Center for Hospice Care

choices to make the most of life

Board of Directors Meeting
Administrative and Foundation Offices
4220 Edison Lakes Pkwy, Suite 200, Mishawaka
August 15, 2012
7:30 a.m.

BOARD BRIEFING BOOK

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CHAPTER ONE

AGENDA

Center for Hospice Care

BOARD OF DIRECTORS MEETING
Administrative and Foundation Offices
4220 Edison Lakes Parkway, Suite 200
August 15, 2012
7:30 a.m.

A G E N D A

1. Approval of June 20, 2012 Minutes *(action)* – Terry Rodino (2 minutes)

2. President's Report *(information)* - Mark Murray (11 minutes)

3. Finance Committee *(action)* – Amy Kuhar Mauro (5 minutes)
   (a) Financial Statements for June and July

4. Patient Care Policies *(action)* – Donna Tieman (5 minutes)
   (a) Fall Prevention - revised
   (b) Plan of Care - revised

5. Human Resources Policies *(action)* – Karl Holderman (5 minutes)
   (a) Dress Code - revised
   (b) Steps to Follow When Government and State Agencies, Medicare/Medicaid Contractors, and Others Make a Request for Information - new

6. Foundation Update *(information)* – Catherine Hiler (15 minutes)

7. Board Education – 2011 – 2015 Strategic Plan Update *(information)* – Mark Murray (15 minutes)

8. Chairman's Report *(information)* – Terry Rodino (2 minutes)

Next meeting October 17 at 7:30 a.m.

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CHAPTER TWO MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
June 20, 2012

Members Present:	Carmi Murphy, Catherine Hiler, Corey Cressy, Julie Englert, Mary Newbold, Melanie Davis, Rita Strefling, Sara Miller, Terry Rodino, Wendell Walsh
Absent:	Amy Kuhar Mauro, Bilal Ansari, Dennis Beville, Ida Watson, Jim Brotherson, Lori Price
CHC Staff:	Mark Murray, Dave Haley, Karl Holderman, Mike Wargo, Becky Kizer

Topic	Discussion	Action
1. Call to Order: 7:30 a.m.		
2. Re-Election to Second Term	• A motion was made to re-elect Corey Cressy and Ida Watson to second three-year terms on the Board of Directors. The motion was accepted.	C. Hiler motioned W. Walsh seconded
3. Minutes	• A motion was made to approve the minutes of the 04/18/12 meeting as presented. The motion was accepted.	R. Strefling motioned M. Davis seconded
4. President's Report	• Copies of the Conflict of Interest and Confidentiality Agreement forms were distributed. The Board is required to sign these forms annually. There will be an additional conflict of interest form for the IRS 990 later this year, which can be done electronically. • A copy of the 2011 Year in Review is in the Board packet. • Industry Update: The number of individual Medicare certified hospice programs has increased from 175 in 1985 to 3,500 in 2011. Many of these programs have multiple sites and there are over 5,500 hospice sites in the U.S. Cancer is now 35%, heart disease 14%, dementia 13%. When hospices started, cancer was 93%. The average length of stay is 67.4 days, median 19 days. Hospices are preparing for rate cuts by controlling costs. Due to tremendous management by the medical team and Donna Tieman, DON, we have been able to reduce Enclara drug costs by 8.4%. In May the Enclara shipping charges were $0.05 a day. • Hospice Action Network (HAN) is urging hospice staff to make face-to-face visits with legislators to talk about care at the bedside this week. What can board members do? Participate in fundraising when they can, but the best thing is to be good ambassadors and talk about	

Topic	Discussion	Action
	what CHC does and who we are whenever they can. Be a witness for CHC. The better educated people are about us, the more likely people will choose us. With ongoing reductions in reimbursement, we may have some expansion opportunities in the future with smaller hospices around our area that may want to join us. The most difficult thing now is we don't know what the future will be like, so the best thing is to just continue growing, because with more patients we can spread costs around. Hospices are getting multiple rate cuts compared to other Medicare providers, and yet many studies show that patients in hospice saves Medicare / taxpayer money, improves quality of care, and has the highest customer satisfaction ratings Mark will email some of the HAN talking points to the board. • 53% of hospices are for-profit. If we expanded into Michigan, we want to have the same product as we do in Indiana, but Michigan has decided they don't want any more home health agencies, so we could only be hospice which would be a different product than we have here. We also don't think we have done all we can in Indiana and should consider this before we go into Michigan and tackle staff licensing issues, additional surveys, etc. Lakeland Health System just bought Hospice at Home in Michigan.	
5. Finance Committee	• April average daily census YTD 349. Operating revenue $1.5 million and YTD $6.3 million. Total revenue $1.5 million and YTD $7.1 million. Expenses $1.1 million and YTD $5.3 million. Net gain $371,000 and YTD $1.7 million. Taking away beneficial interest in Foundation showed net gain of $372,000 and YTD $989,000. • May average daily census YTD 347. Operating revenue $1.6 million and YTD $8 million. Total revenue $1 million and YTD $8.7 million. Expenses $1.4 million and YTD $6.7 million. Net loss $388,000 and YTD net gain $1.4 million. Taking away beneficial interest in Foundation net gain $251,000 and YTD net gain $1.2 million. • A motion was made to accept the April and May financial statements as presented. The motion was accepted.	M. Davis motioned C. Cressy seconded
6. Policies	• The following revised policies were presented for approval: ◊ Abbreviations List	

Topic	Discussion	Action
	◊ Change of Designated Hospice ◊ Home Health Aide/CNA Assignment and Duties ◊ Protection of Clinical Records ◊ Transfer of a Hospice Patient • A motion was made to accept the revised policies. The motion was accepted.	W. Walsh motioned R. Strefling seconded
7. HIPAA Policies	• About 11 months ago we experienced a HIPAA breach by an employee. Per regulations we are required to file a notice with the state, HHS, and potentially affected patients/families. 199 patients were identified. As a result of this breach we also had all of our existing HIPAA policies reviewed by Krieg DeVault's HIPAA attorney specialist in Indianapolis; her only area of practice. She put together the updated set of policies. The experience was of no fault of our own yet involved a tremendous amount of staff time and a great deal of expense. Wendell added that CHC handled the breach beautifully and made very extensive efforts to make sure no patient cared for by the organization was harmed due to a former employee. • A motion was made to accept the revised HIPAA policies. The motion was accepted.	R. Strefling motioned W. Walsh seconded
8. Personnel Committee	• The Executive Committee, acting in their capacity of the Personnel Committee reviewed and approved revisions to the Human Resources Policies Manual 2012-2014. • A motion was made to accept the revised Human Resources Policies Manual 2012-2014 as presented. The motion was accepted.	M. Davis motioned C. Murphy seconded
9. Professional Advisory Group	• The PAG met on 04/25. They reviewed the OASIS home health clinical records. The answers to the OASIS determine the payment from CMS. We are focusing on two areas: pain management and re-hospitalizations. The PAG reviewed and approved the policies that were presented to the board today. The pre-home placement physical policy was moved from a patient care policy to the Human Resources manual under Employee Screening Procedures where it belongs. • A motion was made to approve the PAG report as presented. The motion was accepted.	C. Hiler motioned M. Newbold seconded
10. Foundation Update	• The grounds event in Elkhart was great. Attendance was very good	

Topic	Discussion	Action
	and staff did a great job. • Overall fundraising this year through May was $417,000, up from a year ago at $332,000. • Special events: 20th Helping Hands Award Dinner was the second most successful in its history. Thank you to Chris and Carmi Murphy for chairing the event. • The 4th Annual Bike Michiana for Hospice is 09/16. We are already receiving registrations online. Last year we had 866 riders and our goal this year is to have 1,000. • We are providing publicity for several third party fundraising events: The 14th Annual Joe E. Smith NAIFA golf outing has raised over $60,000 to date for CHC. It was held at Blackthorn this year. Michiana Sodbusters Annual Mud Bog raised over $45,000 for CHC since 2005. This year they raised $6,000. The annual Bill Stankovic Bass Tournament raised $4,500. • The 27th Annual Walk for Hospice will be on 09/30 at Newton Park in Lakeville. This will be the last time at this location, because next year it will be held at the river walk in Mishawaka. • We are working on fundraising events in conjunction with World Hospice and Palliative Care Day in October. • FHSSA Update: We sponsored three students to go through the 12 month diploma program to become certified in palliative care. They have graduated and have gone to unserved districts of Uganda to establish palliative care in those areas. This year we would like to fill 6 of the 12 seats. We try to reserve those seats for areas that don't have palliative care yet. We identified the number of students we are willing to fund. • The *Okuyamba* documentary continues to be screened at various film festivals across the country, winning a couple of awards here and there. We developed the "Event in a Box" for FHSSA's 95 partners in the U.S. to use in their community to raise awareness of the work they are doing. Staff here has does a fantastic job preparing the materials to share. • Mishawaka Campus: We should be at a point next month where we	

Topic	Discussion	Action
	reach a development agreement with the city. At the August board meeting we will be able to provide more details on what it will look like. We should be able to break ground in August. We have communication strategy in place to follow along the way. • The previous issue of Crossroads went out before the Helping Hands Award Dinner in May, because the cover story featured the honoree. The next issue is in the works now and will recap the dinner.	
11. Chairman's Report	• Reminder to sign the Confidentiality Agreement and Conflict of Interest forms and get them to Becky. The Hospice Foundation Board meets afterwards. Next meeting August 15.	
Adjournment	• The meeting adjourned at 8:35 a.m.	Next meeting 08/15

Prepared by Becky Kizer for approval by the Board of Directors on August 15, 2012.

_____ _____

Rita Strefling, Secretary Becky Kizer, Recording Secretary

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
Hospice Foundation
President / CEO Report
August 15, 2012
(*Report posted August 9, 2012)*

This meeting takes place in Suite 200 at the AFO at 7:30 AM.
This report includes event information from June 21 – August 15, 2012.
Hospice Foundation Board meeting will begin at 8:30 AM in Room B in Suite 210.

CENSUS

At the end of July, year-to-date Average Daily Census (ADC) agency wide was running 4.74% higher than at the same time in 2011. The year-to-date total number of patients served was 5.4% higher and original admissions were 5.12% higher than July 2011. Of note: Elkhart Hospice House's occupancy rate was 26% higher than at the same time last year.

July 2012	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	429	1,243	1,179	64
Original Admissions	119	904	860	44
ADC Hospice	319.03	327.90	306.89	21.01
ADC Home Health	23.97	17.98	23.34	(5.36)
ADC CHC Total	343.00	345.88	330.23	15.65

June 2012	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	427	1,124	1,050	74
Original Admissions	128	785	731	64
ADC Hospice	319.50	329.41	309.38	20.03
ADC Home Health	21.10	16.96	23.89	(6.93)
ADC CHC Total	340.60	346.37	333.27	13.10

Monthly Average Daily Census by Office and Hospice House for Calendar Year **2011**

	2012 Jan	**2012** Feb	**2012** Mar	**2012** Apr	**2012** May	**2012** June	**2012** July	**2012** Aug	**2011** Sept	**2011** Oct	**2011** Nov	**2011** Dec
S.B.:	180	189	199	201	202	203	204			167	177	184
Ply:	73	71	67	60	60	63	61			61	67	76
Elk:	78	71	72	70	68	67	68			66	72	73
SBH:	5	7	3	3	5	4	5			4	4	5
EKH:	4	5	3	2	4	4	5			3	4	
Total:	355	365	344	336	339	341	343			302	324	342

HOSPICE HOUSES

July 2012	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
SB House Pts Served	25	176	158	18
SB House ALOS	5.52	5.56	6.50	(0.94)
SB House Occupancy	63.59%	66.66%	69.20	-3.54%
Elk House Pts Served	31	147	132	15
Elk House ALOS	5.13	5.67	4.99	0.68
Elk House Occupancy	73.27%	55.94%	44.41%	11.53%

June 2012	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
SB House Pts Served	27	156	78	27
SB House ALOS	4.93	5.39	7.24	(1.51)
SB House Occupancy	63.33%	66.01%	67.26%	-4.23%
Elk House Pts Served	23	127	112	15
Elk House ALOS	4.74	5.31	4.86	0.45
Elk House Occupancy	51.90%	52.98%	42.94%	10.04%

PATIENTS IN FACILITIES

The average daily census of patients in skilled nursing homes, assisted living facilities, and group homes during July was 126. Year to date through July 2012 is 132.

FINANCES

Karl Holderman, CFO, reports that the July 2012 Financials will be posted to the Board website on Friday morning, August 10th following Finance Committee approval.

June 2012 Financial Information

Center for Hospice Care

June Overall Revenue	$	1,722,128	Year to Date Overall Revenue	$	9,895,362
June Total Expense	$	1,331,067	Year to Date Total Expense	$	8,102,865
June Net Gain	$	391,061	Year to Date Net Gain	$	1,792,497

Hospice Foundation

June Development Income	$	96,559	Year to Date Development Income	$	512,273
June Investment Income	$	288,322	Year to Date Investment Income	$	606,365
June Overall revenue	$	427,870	Year to Date Overall Revenue	$	1,163,605
Total June Expenses	$	142,356	Total Year to Date Expenses	$	717,976
June Overall Net	$	285,514	Year to Date Overall Net	$	445,629

Combined

June Overall Revenue	$	1,864,484	Year to Date Overall Revenue	$	10,613,338
June Overall Net Gain	$	391,061	Year to Date Overall Net Gain	$	1,792,497

At the end of June, Center for Hospice Care's Year to Date Net without the beneficial interest in the Hospice Foundation was $1,346,866.

At the end of June, CHC and HF combined had a net without investments of $1,196,130.

At the end of June, the Foundation's Intermediate Investments (formerly known as Pool Two) totaled $3,960,327. Long Term Investments (formerly known as Pool Three) totaled $9,834,338.

CHC's assets on June 30, including its beneficial interest in the Hospice Foundation, totaled nearly $30.1 million (the first time in history assets topped $30MM) and the only significant liabilities were the trade account payables, accrued payroll, and accrued payroll taxes.

