clarifying a family's goals and helping them choose options that are in line with their values.

Overall, my summer at St. Jude proved to me that when piecing together both curative and palliative care like a jigsaw puzzle, an image of resilience and positive health outcomes is made more colorful through its interconnectedness. Driven by this metaphor and by my passion to strengthen palliative care services worldwide, I have been interning for *Global Partners in Care* (GPIC) since June 2020. As an intern, I work closely with their partnership program, assisting with social media, website updates, and story writing. I am also working with one of GPIC's international partners in Malawi, *Palliative Care Support Trust*, on a nutritional support project to for pediatric palliative care patients.

Working with GPIC, I am again reminded that pediatric palliative care focuses on more than comfort. At its core is longevity and the promotion of quality of living, which involves cultivating a sense of purpose, strengthening community relations, and connecting with family and friends. It truly is more than comfort, and I am so grateful to be a part of it all.



Pediatric palliative care focuses on more than comfort. At its core is longevity and the promotion of quality of living, which involves cultivating a sense of purpose, strengthening community relations, and connecting with family and friends.

Center for Hospice Care
Committees of the Board of Directors

The following committees of the CHC Board of Directors are currently available for board member participation. Contact the Chair of the Board if you are interested in joining one of these committees.

Bylaws Committee
The Bylaws Committee shall consist of the Executive Committee of the Corporation and other appointees by the Chair of the Board of Directors in such numbers as they deem necessary. It shall have the responsibility of reviewing the Corporation's Bylaws at least once every three years.

Milton Adult Day Services Advisory Committee
The MADS Advisory Committee shall consist of appointees by the Chair of the Board of Directors and include caregiver and community representation. It shall have the responsibility to review the scope of services, quality of services, policies and procedures, service reports, evaluation findings, public relations/information materials, marketing/fundraising activities, and grant opportunities. The committee meets twice a year.

Nominating Committee
The Nominating Committee shall consist of the Executive Committee of the Corporation and other appointees by the Chair of the Board of Directors in such numbers as they deem necessary. It shall have the responsibility of nominating candidates for positions on the Board, as well as for officers of the Board of Directors. The committee generally meets two to three times a year.

Personnel Committee
The Personnel Committee shall consist of the Executive Committee and other appointees by the Chair of the Board of Directors, and be chaired by the Chair of the Board of Directors. This committee shall concern itself with the review and recommendations for approval of the Personnel Policies governing the staff of the Corporation. This committee meets at least biannually to review the Human Resources Manual and as needed.

Special Committees
Special committees may be appointed by the Chair of the Board of Directors as the need arises. Some of these committees include the Helping Hands Award Dinner Committee, and the Walk/Bike for Hospice Committee.

Center for Hospice Care

2021 BOARD OF DIRECTORS MEETINGS
Administrative and Foundation offices
501 Comfort Place, Mishawaka IN 46545
Conference Room A
Wednesdays at 7:15 a.m.

Date	Topic of Focus
February 17	2020 Year in Review First meeting for new Board members
May 19	Review of 2020 Audit
August 18	Quality Assurance Performance Improvement updates
November 17	2022 Budget Election of new members and officers

1-800-HOSPICE ♦ cfhcare.org

501 Comfort Place
Mishawaka, IN 46545
(574) 243-3100
Fax: (574) 243-3134

112 S. Center St., Ste C
Plymouth, IN 46563
(574) 935-4511
Fax: (574) 935-4589

22579 Old US 20 East
Elkhart, IN 46516
(574) 264-3321
Fax: (574) 264-5892

309 W Johnson Rd, Ste A
La Porte, IN 46350
(219) 575-7930
Fax (219) 476-3965

Center for Hospice Care
choices to make the most of life

CHAPTER FOUR

NOMINATIONS

2021 CHC Board of Directors Elections

2021 CHC Slate of Officers and Executive Committee Members

Chair = Mary Newbold

Vice Chair = Mark Woobe

Treasurer =

Secretary = Jennifer Houin

Immediate CHC Past Chair / 2021 Hospice Foundation Chair = Mary Newbold

Hospice Foundation Immediate Past Chair = Wendell Walsh

Candidates for 2021 Board Members and Brief Bios

Kevin Murphy, SVP, Group Head of Information Technology, Marketing and Digital Strategy at 1st Source Bank. He joined the bank in 2006, and has lead IT, Consumer and Electronic Banking, worked in Treasury Services and managed the Central Region banking centers. Murphy is a graduate of the University of Notre Dame Executive MBA program, Wittenberg University and DeVry University, with degrees in Political Science and Information Technology. He is active with the Center for History where he served as President and is a Board Member. He also volunteers with the United Way and the Boys and Girls Club and is a graduate of the Leadership South Bend/Mishawaka program.

Jeff Bernel, a former CEO, Board Director, and Senior Director with experience in bank financing, M&A, private equity and venture capital. He is an Adjunct Teaching Professor, Management & Organization, at the Mendoza College of Business at the University of Notre Dame teaching Undergraduate Corporate Strategy, Management and Undergrad and MBA Entrepreneurship courses. He was co-founder of the Gigot Center for Entrepreneurship and its Director for two years. He is the founder and Board Chair of the Healthcare Foundation of LaPorte which was created to oversee the investment and granting making of a $170+ million 501(c)(3) private foundation focused on improving health and wellness in and around La Porte, Indiana. He received his MBA from the University of Notre Dame

Brian Huber, MD is a practicing physician and medical director of The South Bend Clinic's Immediate Care Center. He started and completed his educational journey at the University of Cincinnati. There he got his undergraduate degree in philosophy and then stayed and completed his medical degree at the University of Cincinnati College of Medicine. He came to South Bend to complete his residency at the Saint Joseph Regional Medical Center Family Medicine Residency Program and was Associate Director of that program for six years and was the Department Chair of Family Medicine. Brian is board-certified in family medicine (ABFM) and an active member of American Academy of Family Practitioners.

Re-Elect to Second Three-Year Term

Jennifer Houin

# # #