CHC VP/COO UPDATE

Dave Haley, VP/COO, reports that CHC Chief Medical Officer, Dr. Greg Gifford, MD, our DON, Donna Tieman, and I recently met with Elkhart General Hospital CEO Greg Losasso, Dr. Mark Sandock, and Cindy McPhie, Director of Rehabilitation and Neurosciences. The purpose of the meeting was to explore ways in which we could work cooperatively in the development of their inpatient and outpatient Palliative Care programs. We also discussed Elkhart General Hospital DBAs (EGH's referrals to hospice who expire before being admitted into the hospice program). Greg Losasso requested to see a draft of a contract which would allow for the simultaneous hospital discharge and hospice admission of patients, while leaving them physically in the hospital. The meeting was very positive and productive.

Dave Haley and I also recently met with Lori Price, CEO of St. Joseph Regional Medical Center (SJRMC) Plymouth and Mike Ferry, Director of Quality Improvement at SJRMC Mishawaka. We discussed issues and opportunities surrounding Accountable Care Organization formation, the community-based Perinatal Hospice and Palliative Care project, the Palliative Care service formation, and DBAs. Like EGH, SJRMC requested a draft of an addendum to our present contract which would allow for the simultaneous hospital discharge and hospice admission of patients while they are physically residing in the hospital.

Activities continue in recruiting another fulltime Medical Director. Please feel free to get the word out. We would arrange for and pay for them to become board certified in hospice and palliative medicine. Please contact Dave Haley for further information.

Dave Haley's Census Charts are contained in the Board Briefing Book.

DIRECTOR OF NURSING UPDATE

Donna Tieman, RN, DON, reports Nursing Leadership is developing processes to document and track quality measures in preparation for CMS mandatory quality data reporting. Nursing documentation has become a central focus in all meetings in an effort to comply with regulatory requirements. Current efforts will lay the ground work for future CMS mandatory quality reporting.

Collaboration on a community perinatal hospice program is ongoing. Meetings continue with SJRMC neonatal bereavement nurses to develop the frame work for CHC's partnership in providing perinatal services with SJRMC staff for their patients. This frame work will become the blue print for future collaboration with other area hospitals and CHC in providing perinatal hospice and palliative care services.

Three staff nurses will attend a symposium on Palliative Care: Comfort, Communication, Choices, Control. The knowledge gained at this symposium will enable is to strengthen our skills in pain and symptom management, cultural differences, understanding the patient's perspective, as well as ethical issue related to palliative care.

On August 2, our Elkhart office successfully performed CHC's first ever in-home blood transfusion. We started at 10:15 AM and the final bag was hung at 5:30 PM. This was performed as a "continuous care" level of care under the Hospice Medicare Benefit with our staff. The patient had

very low hemoglobin and was short of breath. This procedure allowed her to become markedly more comfortable. The patient and family were ecstatic. The patient kept telling our nurse she had no idea she could have this done and what a difference it made. The patient also got to remain at home. And instead of paying outside contracted vendors for this procedure, CHC saved expenses by performing it on its own and also realized additional revenue by being able to bill under the Continuous Care level of care – the highest reimbursement available under the Hospice Medicare Benefit.

HOSPICE FOUNDATION VP / COO UPDATE

Mike Wargo, VP/COO, Hospice Foundation, reports…

Fund Raising Comparative Summaries

Year to Date Total Revenue (Cumulative)

	2008	**2009**	**2010**	**2011**	**2012**
January	53,599.91	70,808.77	64,964.45	32,655.69	36,775.87
February	196,404.22	114,791.61	108,025.76	64,530.43	88,893.51
March	332,376.27	156,227.15	231,949.73	165,468.92	194,345.35
April	531,841.59	265,103.24	354,644.69	269,676.53	319,818.81
May	739,948.64	358,108.50	389,785.41	332,141.44	416,792.85
June	847,141.03	739,094.00	477,029.89	427,098.62	513,432.22
July	938,610.40	782,028.00	532,913.52	487,325.01	579,801.36
August	1,291,091.74	831,699.47	585,168.77	626,466.72	
September	1,622,566.59	913,852.09	671,103.04	724,782.28	
October	1,701,183.06	1,249,692.64	992,743.37	1,026,728.58	
November	1,758,820.82	1,294,948.93	1,043,750.46	1,091,575.65	
December	1,943,175.48	1,415,554.25	1,178,938.91	1,275,402.38	

Year to Date Monthly Revenue

(less capital campaigns, bequests and one-time major gifts)

	2008	**2009**	**2010**	**2011**	**2012**
January	43,099.91	36,382.10	52,442.49	32,110.69	32,309.58
February	29,402.31	33,816.42	41,364.37	30,644.74	43,783.64
March	121,906.94	34,722.57	65,886.51	99,796.42	102,351.84
April	174,554.43	105,621.19	104,544.96	97,332.61	123,998.46
May	81,857.05	92,613.21	33,768.72	51,753.98	90,909.04
June	91,962.39	94,353.52	74,084.48	90,718.18	92,036.89
July	41,431.37	43,103.73	55,278.63	53,536.39	62,069.43
August	53,201.14	48,215.45	51,240.25	83,202.86	
September	32,254.39	55,710.51	85,629.27	94,000.56	
October	69,849.74	78,996.22	66,061.97	47,779.09	
November	46,012.07	45,136.29	49,247.09	48,284.08	
December	134,917.88	113,640.59	115,188.45	133,617.73	
Total	**920,449.62**	**782,331.80**	**794,737.19**	**862,777.33**	

Special Events & Projects

The ***Gardens of Remembrance and Renewal*** at the Elkhart Campus was dedicated on June 7th in a memorial celebration attended by more than 100 people. The arbor fountain, six benches, four flowering trees and 22 bricks given in honor or in remembrance of loved ones were dedicated at this time as well. Another mailing to the loved ones of Elkhart Hospice House patients and Elkhart donors regarding naming opportunities was sent in July to approximately 3,500 people. The next round of memorial items will be ordered in early September and a remembrance ceremony for their dedication is planned for October.

Registrations and fundraising efforts for the 4th Annual Bike Michiana for Hospice are well underway. More than 310 riders were registered by the end of July. More than 50 riders have signed up to fundraise for the event so far; two riders have already raised the more than $450 required to receive a special edition riding jersey, socks and t-shirt. The event will be held September 16th at St. Patrick's County Park. Marketing and promotional efforts include: e-blasts to previous bikers, multiple local and regional lists; scheduled Facebook and web site updates; press releases and brochures. Yard signs will be placed in August. Grass Roots Media will produce a :30 public service announcement that will be used to promote the event on the web site, Facebook and which will be sent to local television stations for placement.

The 27th Annual Walk for Hospice will be held September 30th at Newton Park in Lakeville. Sponsor and prize solicitation began in early July. The web site has been updated and Save the Date cards were sent the third week of July. WSBT will once again be the media sponsor for the event.

Okuyamba Fest will be held on October 11th at the Center for History in South Bend. This inaugural World Hospice & Palliative Care Day celebration of CHC/Hospice Foundation's partnership with the Palliative Care Association of Uganda (PCAU) will feature samplings of international foods, wines and beers, a silent auction to raise funds to support FHSSA/PCAU and a screening of *Okuyamba*. Cost is $75 per person. Proceeds will be directed to a designated fund being established for the acquisition of a permanent home for PCAU in the Ugandan capital of Kampala.

FHSSA/PCAU

During Mike's recent visit to Uganda, from July 23 to August 1, he was able to accomplish the following objectives: a private screening of *Okuyamba* during a half-day meeting with Members of the Ugandan Parliament; meetings with PCAU staff; web site development meeting with Javie SSozi, a consultant from the Open Society Institute; dinner meeting with the PCAU board of directors to discuss our involvement in their five-year strategic plan initiatives; visited the African Palliative Care Association and met with Faith Mwangi-Powell; met with Dr. Carla Simmons, executive director of Kitovu Home Care in Masaka regarding child caregiver issues; made ward rounds with Mulago Hospital Palliative Care team; visited Kawempe Home Care and met with its executive director Dr. Sam Guma regarding future internship placements through the Kellogg Institute program at the University of Notre Dame; visited a remote clinic desiring to begin accessing morphine from the government central pharmacy; participated in and presented at the Kibaale District Palliative Care Update Meeting; visited our six current CHC/HF-sponsored Clinical

Palliative Care Course (CPCC) scholarship students, chancellor and faculty at HAU Institute; visited one of our recently sponsored CPCC program graduates, Lameck, and the hospital administrator at Mubende Regional Referral Hospital; visited George (a seven-year old former caregiver for his father who died when he was five and who had been abandoned by his mother), who is now back in school thanks to our recently established "Road to Hope" fund; toured five potential sites for a permanent PCAU home; toured conference facilities at Speke Resort, a potential site for PCAU's 2013 Bi-Annual Palliative Care Conference; visited and toured Mobile Hospice Mbarara; met with Denis and Grace Kidde regarding their upcoming move to the U.S. as well as Denis' upcoming duties and responsibilities as the FHSSA Liaison at the Hospice Foundation; met with USAID representatives to provide an update regarding current initiatives and discuss potential collaborations; met with Open Society Institute representatives to provide update regarding current initiatives and discuss potential collaborations; met with Hospice Africa Uganda founder, Dr. Anne Merriman, to discuss HAU's 2011-12 accomplishments and goals for the future.

During the 2012-13 academic year, The Hospice Foundation is providing scholarship funding for six health care workers coming from un-represented or under-represented districts to complete the one year Clinical Palliative Care diploma program at Hospice Africa Uganda. Classes began for our students in June. They include Dianah Basirika (Hospice Jinja – Jinja district), Antoinette Baganayabo (Kisoro district), Tumwesigye Ambrose (Ibanda district), Kikansa Racheal (Buyende district), Amoris Jane Okoth (Tororo district) and Joni Virginia (Moyo district). Mike met all of the students and Mike reports they are all very excited about their new career path.

That said, we are sorry to report some sad news regarding one of our first two scholarship recipients: Claire Muhumuza, a Clinical Officer in the Kibaale district died on July 20th after contracting what was at the time being described as a "strange disease" while caring for several patients in their home who died with similar symptoms. The CDC and Ugandan Ministry of Health subsequently determined that the "strange disease," as it was being reported in the media, was actually the Ebola virus. It was the lead story in Kampala newspapers nearly every day during Mike's visit. Claire, along with Stephen Abitegeka, our other initial CPCC scholarship student, had been involved in planning the quarterly district update meeting in which Mike participated on July 27th. In addition to the eight people for which she had been caring in their home, both Claire's sister and four-month old baby subsequently died of the virus. This outbreak of Ebola, which was declared on July 28, has so far claimed 16 lives in the Kibaale district and over 176 others are being monitored.

Okuyamba

The film was recently awarded the ***2012 Silver Award for Short Documentary*** from the Prestige Awards for Film competition. In addition, we continue to garner additional film festival awards and screenings. Upcoming festival screenings include: Columbia Gorge Film Festival, Vancouver, WA; Naperville Independent Film Festival, Naperville, IL; and the Cincinnati Film Festival, Cincinnati, OH.

The "Event in a Box" fundraising concept that we developed for FHSSA, in which U.S.-based FHSSA partners may screen ***Okuyamba*** as part of their fundraising efforts to benefit FHSSA and their African partners, continues to draw interest. Among those hospices currently planning upcoming screenings: Hospice & Palliative Care of Western Colorado, Grand Junction, CO;

Visiting Nurse and Hospice Care, Santa Barbara, CA; The Denver Hospice and Optio Health Services, Denver, CO; St. Luke's Hospice Community, Cedar Rapids, IA; Hospice of Washington County, Hagerstown, MD; Prairie Haven Hospice, Scottsbluff, NE; Samaritan Healthcare & Hospice, Marlton, NJ; Talbot Hospice Foundation, Easton, MD; and Cornerstone Hospice, Central Florida.

In addition to film festivals and hospice/palliative care organizations, the film has drawn interest from members of the medical community including the Global Health program at Duke University, Endo Pharmaceuticals and a medical missionary in Kenya. On October 9th, Mike will be screening the film and making a presentation entitled: "Uganda: A Model for Palliative Care in Developing Countries" at the LeadingAge Indiana Conference, being co-sponsored by the Indiana Hospice & Palliative Care Organization, in Indianapolis.

Mishawaka Campus

Scheduled construction completion and occupancy of Phase I facilities continues to be June 2013. The development agreement with the City of Mishawaka was finalized with unanimous approval by the Redevelopment Commission on July 18th and we crossed the final hurdle with the Mishawaka Common Council on August 6th when they unanimously approved the final rezoning requests. The final real estate closings occurred on October 7th. Wightman Petrie has finalized the campus master plan and Indiana Earth has completed demolition of the last remaining house. Helman Sechrist Architecture has completed development of floor plans for the guest house, and the new Life Transition Center Administrative / Foundation building as well as for the transformation of the former Edgewater Florist building into a new Palliative Care Center. DJ Construction has obtained competitive bids for the construction and renovation. Site work will commence this month and a ceremonial groundbreaking event will be scheduled for early fall.

Hospice Foundation Communications

The summer edition of Crossroads is in the final phases of production and will match our largest current issue in the number of pages at 48. Among the items featured are a cover story on the new Mishawaka campus, a recap of the Helping Hands Award Dinner and a recap of CHC/Hospice Foundation's year in review.

The Foundation, Bike and Walk websites are being updated on a weekly basis to encourage visitors to check back often.

The "2012: The Year in Review" was sent to all $1,000+ donors the last week of June along with a letter thanking them for their continued support of CHC/Hospice Foundation. It also highlighted some of 2011's significant financial achievements.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

Amy Tribbett, Director of Marketing and Access reports...

Outreach in June & July

During this time, our account managers Lisa Zollinger, Kim Lintner, and Terri Stahl visited the offices of more than 400 physicians and made nearly160 visits to ECFs. More than 50 visits were made to our service area hospitals. The liaisons also completed 21 patient pre-assessments during this time as well. National Certified Nursing Assistant (CNA) Week was celebrated during this time and included special baskets of goodies delivered to our area contracted nursing homes and other facilities to honor their CNAs.

Media highlight: Through amazing teamwork, the community relations/marketing, volunteer departments, staff's contribution to the "We Believe Fund," and the California-based Dream Foundation arranged for a CHC patient to meet her hero, NASCAR race driver Jeff Gordon, and attend the Brickyard 400 at the Indianapolis Motor Speedway on July 29. We interviewed the patient and family; photos were taken at the Brickyard and will be used along with a full story in fall/winter Choices. Local ABC57 News aired a story about our patient's "final wish" prior to the race.

Provider Relations/ECF Marketing

- Lunch meeting with Executive Director of United Religious Community to pursue CHC membership. This will enable us to post our events on their website and newsletter, and will give us access to congregations for all religions, including Islam, Bahaii, Jewish. My immediate plan is to utilize this group to develop presentations to congregations throughout St. Joseph County. Pat Mitchell is appointing a representative from Spiritual Care at CHC to serve on the URC Board.
- All three account executives had a lunch meeting with Mary Jo Campbell, new Senior Navigator with SJRMC. Discussed partner possibilities and unique features of CHC. Mary Jo is a former Community Liaison for Heartland Hospice, a for-profit who opened an office here about a year ago.
- Terri sent handwritten notes to the eight physicians who completed the Sunburst Race, congratulating them on their event and on the example they set for their patients.
- Lunch meeting with new Director of Nursing (DON) and key staff at Milton Home. Included was CHC ECF Coordinator, Alice Wolff, RN in this meeting. DON had the opportunity to discuss her concerns and goals. CHC had the opportunity to explain our unique benefits. CHC participation at Milton Home has increased from 1 or 2 to 5-6 patients in recent months.
- Lunch for CNAs at Arborwood Assisted Living. This was at the request of their DON who expressed her appreciation for the recognition we gave her 25 CNAs.
- Lunch meeting with Dr. DelPilar and staff.
- Courtesy meeting at Healthwin. CHC was very cordially received by the DON and administrator. Learned that the reason for the recent drop in referrals is due to their building project. During construction they have lost the use of multiple rooms and so have not been accepting any long term patients. They are utilizing their beds for rehab / Medicare skilled.

- Met with regional director for Inwood Hills corporate ownership, who was covering while they looked for a new Wellness Director. She was very interested in our programs, especially Palliative Care Center as she has worked with the CHC Pres/CEO on palliative care projects while she was at IU Health. She will present the information to all their facilities in our service area.
- In-service lunch meeting with key members of administrative team at Kindred Hospital to review how CHC can be a resource for them. Covered Hospice House, specialty programs HeartWize and BreatheEasy. Information was very well received.
- Meeting with Beth Cloud, director of social workers at Cardinal Nursing Home and Rehab to discuss drop in referrals. Learned that there are no problems with CHC, but that the facility is focusing increasingly on residents with behavioral issues. Result is a younger demographic with fewer end-stage residents.
- Met with Sharon Zikowski-Jones, discharge planner director at SJRMC. Provided solar flower to each of the discharge planners at SJRMC, which were well received. Reminded them that the flowers represent how "hospice is about ***living***" – and these flowers are drought resistant.
- Secured a meeting with Chris Crawley, new Clinical Director at Michiana Hematology Oncology South Bend. She has replaced Melissa Collins. Meeting is scheduled August 7.
- Lunch meeting with Dr. Gatzimos of Unity Physicians. Had an especially good conversation with their nurse practitioner and nurses.
- Lunch meeting with Dr. Pearson and staff of River Park Family Physicians.
- Dr. Kolbe agreed to, and did write, a guest article for our physician newsletter, H&P, which will be distributed at the board meeting.
- Lunch with Memorial Home Care in their LaPorte offices.
- Successful face-to-face meeting with Jason and Karen, social workers at Catherine Kasper Home in Marshall County.
- One-on-one meeting with Jenna, RN at IU Health Starke County Cardiology.
- Quality visit with Michiana Hemotology Oncology, Plymouth office with their Nurse Navigator.
- Great meeting at Miller's Merry Manor in Culver with the Social Worker, DON, and Administrator.
- Quality visit with Pilgrim Manor's DON and Administrator.
- Met with Community Hospital of Bremen's DON and Administrator. Learned Scott Grabill is not renewing his contract as CEO.
- Face to face meeting at Bremen Health Care with the Administrator, Social Worker, DON, and ADON.
- One on one meeting at the Memorial Group in LaPorte with the Practice Manager of the I Street practice.
- Attended Miller's Assisted Living – Grab and Go fundraiser
- Met with the following Home Care agencies:
    1. Home Helpers
    2. Comfort Keepers
    3. Visiting Angels
    4. Back at Home Again
- Face to face meeting at Oak Wood Manor with the Administrator.
- Provided an In-service lunch with Dr. Dicky Bhagat and Internist in Goshen.

- Catered an In-service lunch with Cancer Care Center at Kosciusko Community Hospital.

Community Relations

Our Account Managers continue to connect throughout our service area via senior networking opportunities, chamber events and health fairs. Highlights include:

- Gerontology Consortium meeting at East Lake nursing facility
- Met with Elder Caring Attorney Doug German to discuss joint programs on "Consider the Conversation" DVD teaching tool.
- Lunch meeting with Senior 1 Care. Requested opportunity to present to employees. CHC will provide a hospice in-service as part of orientation of each new class of staff.
- Gerontology Consortium meeting at REAL Services
- Continuity of Care meeting in LaPorte
- Marshall County Older Adult Services meeting
- Culver Chamber of Commerce Dinner
- Plymouth Chamber of Commerce Ambassador Committee
- Marshall County Senior Expo Meeting
- Starke County Health Initiative Meeting
- Oak Wood Manor Open House – presenter
- Wintersong nursing facility Open House
- ACT Open House – Radio participation
- Attended Family Night at Arborwood Assisted Living
- Granger Community Church: Met with Dawn Livens to work out details for CHC's presentation to congregation's workshop in September. Supplied her with the workshop name and overview for promotion at Sunday services and at St. Joseph County Fair.
- Presentation at Topeka Community Center
- Red Hat Society of Starke/Marshall Counties
- Senior Expo Meeting
- Farmer's Market – Plymouth Chamber
- Senior Day at the Elkhart County Fair – TRIAD Booth x 2 Senior Days
- Met with owner of Compassionate Caregivers
- Sponsor Senior Bingo at Warsaw Senior Activity Center
- Warsaw Tigers Nutrition Site
- Met with Paul Eash Elder Law Attorney in Elkhart
- Met with Executive Director at Elkhart County Council on Aging regarding possible joint effort with them, EMS, and us on "Consider the Conversation" teaching tool.
- Lisa Zollinger was elected to the Elkhart County Council on Aging Board of Directors – elected to the executive committee
- TRIAD Board of Directors Meeting
- Greenleaf Advisory Board Meeting
- Met with Elkhart County Sheriff regarding involvement in TRIAD
- Kosciusko Continuity of Care Meeting
- Kosciusko Chamber of Commerce Health Care Committee Meeting
- Warsaw Senior Center Bingo Sponsor

- Syracuse Senior Center
- North Webster Senior Center
- Warsaw Tigers Real Services Site
- Salvation Army Real Services Site
- Staffed a green at the Elkhart Chamber of Commerce Golf Outing
- Church Blitz Continues (seven so far in Elkhart)

CHC SEES ITS WORST MEDICARE RATE CUT IN HISTORY BEGINNING 10/1/12

The Centers for Medicare and Medicaid Services (CMS) have published the FY2013 rates for all hospice programs, effective October 1, 2012, the first day of the 2013 federal fiscal year. Nationally, the overall average rates show an increase of 1.6% over FY2012, although this is somewhat overstated due to "hidden cut" calculations. The published calculation includes the following:

Final hospital marketbasket update for FY2013	2.6%
Less productivity adjustment	-0.7%
Less additional hospice-specific productivity adjustment	-0.3%
FY2013 rate increase	1.6%

These payment rates do not include the rate reduction due to the elimination of the Budget Neutrality Adjustment Factor (BNAF). The FY2013 BNAF rate adjustment is a multiplier to the wage index and is already included in the wage index and is invisible to providers. The hospice wage index for fiscal year FY2013 will continue the phase-out of the wage index BNAF, with an additional 15 percent BNAF reduction, for a total BNAF reduction through FY 2013 of 55 percent. The BNAF phase-out will continue with successive 15 percent reductions from FY 2014 through FY 2016.

The wage index multiplier is the same for all Core Based Statistical Areas (CBSA) and rural areas, but the wage index values for a given area change from year to year and that always impacts, either positively or negatively, the wage index and the applicable rates. The wage index value is based upon the Home Health Prospective Payment System current year 2012 wage index values with the BNAF reduction already applied.

Our new rates for 10/1/12 lead us into negative territory from where we are now in a key county we serve. We were hit hard in our St. Joseph County CBSA where about half our patients are located. While we have been getting cuts to our annual increases since 2009, rates came in below the current rates for the first time in our history. We have four different CBSAs throughout our eight county service area. Three of our eight counties (St. Joe, Elkhart, and LaPorte) have their own specific CBSA wage index multipliers which are used to calculate our rates. The other five counties use the

basic Indiana "rural rate" and corresponding index multiplier. Based upon where the patient resides – which county – represents what we bill Medicare. In all of St. Joseph County, the Routine Level of Care will drop $4.03 per patient day and the rates for the South Bend Hospice House inpatient level of care will drop $15.96 per patient day from where they are now. This is about a 2.6% cut. Elkhart will be bumped up ever so slightly by 0.63%, even less in LaPorte at 0.26% and all other rural counties will jump 2.35%, but these are always the lowest rates we have.

NEW RATES EFFECTIVE OCTOBER 1, 2012 PER PATIENT DAY

	St Joseph	Elkhart	LaPorte	IN - Rural
Routine (651)	150.10	149.88	149.37	140.63
Continuous Care (652)	875.99	874.70	871.75	820.73
Respite (655)	155.99	155.81	155.39	148.27
Inpatient (656)	668.70	667.78	665.68	629.46

CURRENT RATES PER PATIENT DAY

	St Joseph	Elkhart	LaPorte	IN - Rural
Routine (651)	154.12	148.93	148.99	137.39
Continuous Care (652)	899.51	869.23	869.53	801.88
Respite (655)	158.74	154.51	154.55	145.11
Inpatient (656)	684.66	663.15	663.37	615.33

Based on year-to-date 06/30/12 per diem days and payor case mix at our current reimbursement rates, we would project annual gross per diem revenue for 2012 to be $18,860,074. Under the new 2013 rates, we would project annual gross per diem revenue of $18,674,206. This would cause an annualized reduction in revenue of $185,868 if these rates were in effect this calendar year at our current census levels.

When the Super Committee failed to produce $1.2 trillion in savings for the federal budget earlier this year, the enforcement mechanism to reach savings, called sequestration, was automatically triggered by law. The sequestration includes automatic reductions split 50/50 between domestic and defense spending. The sequestration process protects Social Security, individual Medicare beneficiaries, and low-income programs from any cuts, but all Medicare providers – including hospices – will see an additional 2% reduction in their market basket updates starting on January 2, 2013. The current thinking is that Congress will try to undo these broad, across-the-board cuts after the November elections (during the 'lame duck' session), but it is by no means a certainty that hospice and other Medicare providers will be spared. If sequestration is factored into the FY2013 rates we would project annual gross per diem revenue of $18,423,580 at our current census and census mix levels. Even though Medicaid is protected in sequestration, Indiana is set up so that its Medicaid Hospice Benefit rates mirror the current rates of the Medicare Hospice Benefit at any given time. We cannot imagine Indiana leaving this alone and end up paying more than Medicare pays. Therefore, Medicaid is included in the upcoming number. Sequestration would cause an additional reduction of $250,062.66; giving us a total annual revenue reduction of $436,494.25 from current 2012 rates or a 2.31% percent loss of revenue.

NEW AND REVISED POLICIES FOR THIS MEETING

We have two updated patient care policies to be passed at this meeting. They are "Falls Prevention" and "Plan of Care" and are fairly self-explanatory. The falls policy is now part of our Quality Assessment Performance Improvement efforts and has been updated for that purpose. There is one minor change in the plan of care policy to indicate new regulations that the election of the hospice benefit and the admission visit into the hospice program are separate events.

There are two Human Resources manual policies. The no more Capri pants policy was met with instantaneous rile by staff. In the first hour after the email went out, the HR department was deluged with emails from staff. Many staff instantly went to their supervisor to complain. Staff made many good points like: when it comes to non-care staff that is never out in patient's homes or in facilities, why can't they wear Capri pants? So the policy was updated in this area to allow for individual supervisors to decide if their direct reports who wear Capri pants are appropriate in appearance for their position. The other policy is a result of the various government contractors available now to show up in our lobby for an audit and demand patient records, etc. We developed a policy for staff on what to do and what not to do if "The Feds are in the lobby." The content came from our attorney specializing in compliance issues. This was covered in draft form at our most recent staff meeting. A cheat sheet on this policy is also now posted at the reception stations at all five CHC offices.

MEDICARE COMPLIANCE COMMITTEE MINUTES

To allow the board to be informed of our ongoing efforts toward compliance with Medicare rules and regulations, we are including a copy of the minutes of our most recent internal Medicare Compliance Committee meeting.

HOSPICE HOUSE(S) UTILIZATION

For several years I have been expressing my concerns to staff related to CHC's utilization for the General Inpatient (GIP) Level of Care (LOC). The national average in 2010 was 2.9% among all Medicare certified hospice programs. CHC's percents were 2.2% in 2011, 2.1% in 2010, and 2.4% in 2009. In 2011, CHC had an Average Daily Census (ADC) of Medicare Hospice Benefit (HMB) patients of 305. Our ADC of GIP patients for that year was eight. To hit the national average we should have been at an ADC of nine every day of the year. When we consider that 80% of hospice providers do not have a Hospice House(s) of their own, the ADC number should have been even higher. Additionally, the percentage of CHC Hospice House days at the GIP LOC as a percentage of the total number of all Hospice House days has fallen from 84.8% in 2008 to 81.2% in 2011. Comparing calendar year numbers from 2008 to 2011 the overall numbers of HMB patients served increased 17% which – one would think – should have expanded the pool from which to draw more GIP days; not fewer. Additionally, overall Hospice House(s) occupancy was down 10% in 2011 compared to calendar year 2009 -- years when both Hospice Houses were fully operational throughout the calendar years.

Even when looking at the Top Five providers in Indiana for 2010 (most recent Medicare stats available) and comparing the percentage of GIP level of care days to all Hospice Medicare Benefit days, CHC had the lowest percentage even though it served the most patients.

RANK	Provider	Patients Served	% GIP DAYS
#1	CHC	1,538	1.8%
#2	I.U. Health (Indy)	1,024	6.4%
#3	St. Vincent (Indy)	960	8.7%
#4	Hospice of S.C. IN (Columbus)	952	3.6%
#5	Parkview (Ft. Wayne)	925	3.0%

This year I noticed the combined ADC for both our Hospice Houses was lower than that of 2011. I called a meeting for May 11 to discuss this with our key Medical and Clinical Staff and the Coordinators for both Hospice Houses to go over the data once again asking for thoughts and assistance in solving the problem. The meeting was called the "Win One for the GIP'er Meeting." While I wouldn't characterize the meeting as wildly successful, by way of reviewing the evidence, it may have had a positive effect as shown below.

CHC Hospice Houses Recent Combined Average Daily Census

	2011	2012
March	9.0	6.3
April	8.9	5.4
		(May 11, 2012 GIP Meeting Held)
May	7.8	9.9
June	7.4	8.1
July	8.0	9.6

Near the end of July we had ten consecutive days of being over ten patients per day and four days in a row of being full. Two of those days came in at an ADC of 15 patients per day and that's with just 14 beds. So far this month, through August 8th, the combined ADC is 10.5. An interdisciplinary patient care plan review meeting takes place on each HMB patient every 14 days. The team is now asking about the potential need for Hospice House at each meeting. Sometimes the barrier to a Hospice House admission lies with the patient and/or family. When patients and/or families decline using Hospice House, we are going to be installing a "photo tour" on each nurse's laptop so the patient and family can see how nice and pleasant our facilities are, in hopes of having them make a decision that everyone will benefit from. The latter was an idea from staff that came out of the May 11 meeting.

HOSPICE "PEPPER" REPORT COMING IN LATE AUGUST

CHC is expected to receive its first PEPPER Report in late August. The report is from TMF Health Quality Institute who is under contract with the Centers for Medicare & Medicaid Services to provide comparative data reports to various Medicare provider sectors and to Medicare Administrative Contractors/Fiscal Intermediaries in support of efforts to reduce Medicare fee-for-service improper payments. PEPPER stands for Program for Evaluating Payment Patterns

Electronic Report and is designed to show individual hospices how their live discharge rates and lengths of stay stack up when compared with other hospices in Indiana and nationwide. The Hospice PEPPER is a report that summarizes a hospice's Medicare claims data in areas that may be at risk for abuse or improper payment. Hospices with high billing patterns (at or above the national 80th percentile) are identified as "at risk" for improper Medicare payments and are encouraged to ensure that they are complying with Medicare payment policy, that services provided to beneficiaries are medically necessary and that medical record documentation supports the services that are billed. PEPPER cannot identify the presence of improper payments. Only an actual review of an individual beneficiary's medical record can determine whether services were medically necessary and appropriately billed. This PEPPER information is intended to generally tell us if we have a problem and where we might want to look to correct it. However, this report will not only be mailed to all hospices in the nation, but, as I understand it, individual hospice provider's data will also be shared with our fiscal intermediary. I find this to be the equivalent of the ultimate "sales lead" for the contractors wanting to know who to look to when wanting to recover Medicare payments from providers or put them on focused medical review.

NOTRE DAME MARKETING STUDENTS TO TAKE ON CHC FOR PROJECT

The marketing course at the Mendoza College of Business at the University of Notre Dame this Fall is called Competitive Growth Strategy. The course goal is to build a sustainable growth strategy with the following framework:

-- Contemporary strategy/business model frameworks
-- Growth strategy / business model development
-- Sustainability: building structure/process to remain customer-centered

Surveys of CEOs show that top- and bottom-line growth is a very top priority today. Yet, methods for identifying effective strategy to position for growth are often nebulous and inefficient, especially for smaller companies. Leaders often take an "inside-out" view in planning which has them focused on their own capabilities rather than real market need. Currently, to solve this problem companies either develop ad-hoc internal processes or hire management consultants to guide the development of growth strategy. The goal of this course is to increase the value of students in the job market by equipping them with skills in building growth strategy for prospective employers. In this course students will learn and apply an actionable framework for building growth strategy that applies to any organization: small, large, for-profit, non-profit. CHC has been chosen for one of the group projects. The core of the process is uncovering the broad landscape of growth opportunities for CHC and then zeroing in on deeply understanding the value sought by customers and breaking down that value (both known and unknown) into actionable parts. Frameworks for the course include the 3-Circle model, Osterwalder's (2010) business model generation, and Blank and Dorf's "Start-Up Owner's Manual." Students will build a growth strategy plan for CHC around a unique value proposition that leverages our key capabilities and corrects for existing points of non-value. The plans will also emphasize how to build a customer-centric perspective into the organization. Three students will participate in this team growth strategy project conducted for CHC, building a growth plan for CHC and offering real time guidance for our ever-growing agency.

STRATEGIC PLAN 2011-2015 UPDATE

The "theme" of the August board meeting is a strategic planning update. This will be the education portion at the end of the meeting. The five year plan is barely over a year and a half old, but we take time each September to review our progress. If there are any board members who have a particular interest in any of the activities and would like to assist in a strategic area, please let me know. With the upcoming Mishawaka Campus project and capital campaign, we do expect additional opportunities for board engagement and participation.

SUCCESSION PLANNING FRAMEWORK

In the 2011-2015 Strategic Plan there is a section regarding succession planning. It states:

Objective: Enhance Succession Planning

Strategy: Create a framework document to assist the Board of Directors in finding the next President/CEO.

Explanation and Expected Outcomes: A succession planning framework is important for all organizations. Few events in the life of a non-profit hospice program are as critical, visible, or stressful as when leaders transition unexpectedly. In the hospice world, transitions of long-term, non-profit leaders draw the attention of donors, employees, consumers and stakeholders, including leaders of other local non-profit agencies as well as other hospice programs across the country. Leadership transition is an integral process that begins long before the outgoing leader transitions their role. While CHC has a policy and structure in place to find a new President/CEO, it might be useful for the Board of Directors and its Search Committee to have a framework document on hand at the time to assist them with the search, particularly if a current President/CEO leaves abruptly due to resignation, termination, incapacitation, or death. This framework document would cover: demographic trends; the work of current CHC leadership; ideas for the creation of successful transitional capacity; an assessment of the current leadership profile; an age/retirement profile; identification of risks and goals; key leadership skills and expertise profile; key leadership cultural contributions; a leadership replacement profile; and a section on key factors to consider to insure organizational sustainability and growth. As CHC and the hospice industry changes, this framework could be updated bi-annually in perpetuity.

The succession planning document is included as an attachment to this report. Because our policy is that the Executive Committee becomes the Search Committee, they reviewed it last week. This is an internal tool only and needs no approval.

NATIONAL LEGISLATIVE UPDATE

Congress adjourned for the August recess last week, and will not return to Washington for six weeks. Hospice advocates, including CHC, continue to rally around legislation to help the hospice community navigate new challenges. The HELP Hospice Act (S. 722 / H.R. 3506) would (1) require the Secretary to establish a payment reform demonstration program to test and evaluate any prospective payment revisions to hospice before a new payment system was put into place, (2)

increase hospice survey frequency to every 3 years (some parts of the country are going 15 years or more between surveys; Indiana attempts to hit every six years), and (3) amend the new face-to-face encounter requirement to reflect operational realities for hospice programs, and the needs of the patients and families they serve. Passage of this legislation is a necessary first step to preserving access to hospice for future generations. The Senate sponsor is Sen. Ron Weyden (OR) and the House sponsor is Rep. Tom Reed (NY-29). So far, there are 17 co-sponsors in the Senate and 56 co-sponsors in the House. Sadly, despite our many efforts, including personal visits on the Hill, there are NO co-sponsors from Indiana in either the House or the Senate.

OUT AND ABOUT

I attended the board meetings of National Hospice and Palliative Care Organization, National Hospice Foundation, Hospice Action Network, and FHSSA in San Francisco, CA July 18-22.

I was delighted to be the opening speaker for the Indiana Hospice and Palliative Care Organization meeting in Indianapolis on June 14. It was the annual "Regulatory and Reimbursement" day and was also attended by Dave Haley and Donna Tieman. It provided the audience with an opportunity to learn first-hand about new regulatory changes which will become effective in the near future.

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

CHC Succession Planning Framework.

Copy of "Navigating the Winds of Change: A Strategic Plan 2011-2015"

Internal Medicare Compliance Committee minutes

Various South Bend Tribune articles and letters to the editor regarding the Mishawaka Campus Project.

Copy of CHC Pres/CEO's letter in support of the Veteran Administration's application for the 2013 "Circle of Life Award." This Award honors innovative programs in palliative and end-of-life care. Major sponsors of the 2013 awards are the American Hospital Association, the Catholic Health Association, NHPCO, and the National Hospice Foundation. The awards are cosponsored by The American Academy of Hospice and Palliative Medicine and the National Association of Social Workers, with additional support from the Hospice and Palliative Nurses Association. As an initiative of the current Strategic Plan, CHC will apply for the award sometime before 12/31/15.

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

July 2012 Financials including year-to-date information.

2011 Annual Report

Okuyamba Fest Celebrates World Hospice Day postcards.

Latest issue of the Hospice and Physician Team Newsletter for Summer 2012.

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be Wednesday, October 17, 2012 at 7:30 AM in Conference Room E in Suite 200. In the meantime, if you have any questions, concerns, suggestions or comments, please contact me directly at 574-243-3117 or email mmurray@centerforhospice.org .

# # #

Center for Hospice Care

Succession Planning Framework

August 2012

Purpose of Framework

This document is a framework containing information and suggestions which the board's Search Committee may want to consider when the time comes for the replacement of Center for Hospice Care's top leadership position. It has been customized (with permission) from a succession framework document at a national hospice organization. Additional content from a variety of other sources has also been added. It is not a step-by-step tool or a specific action plan. Times change and the leadership needs for Center for Hospice Care will also change. This framework is not directive or prescriptive. It is not intended to provide the answers, but rather assist with the questions the Search Committee may want to ask when faced with the circumstance of finding and appointing new leadership. This document is merely a tool to support the development of an assessment and decision-making process. There are no "correct answers" today for tomorrow's environment and needs.

Background

A succession planning framework is important for all organizations. Few events in the life of a non-profit agency are as critical, visible, or stressful as when the top leader transitions, particularly if it is unexpectedly. Transitions at high profile non-profits agencies like Center for Hospice Care draw the attention of current and future patients / caregivers, referral sources, employees, donors, the media, partner organizations within the local healthcare provider system, and other stakeholders including the CEOs of other hospice programs across the nation.

Leadership transition is an integral process. Considerations toward that process ideally should begin before the outgoing leader transitions their role. This framework document is meant to represent that proactive process. It has been developed to help facilitate a course of action when the time eventually comes. It is important that this document be updated from time to time.

Demographic Trends

Demographic and economic trends point toward leaner times for all U.S. healthcare providers and this includes hospice agencies. The U.S. population will continue to age and this includes the hospice industry workforce and its current leaders. Significant competition for top talent will continue to be the norm for all hospice organizations across the nation. At the same time, heightened competition for good talent makes general staff retention an additional concern for many hospice organizations. Hospices do not want to find themselves at risk for high turnover rates and lost organizational knowledge and experience. Historically, Center for Hospice Care has enjoyed comparatively low turnover rates across the board, particularly when compared to the general healthcare industry.

In the recent past, large, nationally recognized hospice organizations faced with the retirement or the sudden loss of strong leaders have simply recruited experienced leaders from other like-sized hospice programs. There continues to be an increasing importance for Center for Hospice Care to be prepared to make the investment to recruit nationally recognized talent if needed. But attracting talent from the competition is no longer the viable option it was at one time. Many experienced and nationally recognized hospice leaders who were in attendance at the birth of the industry have already retired and more and more are concluding their hospice careers. The pool of experienced hospice leaders with the capacity and experience needed to lead older, successful programs is shrinking quickly. Many of those who are currently viable candidates are ten years or less away from retirement and are not looking to "start over" in a new ten-year career. Still other experienced leaders – who began their careers as hospice clinicians (nurses, social workers, etc.) are leaving the industry altogether. Some are retiring earlier than expected because of the palatable distaste for what the industry has become (big business; ongoing additional scrutiny; more than 50% for-profit; large chain hospice programs, franchises, etc.). Additionally, many seasoned leaders are leaving due to an unwillingness to develop the needed business skills for managing today's hospice programs. After 30+ years hospice is not as "special" as it once was. It is no longer a "social movement" but a $12+ billion (2009) industry. The original desire from the formative launch in the late 1970s to become an accepted component of the U.S. healthcare system has succeeded spectacularly. This achievement has also brought with it all of problems and headaches experienced by every other provider across the healthcare continuum.

Whether top leadership is developed internally, or comes from within the industry, there clearly will always be a need to continue to develop talent.

Empirical evidence abounds that succession planning and management development can and do contribute to extraordinary business success. In their book ***Built to Last: Successful Habits of Visionary Companies***, Jim Collins and Jerry Porras identified 18 organizations that have led their industries for at least 50 to 100 years. They found that one of the key reasons such visionary organizations enjoy long-term success is because of their strong focus on succession process preparedness and leadership development. These companies develop, promote, and

carefully select managerial talent from inside the company to a much greater degree than comparison companies, ensuring leadership excellence and continuity.

James Citrin and Julie Daum, in an article for executive search firm Spencer Stuart write that every company wants to hire the best CEO. But many organizations fall victim to hiring a "second in command" as a potential future successor. "It sounds logical to pick a CEO-in-waiting who can learn the ropes of the job," they write. "The reality is that someone in this position begins their tenure as a subordinate without the ability to exercise personal initiative." They lack the credibility of a true insider or an outsider charged with driving change and tend to play it safe to hang on to the potential spot as chief executive.

Citrin and Daum also warn of four other common missteps during leadership selection: 1.) Using past failure to reject a candidate, 2.) assuming someone thinks like you do, 3.) failing to determine what kind of leader you're looking for, and 4.) rushing the process.

As stated earlier, there are no "correct answers" today for tomorrow's environment.

The Work of Leadership

It can be said that the ultimate goal of leaders is to work themselves out of their jobs. Effective leaders plan an exit that is as positive and graceful as their entrance. They come to the job committed to the mission and goals of the organization and to their personal goals. When those goals are realized, the transition to new leadership becomes a primary focus. An excellent successor becomes, literally, the ultimate leadership responsibility.

Succession planning is an ongoing process of systematically identifying, assessing, and developing talent to ensure leadership continuity. Succession planning does not exist in isolation. It must be interwoven with the agency's strategic objectives and should reflect the way the agency needs to evolve in order to achieve its strategic goals. This means that the kinds of leadership styles, skills, and behaviors desiring to be developed and promoted might be different in the future from those in the existing culture.

For example, at any large, older, and successful hospice program today, the current board and the current President/CEO must understand that the business situations facing current hospice leaders is very different from the one faced by previous generations. Current conditions consist of the rapid growth of emerging technologies, a demand for more public accountability, historically numerous and diverse scrutiny from a variety of payment recoupment investigators and audit contractors, ever changing and increasing regulatory pressures, heightened expectations by Center for Hospice Care stakeholders, growing competition in the marketplace, national healthcare reform and payment reform, the stewardship of sustainable growth and value, increasing philanthropic importance, and the changing roles of non-profit hospice programs as they focus on policy, education, program development, and return on investment.

Creating Successful Transitional Capacity

A key issue related to succession is the transfer of knowledge. A leadership transition often leads to the loss of critical tacit knowledge that has built up throughout the years. Strategies such as intentional documentation, attention to effective systems and processes, and deliberate knowledge sharing are just a beginning. Creating a so-called "knowledge-based culture" can deliver dividends when an organization is faced with succession of a leader.

Knowledge transfer should start with intention and a road map that outlines the possible high-gain areas on which to focus. Creating a knowledge-based culture within a hospice agency can streamline the duplication of effort needed to reconstruct existing knowledge, and more importantly, it can minimize the risk of critical agency knowledge residing in the heads of only a few staff members.

When the time comes, a successful succession process will map the landscape, prepare for contingencies, and minimize disputes. Simultaneously, Center for Hospice Care will need to enable an orderly transition, ensure continuity, and build a continuing legacy of successful outcomes.

Center for Hospice Care Current Administration Profile

Assess Current Administrative Team Profile

Center for Hospice Care has been fortunate to have a relatively long-tenured leadership team. Over the last few years, the evolving organizational structure of the Administrative Team has created leadership positions that broaden and deepen our capacity. The Administrative Team currently consists of six individuals, four of which report directly to the President/CEO. With lively debate tempered by mutual respect, the team works collaboratively and usually reaches consensus. The Center for Hospice Care Administrative Team approach has been taken directly from the hospice model of care. The agency is the “patient” and the Administrative Team takes an “interdisciplinary team” approach to its care. The team clearly understands being the number one hospice program in the market is extensively more difficult than being number three. There is also an appreciation of the fact that our biggest challenge is our success. In order to stay number one, the Administrative Team begins by always being dissatisfied with everything “as it is now.” The team dreams of what could be and then plans the approaches on getting there within a culture of shared ownership.

Assess Current Administrative Team Tenure:

Mark Murray – President/CEO -- 22 Years with CHC – Additional experience in national, regional, and state level hospice and palliative care leadership, and previous experience in corporate communications, radio/television, advertising and marketing.

David Haley – Vice President/ COO -- 6 Years with CHC – Previous experience in hospital administration, managed care products, HMOs, PPOs, and Physician Health Organizations.

Karl Holderman – CFO -- 16 Years with CHC – Previous experience as Controller with local automotive industry, software business, and U.S. Army audit.

Mike Wargo -- VP/COO Hospice Foundation – 4 years with CHC – Previous experience with a wide variety of positions including banking, human resources, insurance, recruiting, and retail.

Donna Tieman – Director of Nursing -- 6 years with CHC – Previous experience as Director of acute care emergency department along with hospice nursing field experience.

Amy Tribbett – Director of Marketing and Access -- 4 years with CHC – Previous experience in hospital marketing, various industry specific marketing, and advertising / public relations agency work.

Administrative Team Average CHC Tenure = 10 years

Assess Administrative Team Age/Retirement Profile

Administrative Team Average Age = 55

Retirement Estimation: Two members in less than 10 years. All others, over 10 years

Identification of Current Administrative Team Risks/Goals

- Organizational Systems/Knowledge Base – Administration's goal is to have systems documented, knowledge base documented, and access to information available to all members of the Administrative Team. Knowledge of the industry, the business model, challenges and opportunities are regularly shared with all staff across the board at bi-monthly staff meetings.

- Leadership Transitions – We are fortunate to have long-tenured leaders with strong relationships to Center for Hospice Care. When transitions have occurred on the Administrative Team, from a skills and experience standpoint, we have and will continue to take these events as opportunities for growth and to deepen the bench.

- Relationships – Members of the Administrative Team has valued organizational relationships with key local institutions and designated national institutions and their leaders, local and federal government leaders, policy-makers at the state and federal level – many of which are directly related to end-of-life care. It is the Administrative Team's goal to continue to assess these relationships and strengthen and broaden them so we have "multiple" and/or "tiered" relationships.

Key Administrative Team Skills

- Organization Skills and Ability to Multi-task
- Consensus Building
- Internal/External Communications
- Strategic Communications
- Creativity/Program Development
- Opportunity Assessment
- Development/Advancement of Relationships with Key Leaders – External/Internal
- Staff Capacity Building
- Creative Thinking
- Listening
- Facilitate Discussion
- Evaluate (Offer) Multiple Perspectives
- Skill to "read" Situations and Fashion Strong Arguments on Both Sides to Frame Issues
- Knowledge of Governmental (regulatory, legislative, administrative, policy) Processes
- Ability to Develop and Implement Strategic and Tactical Initiatives

Key Administrative Team Expertise

- Operational Management
- Not- for-Profit Management
- Hospice/Palliative Care Expertise
- End-of-Life Care Disease Specific Experience
- Consumer Engagement/Outreach
- Finance

- Charitable Fund Development
- International Expertise
- Strategic Planning
- Legislative Process
- Strategy Development/Strategic Implementation

Key Administrative Team Culture Contributions

- Staff Communications, Relationships
- Sharing with Staff How "The Business" Works
- Insuring All Staff Are Regularly Updated on Current Agency Status
- Consensus Building
- Building Board Relationships
- Building Trust -- internally/externally
- Strong Commitment to Service
- Living/Promoting Organizational Values
- Mentorship/Development of Staff
- Fostering Culture of Philanthropy – internally/externally
- Fostering Inclusiveness
- Fostering Culture of being a Learning Organization
- Fairness

Leadership Replacement Profile

- Individuals with non-profit Finance & Operations experience; who understand the relationship between management and the Board; who can multi-task and can build trust and consensus.
- Individuals with strong management and leadership skills with ability to communicate and work well with people at all levels.

- Individuals having an in-depth understanding of hospice/palliative care and outstanding communication skills.
- Individuals with knowledge, skills, and abilities committed to the mission and vision of the organization with perspectives on patients / caregivers served, consumer needs, and the ability to develop and sustain relationships.
- Individuals with initiative, good judgment, and the ability to make decisions in a timely fashion.
- Individuals with a strong work ethic; achievement-oriented; motivated beyond personal interests.
- Individuals with maturity, flexibility, and successful fundraising expertise.
- Individuals with internal/external knowledge and skills to advance strategic initiatives and evaluate opportunities, with quick responsiveness.
- Individuals who are highly engaged, energetic, focused, and execution-oriented.
- Individuals with strong business acumen, intelligence, and capacity; able to think strategically and implement tactically.
- Individuals with an open leadership style who actively seek out and support collaborative thinking and problem solving and who do not view such dialogue around decisions as a personal attack on abilities.
- Individuals with strategic vision and thinking skills, and the ability to position the organization for the future by looking beyond the present situation to conceptualize key trends and identify changing market demands.

Ensuring Sustainability and Growth

Administration's goal is to continue to strengthen the organizational capacity, sustain ongoing growth of patients served, develop programs and services to support our community, and to continue to serve in a national and international leadership role to advance quality, comprehensive end-of-life care.

Administration's goal is to make succession planning a more integrated component of our ongoing work, recognizing the importance of having a broader and deeper "bench" to sustain the work of the organization, from a knowledge base and system acumen perspective as well as a relationship development position.

Administration's goal is to continue to invest in leadership development, staff development and staff evaluations that provide team members with the opportunity to advance skills and abilities

for promotional opportunities. We are also committed to ongoing internal evaluation of return on investment, staff performance outcomes, and ways to enhance productivity and efficiency. Program evaluation will also be completed to be sure current programs are relevant to the needs of our community while seeking alternatives or elimination of program services where appropriate. We also continue to review our competition. Center for Hospice Care is dedicated to continuing to be a technology-based organization – not technology for technology sake, but for efficiency and effectiveness.

Attracting Leadership Candidates

Should Center for Hospice Care have a vacancy within the organization's Administrative Team, we would, as we have in the past, review opportunities that come with any position change, determine the needs to continue to advance the work of the organization, and recruit internally and externally. For non-CEO Administrative Team position openings, depending upon the position, we would anticipate a potential need to engage a recruitment firm to assist with the search process. Recruitment would likely first focus on hospice and palliative care and/or health care leaders with previous or similar experience in the open position.

Internal Leadership Development

The staffing responsibility for the Board of Directors lies solely with one employee – the President/CEO. However, the board should be aware that Center for Hospice Care has invested in professional development for a majority of staff, with specific programs designed to increase leadership capacity throughout the organization. We have a strong history of promotions within the organization, as well as recruiting staff members who may have left the organization to gain growth and experience, and returned when leadership roles became available.

While we currently have not identified the next generation of Administrative Team leaders for the organization from within our existing staff, we will continue to evaluate and invest in staff that are identified for future leadership roles. We also expect to continue our investment in professional development, and developing career ladder opportunities for staff where possible.

Sudden/Unexpected Loss of President/CEO

Should there be a sudden/unexpected loss of the President/CEO, our goal would be for the organization to continue to operate without interruption while staffing evaluation, planning and recruitment occurs.

The sudden and unexpected loss of a President/CEO has the potential to throw the best-performing corporations into a tailspin if emergency succession process is not enacted. An emergency succession process should include: (1) the immediate appointment of an interim President/CEO by the board of directors, (2) communicating with key stakeholders, and (3)

rapidly initiating a search for a new President/CEO once roles, skills, and goals are outlined by the Search Committee. A rapid transition to interim leadership is critical to avoid a vacuum in a key leadership position.

It's also essential that we communicate to key stakeholders that existing staff capacity has the skills and abilities needed to continue the work of Center for Hospice Care. Throughout the past several years we have been focusing on internal communications, expanding the organizational knowledge base with access to information being available to the Administrative Team, and deepening our bench strength in all key positions when opportunities arise. Center for Hospice Care is perfectly capable of operating for some time under an interim President/CEO.

Specific Plans for President/CEO Sudden/Unexpected Change

While the President/CEO has the key role in managing transition of the Administrative Team members, the Center for Hospice Care's Board of Directors, and specifically its Executive Committee, has the key role in managing and leading a transition of the CEO. The overall current policy process is as follows:

If the President resigns, dies, is terminated by the board, or the board does not renew his/her contract, the Executive Committee must immediately appoint an interim President/CEO. If the President/CEO dies while employed by Center for Hospice Care, the corporation will be the beneficiary of a $500,000 life insurance policy. These funds are intended to provide for expenses related to a national and local replacement search, potentially needed consulting services, potential legal services, potential outside interim leadership, and any other expenses related to the replacement of the President/CEO. This life insurance policy has been in place since 1998 and the amount was increased in 2003. To allow the Search Committee to concentrate on the search and not worry about expenses, the board chair at that time suggested the half million amount for this reason and also to, "…allow for one mistake." Under current policy, the Executive Committee acts as the Search Committee for replacing the President/CEO and the entire search process is under the direction of the Executive Committee. The Search Committee will review potential candidates and make a selection. The Executive Committee shall inform the board of its final candidate selection and make a recommendation to the full Board that the candidate be hired. If the Board approves the selection, the candidate shall be hired and the new President/CEO assumes office.

Within the process above, once an individual and/or team have been identified to serve as an "interim" leader for the organization and a communications plan is in place, the next steps may involve planned Search Committee discussions around two questions:

No. 1: What does our next CEO look like?

The first effort a Search Committee may undertake is to work together to develop an image of what the next President/CEO needs to be. In doing so, the Search Committee has to evaluate

myriad factors -- the organization's strategic plan and positioning, the state of the field, economic variables and so on. Even if the current President/CEO – whomever that may be at any point in time -- with his/her skills and abilities, is winning the game today, it isn't necessarily the case that those same skills will win the game tomorrow. This is sometimes difficult for Search Committees to recognize, particularly if the current/former CEO had produced strong past results.

Once the Search Committee develops an understanding of where the organization needs to go and what challenges will be encountered along the way, a clearer picture of the sort of President/CEO required will emerge. Just as the organization may have several potential futures, the Search Committee may want to identify several potential future leaders. Additionally, a detailed skills and experience profile will allow candidates to be assessed against the needs of the organization, rather than simply against one another, which can help reduce the appearance of a horse race.

No. 2: Where is our next CEO now? And where are two more?

Overwhelming advice for Search Committees from search experts is to be several candidates deep when it comes to succession decision-making. Though there are no specific recommendations on how many candidates a Search Committee may consider during its process, it is certainly possible they may choose to select several internal applicants for candidate status. To be sure, there are risks to this strategy. When the succession event ultimately occurs, candidates not selected may feel jilted and depart for opportunities elsewhere. Or if strong contenders stay behind, the new CEO (coming to the role either externally or internally) may worry that someone is waiting in the wings to take his or her spot at the first stumble. These risks are real and, as such, must be managed. However, it is clear that these risks are not nearly as threatening to a non-profit corporation as a Search Committee's inability to provide its own great leadership.

Quite often, internal candidates face some common challenges in demonstrating their potential as leaders. First, for completely legitimate and appropriate reasons, they rarely have the sort of relationship with the board as the current/former President/CEO has/had. And current board members often forget how the current/former President/CEO looked on his/her first day on the job. In many instances for long tenured President/CEOs, most or all of board were not present at that time and have no knowledge or memory of how much the current/former President/CEO grew in his/her position over the years. Thus, such comparisons are not fair. Internal candidates can suffer from that unfairness.

Another challenge faced by internal successors is the presumption that somehow external candidates are more exciting. The overriding goal of succession planning is the reduction of risk. It almost always makes sense to look outside for potential leaders, but sometimes Search Committees may mismanage this process. One mistake is failing to shut down the outside

process at the right time when there's a strong internal candidate. That can lead to the board losing its internal candidate to another company as he or she tires of waiting for the external market to be screened. Or an internal successor may ultimately be chosen but be left feeling he or she was settled on only after the external search was exhausted. That isn't a great vote of confidence for a fledgling President/CEO.

Another common Search Committee error pointed out by Citrin and Daum is mistaking charisma for skill. "Personal charm is an attribute, like eye color or left-handedness," they write. "It can be a useful tool in navigating interpersonal relationships but is nowhere near as important as performance in critical parts of the job." In the preface to his book, ***Searching for a Corporate Savior: the Irrational Quest for Charismatic CEOs***, Harvard Business School professor Rakesh Khurana says that troubled companies seeking new CEOs are especially vulnerable to the charisma trap. "Boards of directors bent on finding a corporate messiah are not much interested in ordinary qualifications (for example, knowledge of their company or relevant industry or functional background). Rather, the kind of candidate qualified for the role of corporate savior is one who is thought to possess 'charisma.'"

These final points, like all non policy aspects of this document, are not intended to be prescriptive or directive, but only to offer potential items for consideration and discussion during the succession process.

Recommended Search Firms with Specific Hospice Industry Experience Following an Unexpected President/CEO Transition

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Center for Hospice Care
Hospice Foundation

"Navigating the Winds of Change"

A Strategic Plan

2011 - 2015

Center for Hospice Care
Hospice Foundation

STRATEGIC PLAN

2011 - 2015

What is Hospice and Palliative Care?

Considered to be the model for quality and compassionate care for people facing a life-limiting illness, hospice and palliative care involve a team-oriented approach to medical care, pain management, and emotional and spiritual support expressly designed to meet the patient's needs and wishes. Support is also provided to the patient's loved ones. At the heart of hospice and palliative care is the belief that each of us has the right to a self-directed, pain free, dignified end-of-life experience, and that our loved ones will receive the necessary support during this time.

Hospice focuses on caring, not curing and, in most cases, care is provided in the patient's home. Hospice care also is provided in freestanding hospice centers, hospitals, licensed nursing homes and other long-term care facilities. Hospice services are available to everyone of any age, religion, race, or illness. Hospice care is covered under Medicare, Medicaid, most private insurance plans, HMOs, PPOs and other managed care organizations.

Palliative care extends the principles of hospice care to a broader population that could benefit from receiving this type of care earlier in their illness or disease process. No specific therapy is excluded from consideration. An individual's needs are continually assessed and treatment options explored and evaluated in the context of the individual's values and symptoms. Palliative care, ideally, would segue into hospice care as the illness progresses.

What is the mission of Center for Hospice Care?

Our mission is, "To improve the quality of living."

What is the vision statement of Center for Hospice Care?

Our vision statement is, "To be the premiere hospice and palliative care organization for all end-of-life issues."

What are the core values of Center for Hospice Care?

Our seven core values in alphabetical order, each with equal importance, are:

Compassion
Dignity
Integrity
Innovation

Quality
Service
Stewardship

What is the History/Timeline of Center for Hospice Care?

1978 -- Our hospice was incorporated as an independent not-for-profit organization called Hospice of St. Joseph County, Inc.

January 1980 -- Our hospice began serving patients under a home health license and was also certified which allowed for third-party reimbursement, but only for the traditional home care services the agency provided. The first year we served 27 patients out of the Angela Building on the campus of what was then called St. Joseph's Hospital. By September 1980, expenses for the agency were $3,000 per month.

Early 1980s -- The office moved to a residential house on Cedar Street near St. Joseph's Medical Center. Patient care milestones included serving over 100 patients during 1983.

1985 -- After operating for several years with revenue coming only from donations, direct patient charges (approved in 1983), and from third-party payors, our hospice applied for and received certification to operate under the relatively new Hospice Medicare Benefit. Over 200 patients were served in 1988.

Early 1990s -- The office moved into the basement of the JMS building in downtown South Bend. Revenue climbed over the $1 million mark for the first time in 1991. We served over 300 patients in 1992 and 400 patients in 1993.

October 1995 -- Our hospice was invited by several medical communities to serve Marshall, Fulton and Starke counties. Marshall County Hospice, our first satellite office, opened in Plymouth during November 1995. Revenue climbed to over $2 million for the first time in 1995.

Late 1995 -- We embarked on our first-ever capital campaign to build the area's only Medicare certified hospice inpatient unit, to establish and own new corporate offices, and to start a small endowment. When the campaign was completed five years later, it had raised $2.1 million.

1995-96 -- Due in part to our expansion into other counties, along with Medicare allowing hospices to see patients in skilled nursing homes, the number of patients served increased from 466 in 1995 to 636 in 1996.

June 1996 -- The offices moved from a rented downtown office in South Bend to a renovated facility purchased along Juday Creek in Roseland just off SR 933 and immediately south of the Toll Road.

September 1996 -- Hospice House opened and today is still north central Indiana's only Medicare certified hospice inpatient unit. Today, over 280 patients call Hospice House a home each year.

June 1997 -- Growth continued and we received official permission from Medicare to serve a total of six counties – St. Joseph, Marshall, Fulton, Starke, Elkhart, and LaPorte. In 1997, the Hospice annual budget broke the $3 million mark and the number of patients served went over 700 for the first time.

1999 -- Our corporate name was changed from Hospice of St. Joseph County, Inc. to The Center for Hospice and Palliative Care, Inc. Individual offices kept their original names, but were owned entities of the larger, independent, not-for-profit corporation. In 1999 the Hospice annual budget broke the $4 million mark for the first time.

September 2000 -- Based in-part upon a feasibility study by University of Notre Dame MBA students, our board resolves to open our second satellite office in Elkhart by May of 2001. During 2000, the number of patients served went over the 800 mark for the first time.

May 2001 -- Hospice of Elkhart County opened and began to serve patients. Hospice's annual budget broke the $5 million mark for the first time during 2001 and the number of patients served went over 900.

2002 -- The Hospice annual budget broke the $7 million mark for the first time.

2003 -- Permission was received from the Centers for Medicare and Medicaid Services and the Indiana State Department of Health to add Kosciusko County to the service area, bringing to seven the number of counties served by The Center for Hospice and Palliative Care, Inc. For the first time more than 1,000 patients had been served during a single calendar year.

December 2004 – The Board approves the corporation's first-ever three-year Strategic Plan called, "Capitalizing on Success: Taking Opportunities to the Next Level." Revenues for the year topped more than $9 million. For consistency and to alleviate confusion, all care offices began to be referred to under the single corporate name.

2005 – The silver anniversary year of caring for patients saw a 25% increase in patients served, due in part to the assumption of the former hospice program operated by Elkhart General Hospital. Permissions were received to add LaGrange County to the service area. The Life Transition Center, a community bereavement facility, opened in Mishawaka. The agency won the Leighton Award for Nonprofit Excellence. The agency published a 270 page hardcover fine arts book. Fundraising / Development income broke the $1 million mark for the first time.

2006 – The number of paid staff hit the 175 mark. The annual agency budget topped $12 million for the first time. More than 1,400 patients were cared for during the calendar year. CHAPC completed its first Strategic Plan. Assets topped the $17 million mark for the first time. Since 01/01/80 through 12/31/06, CHAPC has cared for 14,160 patients and 54% of all the patients served by CHAPC over the course of 26 years have been seen in just the last seven years alone.

2007 -- On a national comparative level, looking at annualized numbers of patients served, CHAPC entered the top 5% of all hospice programs in America. Our first disease specific specialty program, "HeartWize," began. For heart disease patients, the goal of HeartWize is to improve the quality of the patient's life and decrease or eliminate emergency-room visits and hospitalizations. To bring a strong and single focus to our fundraising and development efforts, CHAPC created a second and separate charitable corporation called, The Foundation for the Center for Hospice and Palliative Care, Inc. Additional office space was needed and several staff moved to the Administrative / Foundation offices in Edison Lakes.

2008 -- CHAPC was proud to become a partner hospice with the Foundation for Hospices in Sub Saharan Africa (FHSSA). While most American programs receive an individual African hospice program as a partner, FHSSA matched CHAPC with an entire country. Our partner is the Palliative Care Association of Uganda (PCAU) and two staff visited PCAU. The culmination of more than three years of planning and development produced a new facility – the freestanding Elkhart business office and Hospice House sitting on 11 beautifully wooded acres purchased by donors and then deeded to CHAPC.

2009 – Rose Kiwanuka, national coordinator for PCAU, visited our program and made presentations to staff and volunteers at all offices as well as to students at IUSB and the University of Notre Dame. Independent marketing research was conducted which showed our agency had little name recognition and our logo was recognized by only 5% of the public. Upon the advisement of our new marketing firm, our name was shortened to Center for Hospice Care and new logo debuted.

2010 -- The Palliative Care Center, intended for palliative care consultations, became operational to offer non-CHC patients and families an opportunity to talk about priorities regarding care. These consultations include palliative medicine treatment plans and provide information on all end-of-life care options and choices. In conjunction with a new media campaign, the Beacon newsletter became CHOICES and a new publication, Crossroads, began to be published by our Hospice Foundation. A new point of care electronic medical record and billing software suite by Cerner corporation was implemented. CHC was chosen as the exclusive provider in its service area for chronic care case management by the Indiana Comprehensive Health Insurance Association. The Greater Elkhart Chamber named CHC the recipient of its 2010 Not-for-Profit of the Year Award.

Introduction

Since its humble beginnings in the U.S. 37 years ago, the hospice industry has changed considerably. From one hospice in 1974 to more than 5,000 in 2009 the number of Americans receiving hospice care has also increased – from reaching the milestone of 100,000 patients in a single year in 1984 to 1.56 million during 2009. Since 2000, the number of for-profit hospice agencies in the United States has more than doubled. In 2000, there were 725 for-profit hospices, and in 2007 that number had risen to 1,660. During that same period, the number of

non-profit hospice programs has held steady at about 1,200 providers. In the last three years we have seen a sizable increase in federal regulations, increased risk for various audits, additional expenses to comply and insure compliance, and all of this with no increase in reimbursement rates to perform these expensive new activities. Instead, we have received the opposite: Medicare reimbursement cuts. This, even though independent studies from renowned institutions like a 2007 study by Duke University that showed the federal government actually saves over $2,309 per hospice patient compared to patients on regular Medicare. Intuitively, one would think the federal government would want to expand hospice care and not do whatever it can in an attempt to scale it back. From a regulatory standpoint, the Centers for Medicare and Medicaid Services' (CMS) ongoing required data collection exercises have grown immeasurably. We are now required to count every visit by an RN, Social Worker, Hospice Aide, and hospice physician and report this information on a weekly basis on a Sunday thru Saturday schedule and publish this on every reimbursement claim submitted each individual patient. Overhead costs associated with this data collection are not reimbursable. And unlike every other Medicare provider in the U.S. healthcare system, hospices are required to submit claims in sequential order. Meaning, if in March a patient claim submitted back in January was found to be in error, all of the reimbursement going back to January would need to be returned to Medicare, the January claim corrected and then re-submitted along with all of the other claims through March. Such a system proves troublesome for small hospice programs with razor thin cash flow needs. We now have an excess of auditors that can take back our reimbursement long after the fact. Along with the fiscal intermediaries known as the Medicare Administrative Contractors (MAC's), some of the newer threats include: Comprehensive Error Rate Testing (CERT) which reviews medical records and claims for compliance with Medicare coverage, coding, and billing rules; Recovery Audit Contractors (RAC's) that are allowed to audit whatever they choose and keep a percentage of what they believe were improper payments; Medicaid Integrity Contractors (MIC's) who are primarily concerned with questions of eligibility; and Zone Program Integrity Contractors (ZPIC's), which are currently active in 17 states, and are the most serious of the audits looking at payment errors, high volume, high costs, and extrapolating a sample of errors to the entire universe of claims requiring payback on claims that were not actually examined due to the sampling methodology. The Office of Inspector General (OIG) is looking at payments for medications related to the terminal illness and whether Part D Medicare was inappropriately charged, Hospice Physician billing and coding issues, drugs covered by Medicaid that should have been paid for by the hospice, eligibility issues, and hospice care in the nursing home which has always been ripe for fraud, abuse, and inducement payments and services in exchange for referrals.

Managing hospice is more challenging than ever and these provocations will only escalate in the near term. There is more attention than ever to end of life care – like the unfortunate and misguided "death panels" discussions -- more pressure on hospice providers, new requirements like the un-reimbursable Face-to-Face hospice physician visits for patients who are entering a certification period past 180 days, more review of claims and eligibility, payment cuts via the elimination of the Budget Neutrality Adjustment Factor which began in 2009 and will continue for seven years, and the upcoming productivity cuts under Healthcare Reform to start in October of 2012. When added together these payment cuts will eventually yield a combined 14.3% decrease in reimbursement by October 2019. The Medicare Payment Advisory Commission (MedPAC), which advises Congress on issues of Medicare reimbursement and quality, also

wants to completely overhaul how hospices are paid by 2014. There are no concrete plans yet on what that will look like. Many small hospices will simply go out of business or be sold to larger providers due to the physician face-to-face visit requirements alone.

Hospice in America has entered a somber era of alteration. This document is intended to assist CHC navigate the winds of change over the next five years.

What are the organizational directives and goals for Center for Hospice Care during the period 2011 – 2015?

Our goals during this 180-month period can be broken down into four main areas. They are:

A. Enhance Patient Care

B. Position for Future Growth

C. Maintain Economic Strength

D. Continue Building Brand Identification

Each of these four overall goals has a set of objectives to be realized between 2011 and 2015. Each objective contains one or more thoughtful strategies needed to reach the objective. Appropriate implementation of the strategies should allow for the objectives to be attained. Additionally, each strategy is followed by a brief explanation and narrative of expected outcomes. The manner in which expected outcomes are produced may be used for measurement purposes regarding how well the objectives are realized. This may indicate how well the strategy is/was implemented, and ultimately, how well the four overall goals were achieved.

GOAL A. Enhance Patient Care

1.) ***Objective: Promote confidence of care***

Strategy: Implement 24 / 7 LIVE telephone answer with a CHC nurse. No more answering service.

Explanation and Expected Outcomes: After hours, when a patient or family calls, it is frequently a crises situation. Currently, after hours calls are answered by the answering service and they take a message. The answering service then calls the nurse on call and presents the message. The nurse on call then returns the call to the patient / family. This process can sometimes take up to ten minutes. CHC should eliminate the answering service and have a CHC staff RN on hand at a CHC office, logged into the Cerner system to answer and triage all after hours calls by

picking up the phone on the first few rings. During a terminal illness, time is a precious commodity and CHC should do everything it can to meet the needs of its patients and families as expeditiously as possible. Not only do we believe this will enhance patient care, we also believe this will be a good market differentiator for us and will be appreciated by the greater medical community and our referral sources. Currently patient after hours calls to our competitors are answered by services located in other states.

2.) ***Objective: Expand programming for children***

Strategy: Enhance marketing efforts for pediatric palliative care services

Explanation and Expected Outcomes: CHC has always provided care for children and has never had minimum age limits in place for admission to our programs. Over the years, the numbers of children in our care has slowly increased. While a terminal diagnosis is extraordinarily difficult for many parents to accept, one positive component of Healthcare Reform may help to mitigate such decisions. Effective upon enactment – March 23, 2010 -- children in the United States enrolled in Medicaid and CHIP (Children's Medicaid) may elect the hospice Medicaid benefit and also receive curative treatments at the same time. The implementation of this new provision is important for children and their families seeking a blended package of curative and palliative services. We believe it will increase utilization of hospice services since parents and children will no longer be required to forego curative treatment in order to gain hospice and palliative care. CMS published the state Medicaid Director Letter providing direction to the state Medicaid agencies to implement this program in 2010. Due to widely publicized funding issues for states and Healthcare Reform, most states are not there yet, but when Indiana comes around, CHC should be ready.

Strategy: Add Perinatal Programming

Explanation and Expected Outcomes: To be a true provider along the continuum of care, CHC should consider adding perinatal services. These services are offered to expectant parents whose baby is diagnosed with a life-threatening condition before birth. The perinatal program would help the expectant parents and families prepare for and cope with physical, emotional and spiritual issues through support and education at the time of diagnosis through the remainder of the pregnancy. Services could include:

- Admission evaluation in the hospital, doctor's office or at home
- Development of a birthing plan that honors parents' wishes, through coordination with physicians/labor & delivery staff
- Assist in creating special keepsakes and treasures prior to and after the baby's birth
- Links to primary physicians, clinics, specialty disciplines, community services and financial assistance programs
- 24-hour, 7 day a week on-call availability by a registered nurse

- Guidance for siblings and other children in the family
- Physician consultation for palliative (comfort) care and symptom control in the hospital and home
- Links to resources that help families cope during the pregnancy and after the birth of the baby

Additionally, our special connection to professional grief counselors at the Life Transition Center will allow our perinatal program to provide guidance to help parents cope with the serious illness of their baby. We will honor cultural rituals and spiritual beliefs at birth and end-of-life, preserve dignity, help plan final arrangements, memorial services and precious good-bye's at the hospital or at home, as appropriate, as well as provide bereavement counseling to parents and siblings

3.) ***Objective: Create a culture of innovation to foster memorable first impressions***

Strategy: Create innovative, remarkable, memorable, "tell your friends about it" experiences

Explanation and Expected Outcomes: CHC has just one chance to make a good first impression and it's almost impossible ever to change it. We will Involve CHC staff in the creation of innovative, remarkable, memorable experiences to delight the senses for: the First Day of Patient Care, the First Day of Patient Care with children present, the First Day of Employment with CHC, the First Day of Volunteering, the First Contact from a new Referral Source, etc.

4.) ***Objective*****:** ***Avoid Indiana State Department of Health surveys / inspections***

Strategy: Become accredited with a "deemed status" approved accrediting body.

Explanation and Expected Outcomes: With CMS and individual states clearly desiring to exit the survey business, CHC should become accredited by a deemed status organization to avoid state surveys. Community Health Accreditation Program (CHAP) and Accreditation Commission for Health Care (ACHC) are two organizations CHC should consider. ACHC is the only national health care accrediting organization started at the grass-roots level by a few home care providers endeavoring to create a viable option of accreditation sensitive to the needs of small providers. The model was to "ensure a voice for providers". The inception began in 1985 in Raleigh, NC through the efforts of members of the state home care association and a few representatives from four divisions of state government. Incorporation was accomplished in August of 1986, with the first accredited organization being awarded a certificate in January of 1987. ACHC began offering services nationally in 1996. CHAP accreditation is a process. The process includes access to and adherence with a set of quality and performance standards geared to drive performance above the minimum standard. For organizations seeking to excel, the external standards and on-site validation and consultation by industry experts provides exceptional value. CHAP's broadly structured national Standards of Excellence provide insight

into best practices for quality and performance. Not described as an operations manual, CHAP standards provide a much broader set of guidance about the structures and processes that lead to quality outcomes. Standards reflect a broad overview of requirements fundamental to the sound operation of any community based organization, and they partner with CHAP's series of service line specific Standards of Excellence to provide a complete foundation for quality practice. Structured to support a myriad of business structures, CHAP's standards provide guidance and support to all community based provider organizations from start-ups to seasoned national firms, to owner operated single or multi-location, and single or multi-service line organizations.

5.) ***Objective: Involve caregivers in CHC programming well before it is needed.***

Strategy: Create a Caregiver Training Center

Explanation and Expected Outcomes: (2009 CBS News Report) —About one in three adults in the United States cares for a loved one who is elderly, sick, or has special needs. "Old Age, Alzheimer's Major Reason for Care"—the survey found:

- 70% were caring for loved ones 50 yrs. old or older
- Provided an average of 20 hrs. of care per week
- Lasting 4.6 years
- Older care recipients generally needed help because of deteriorating physical health (76%). 51% still live in their own homes and 29% lived in their caregivers home
- Old age was cited as the main reason for needed care
- 3 out of 4 caregivers who responded to the survey had paid jobs outside the home, and 2/3 said they missed work as a result of caregiving responsibilities
- The findings highlight the need for more support services for caregivers

CHC should create a Caregiver Training Center (CCT). The CCT would be modeled like an ordinary residential bedroom with common clinical home medical equipment to provide "hands on" instruction for people approaching the role of caregiver. The outcomes of this training include decreased stress in the home, increased confidence / communication, and basic skills learning. Classes would be offered regularly at no charge to anyone, including current hospice family members, potential hospice family members, as well as the general community wanting to learn.

The CTC Curriculum Content might include:

- Medication administration
- Oral Care
- Catheter Care
- Physical Therapy Training (ROM exercises, etc.)
- Home Safety for Patient and Caregiver
- Use of assistive devices

- Transfer Techniques
- Signs and Symptoms of the final stages of Life

This hoped for perception would be the CTC is a wonderful community service that reflects CHC's leadership in field and provide proactive opportunities to educate current / potential patients and the community on end of life choices and care options. We could also potentially increase Caregiver Satisfaction (a Quality Indicator) on our post care surveys. Caregivers' wellbeing is important in the overall care of the patient. The CTC would provide the necessary training, education, and resources for those who otherwise would not have the means to seek it. Caregiver Training is part of our Continuum of Care. Caregiver training will not substitute for care provided by hospice clinical staff; rather it enhances the ability of caregivers to feel secure about tending to their loved one between our visits. We see a potential for decreased hospital readmissions, increased patient safety, and a decrease potential for after hour calls. The CTC should be a consideration for the new St. Joseph County campus.

6.) Objective: Add an underserved niche population

Strategy: Become a "We Honor Veterans" Partner Hospice

Explanation and Expected Outcomes: One out of every four dying Americans is a Veteran. Hospice professionals across the country focus on a single purpose: to provide comfort and support at the end of life. That's why America's hospice professionals are on a mission to learn how to serve Veterans through the challenges they may be facing from illness, isolation or traumatic life experience. We know the hospice mission to be straightforward, and we also know fulfilling it is anything but simple, because each patient has a unique life story and a unique set of needs. And when it comes to the needs of America's Veterans, if we are unprepared, our mission can be challenged or even made impossible. "We Honor Veterans" is a pioneering program focused on respectful inquiry, compassionate listening and grateful acknowledgment. By recognizing their unique needs, we accompany and guide our local Veterans and their families through their life stories toward a more peaceful ending. America's Veterans have done everything asked of them in their mission to serve our country and we believe it is never too late to give them a hero's welcome home. Now it is time that we step up, acquire the necessary skills and fulfill our mission to serve these men and women with the dignity they deserve. Hospice-Veteran Partnerships (HVP) are coalitions of Department of Veterans Affairs (VA) facilities, community hospices, State Hospice Organizations, and others working together to ensure that excellent care at the end of life is available for our nation's Veterans and their families. HVP is a national program of the Department of Veterans Affairs (VA) Hospice and Palliative Care Initiative. Goals are to improve Veterans' access to hospice and palliative care across all sites and levels of care, to assure that every Veteran is able to receive hospice care at the time and place of need, to strengthen the relationships between community hospice and local VA facilities, and to initiate comprehensive end-of-life community engagement plans designed to reach Veterans. We believe in this program and should plan on implementation, particularly with the relatively new VA Clinic in South Bend operational.

GOAL B. Position for Future Growth

1.) Objective: Test new models of caring

Strategy: Apply for the CMS Concurrent Care Demonstration Project

Explanation and Expected Outcomes: The Patient Protection and Affordable Care Act, also known as the Healthcare Reform law, establishes a three-year demonstration program that will allow hospice beneficiaries to receive all other Medicare-covered services while in hospice care. Meaning, patients may receive hospice care and curative care concurrently. The demonstration will be open to 15 hospice programs in both rural and urban areas in the United States. The Secretary of Health and Human Services will evaluate the potential for improved patient care, quality of life and cost-effectiveness in determining whether the program should be continued beyond the three year demonstration process. It is understood that the hospice programs chosen to participate will be of outstanding quality and not a "routine" hospice program. Competition for these 15 slots is expected to be tough. CHC should attempt to become one of these programs. Even if we are not selected, the value of applying will likely assist us in future planning.

2.) Objective Achieve a heightened awareness of Merger and Acquisition Opportunities

Strategy: Explore opportunities with a potentially shrinking number of hospice providers

Explanation and Expected Outcomes: Currently, end-of-life care is a diversification strategy for long-term care, home health and other senior service providers. Mid to large providers (for-profit and non-profit) are exploring mergers and acquisitions to realize administrative cost savings. Mid to large providers are also looking to diversify their business model beyond Medicare hospice services. Recently, there have been significant transactions involving publicly-traded companies and privately-held organizations. Some have been large, very public transactions and others have been relatively small, attracting almost no media attention. Numerous home health providers have indicated via the financial / investment press that they plan to move into hospice to diversify reimbursement risks. The economy has seen an improved credit market making investment dollars available to organizations looking to expand. A member of the national Hospice Executive Roundtable that I participate in just purchased a 100 average daily census hospice program in Boston in late December 2010 ago for $1 million. Hospice M&A activity was up 18% in the third quarter of 2010. The hospice field is expecting to see ongoing mergers and acquisitions for the foreseeable future. This is due in part to a tightening reimbursement environment that will drive consolidation across all healthcare sectors. The current hospice phenomenon is indeed a "bubble" that will not last. Pricing will inevitably fall as the industry gets closer to payment system changes and buyers begin to factor those other

unknowns into their valuations. CHC should be open to such opportunities and appreciate its size and its substantial resources to take advantage of M&A activities over the next five years.

3.) Objective: Enhance Succession Planning

Strategy: Create a framework document to assist the Board of Directors in finding the next President/CEO.

Explanation and Expected Outcomes: A succession planning framework is important for all organizations. Few events in the life of a non-profit hospice program are as critical, visible, or stressful as when leaders transition unexpectedly. In the hospice world, transitions of long-term, non-profit leaders draw the attention of donors, employees, consumers and stakeholders, including leaders of other local non-profit agencies as well as other hospice programs across the country. Leadership transition is an integral process that begins long before the outgoing leader transitions their role. While CHC has a policy and structure in place to find a new President/CEO, it might be useful for the Board of Directors and its Search Committee to have a framework document on hand at the time to assist them with the search, particularly if a current President/CEO leaves abruptly due to resignation, termination, incapacitation, or death. This framework document would cover: demographic trends; the work of current CHC leadership; ideas for the creation of successful transitional capacity; an assessment of the current leadership profile; an age/retirement profile; identification of risks and goals; key leadership skills and expertise profile; key leadership cultural contributions; a leadership replacement profile; and a section on key factors to consider to insure organizational sustainability and growth. As CHC and the hospice industry changes, this framework could be updated bi-annually in perpetuity.

4.) Objective: Perform additional market research

Strategy: Find out what our customers want and customize our relationship with them to meet their needs and expectations

Explanation and Expected Outcomes: Gain an understanding of basic and advanced customer segmentation and then create mechanisms to meet the diverse needs of our constituencies. Constituencies might include:

--Patients
Ethnicity, religion, affluence

-- Families
Ethnicity, religion, affluence, out of town

-- Physicians
Oncology, Primary Care, Pulmonary, Cardiology, Facility Medical Directors

-- Hospital Staff
Discharge planning / social work, “C” Suite, Hospitalists

-- Long Term Care Facilities
DON, Administration, Local / Regional / National Chains, Medical Directors

-- Assisted Living Communities
Administration, available clinical staff (varies by facility)

Research the needs, preferences, and expectations of each group, with particular consideration to communication delivery preferences, and make changes to meet their needs within a “service sells” modality.

5.) Objective: Become an educational destination

Strategy: Continue exploration of and the intent to become an accredited site for Residency Education in Palliative Medicine.

Explanation and Expected Outcomes: To make a very long story short, up until recently board certification in hospice and palliative medicine was offered by the American Board for Hospice and Palliative Medicine (ABHPM). Due to relatively recent approval of a restructuring of this board certified specialty under ABHPM to what has become a sub-specialty under some eleven different specialties (for example: Emergency Medicine, Psychiatry, Anesthesiology) by the American Board of Medical Specialties (ABMS), there is now a requirement for physicians seeking board certification in palliative medicine to perform a residency training program as part of their board certification. These residency training programs are accredited by the American Council for Graduate Medical Education (ACGME). There are about 29 training programs in the U.S. that are available for accreditation. In the future, once the interest in board certification begins taking hold, the need for residency training programs will jump to perhaps 100 – 150. The Centers for Medicare and Medicaid Services (CMS) has said in the past that it would make some funding available for additional training centers, but that funding will be capped. As a leader in the field currently employing two board certified hospice and palliative medicine specialists, CHC should investigate what it would take to become an accredited site for Residency Education in Palliative Medicine. Two of CHC’s advantages include the operation of two Medicare certified hospice inpatient units, and, being located geographically within an attractive area of higher education opportunities -- including the Indiana University School of Medicine at the University of Notre Dame.

GOAL C. Maintain Economic Strength

1.) Objective: With Medicare reimbursement cuts of up to 14.3% by 2019, CHC should begin to diversify its revenue stream now

Strategy: Expand upon chronic care case management experiences from the Enhanced Care model.

Explanation and Expected Outcomes: The new Indiana Comprehensive Insurance Association (ICHIA) Enhanced Care product is likely a sign for our future. Chronic Care case management is developing rapidly and commercial insurance is beginning to pay for it. Insurance companies understand that 5% of their pool will represent 50% of their costs. Spending dollars to keep these patients out of the emergency is cost-effective. To date, chronic care case management has been almost exclusively Tele/Internet based. Few models currently exist to "manage" high cost patients, but in-home care teaching and monitoring is thought to be effectual. As ICHIA recognizes, this is what palliative care does best. This could take us far outside our county walls. Gain sharing opportunities may also exist. Since CHC already participates in a statewide network, we should attempt to convince the other network providers to build this infrastructure, create a product, and take it to commercial insurers.

Strategy: Investigate the development of a Geriatric Physician Practice

Explanation and Expected Outcomes: Within our eight counties there are numerous Long Term Care / Assisted Living (ALF) facilities. Many of the residents do not have regular access to physician services and transportation is frequently an issue. The population of these facilities is largely Medicare eligible. CHC should investigate what the market might look like for "house calls," home visit consultations, and scheduled "ALF clinics". With several part-time near-retired or semi-retired physicians on staff making facility visits on a scheduled basis, we would bill Medicare Part B for the services and also be there in-person to identify potential palliative care / hospice patients much further upstream from the usual time we receive a referral. Optimally, this program would produce a new revenue stream along with longer lengths of stay. CHC currently provides care to 32 different assisted living facilities.

Strategy: Investigate the development of a Private Duty line of business

Explanation and Expected Outcomes: According to the National Private Duty Association, in 2011 more than 8,000 people will turn 65 each day, and the senior population in the U.S. is projected to reach almost 49 million by the end of that year. A private duty home care business can provide service to this growing, aging population or to the population of disabled persons and minors. Whichever of these population segments is being served, private duty home care workers help people stay in their home. The job requires a provider who has patience and empathy in helping others to manage daily activities. Private duty providers provide an array of services and assist with daily life activities often in eight hour shifts. Sitter-type services for

working caregivers are also a reason families look for private duty assistance. CHC's target audience could be its own census as well as the greater community. CHC is already a licensed home health agency. We believe private pay for private duty services would be welcomed by CHC patients who could afford these services. Custodial care is not a Medicare covered service and therefore CHC is not required to provide this type of service to its customary range of Medicare home health and hospice patients. Many CHC patient families are currently paying other local home care agencies for private duty services now. Why shouldn't they pay CHC for these services? It's possible our families would be more comfortable with CHC private duty. These services would not replace the volunteer component of our care, but be another option for families. Frequently, families do not want to leave their loved one alone while they are at work all day, or they would like overnight staff on hand to provide care while they sleep. We would promote the service in our own publications and those directed to the niche market for the private duty business throughout the greater community. As time goes on, the best marketing is word of mouth based on the provider's reputation. Arguably, CHC may have the best service reputation in our area.

2.) ***Objective: Have ongoing philanthropic revenue streams***

Strategy: Increase Fundraising / Development / Investment Activities

Explanation and Expected Outcomes:

1. **Fund Raising**. Increase private giving to Hospice Foundation and CHC, exclusive of capital campaigns and planned giving, at a 6% compound annualized growth rate for the 2011 thru 2015 planning period. Using the 2010 year-end revenue figure of $794,737 as the baseline, cumulative fund raising during this period will amount to $5.5 million thru 2015.

2. **Planned Gifts**. Increase private giving through newly documented planned gift expectancies for the 2011 thru 2015 planning period to a cumulative total of $2 million by 2015.

3. **Number of Donors**. Using the year-end 2010 annual unique donors figure of 7,931 as the baseline, increase the number of unique annual donors to 8,973 by the end of 2015, representing a 13.1% increase, or a 2.5% average annual growth rate over the planning period.

4. **Total Voluntary Support**. Total Voluntary Support (private giving and grants to The Foundation/CHC, exclusive of capital campaign revenue) is projected to grow at a compound annual growth rate of 8% over the planning period and will reach an additive cumulative total of $5,830,000 thru 2015.

5. **Investment Returns**. Achieve investment returns that exceed the sum of the annual distribution, management and administrative fees, and the impact of inflation, calculated as a 5-year rolling average.

6. **Investment Performance**. Perform in the top one-half of a peer group selected by the Investment Committee of the Foundation Board of Directors.

7. **Invested Assets**. Increase the market value of current invested assets from $10,121,633 on 2/11/2009 to $15,190,000 by 2015, less total withdrawals.

8. **Operating Endowment**. Begin work toward building a Hospice Foundation operating endowment.

9. **CHC President's Fund**. Support the CHC President's Office with a total of $265,500 in discretionary gift funds ($50,000 in 2011, with projected 3% annual inflationary adjustments) through 2015 to assist CHC in sustaining its local support presence and its leadership status among other hospice organization's nationally.

10. **Capital Projects**. Design, build and provide funding for current and forecasted capital projects, which include the 12,000 sf Elkhart Hospice House ($600,000 remaining on a $3 million capital campaign goal) and a new St. Joseph County campus.

GOAL D. Continue Building Brand Identification

1.) ***Objective: To convey to all target audiences the essence of Center for Hospice Care through consistent branding via graphics, logo, positioning theme, photos, color and fonts.***

Strategy: Continue with Transcend Hospice Marketing's multi-year approach to increase average daily census and increase average length of stay.

Explanation and Expected Outcomes: This educational and awareness plan is designed to:

Plan Primary Goal

- Increase ADC by 30% (ADC was 314 at time of adoption of plan)

Plan Secondary Goal

- Increase MLOS by 25% (MLOS 16 at time of adoption of plan)

Plan Objectives

- Establish CHC as the hospice of choice throughout its service area
- Increase unaided awareness of the CHC name as the top-of-mind provider for hospice care
- Establish expertise, quality of staff and reputation as differentiators for CHC
- Position CHC as the authoritative resource and thought leader for end-of-life and care
- Increase understanding of the full scope of services provided by CHC
- Increase knowledge of how hospice care is paid for

Over the course of the next few years, through mid 2013, we will accomplish the following:

1. Educate **family healthcare decision makers** about CHC's expertise and full scope of services, factors that differentiate CHPC from other options, as well as the benefits of early referral.

2. Educate **physicians** regarding the advantages of referring patients early to CHC for hospice care, and the availability of palliative care if a six-month prognosis is in question.

3. Partner with **non-physician referrers** such as hospital discharge planners, nursing homes, and clergy and parish nurses to recognize when it's time for hospice care, and recommend or at least include CHC in the patient's options.

4. Educate **CHC staff and volunteers** about primary key messages of the campaign and promote consistent representation of the brand since they are ambassadors to the community.

5. Target primary **minority populations**, specifically Hispanics and African Americans, to tailor targeted messages regarding the support CHC provides for the family of terminal patient caregivers.

Year One (May 2010-April 2011)**:** Emphasize communications to family healthcare decision makers and coordinate message continuity with CHC staff and volunteers. Experience has taught us that the public is generally more receptive than physicians to changing perceptions and behavior regarding hospice care, and can be encouraged to bring up the subject more readily with referrers. Begin creating communications and referral tools for physicians and non-physician referrers.

Year Two (May 2011 – April 2012)**:** Add heavier weight to communications with physicians and non-physician referrers. Adjust messages to family healthcare decision makers based on second round of research.

Year Three (May 2012 – April 2013)**:** Add targeted communications to minority audiences. Adjust messages to family healthcare decision makers to provide more detail regarding CHC's services and benefits.

May 2013 – December 2015: Following research, fine-tune campaign as necessary, particularly related to the new St. Joseph County campus.

2.) ***Objective: Gain More National Attention as a National Leader Hospice Program***

Strategy: Apply for and win the "Circle of Life Award"

Explanation and Expected Outcomes: The American Hospital Association (AHA) Circle of Life Award honors innovative programs in palliative and end-of-life care. The awards are currently supported, in part, by the Archstone Foundation and the California HealthCare Foundation, based in Oakland, California. Existing major sponsors are the American Hospital Association, the Catholic Health Association, National Consensus Project for Quality Palliative Care, and the National Hospice and Palliative Care Organization & National Hospice Foundation; the American Academy of Hospice and Palliative Medicine and the National Association of Social Workers. The Circle of Life Award is administered by the Health Research and Educational Trust. The Circle of Life Award honors programs that:

- are striving to equitably provide effective, patient-centered, timely, safe, and efficient palliative and end-of-life care
- are striving to implement the domains of the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care and the corresponding preferred practices identified by the National Quality Forum
- show innovation and serve as models for the field particularly in moving palliative care upstream
- support hospitals' and health organizations' efforts to improve palliative and end-of-life care
- build awareness of the importance of serving people with life-limiting illnesses throughout the continuum of their illness and supporting those close to them
- are actively working with other health care organizations and the community across the continuum of care

All organizations or groups in the United States that provide palliative or end-of-life care are eligible for the award. Two of the eleven programs in the national Hospice Executive Roundtable are previous Circle of Life Award winners. It would be beneficial to CHC to win this prestigious award before the end of 2015.

3.) ***Objective: Expand what we do well and transform it to new revenue stream.***

Strategy: Create an EAP for end-of-life issues in the workplace

Explanation and Expected Outcomes: Based on current experience with the Caring Connections sponsored, "It's About How You LIVE at Work," CHC should develop specific programming for grief counseling targeted directly for employers as part of their Employee Assistance Programming. We are the experts in bereavement and grief intervention services in our area. We should develop and offer specific products for the employer to offer their employees as a quality add-on to their EAP offering. We could greatly expand our community grief counseling

opportunities and potential revenue. Hypothetically, 25,000 employees across eight counties at $1.00 per month per covered life is $300,000 in new revenue per year. Only a small fraction of the total would like be users of these services. Some services could be done on-site, some at the LTC, or our other offices. While we would continue to offer grief counseling at no charge to anyone in our communities, this service line would include some yet to be determined value-added differentiation from our "customary" counseling practices. Positive experiences with CHC through an EAP may lead to future patient care referrals by the participants who learn about all that CHC provides through this point of entry.

4.) ***Objective: Continue to enhance Physician Relationships***

Strategy: Investigate advisory board opportunities for CHC participation, consultations, speaking opportunities, regularly scheduled rotated onsite palliative care consultations by CHC NPs, and RN hospital liaison positions.

Explanation and Expected Outcomes: Continue to develop disease specific, specialty programming, involve area physicians and invite champion participation. Investigate roles for CHC staff participation on local advisory boards. Offer site of care specific onsite palliative consultations with CHC employed NP staff. Develop key opinion leader programming. Offer a library of one-sheet communication publications and informational tools on a variety of topics for physician offices and non-physician referrers to download from the CHC website for their use with their patient population and to be able to distribute freely.

Strategy: Continue to enhance Medical School, Residency Relationships

Explanation and Expected Outcomes: Seek opportunities to enhance Residency training with hospitals. Begin Curricula involvement / teaching with medical students and encourage student volunteers via the Ruth M. Hillebrand Center for Compassionate Care in Medicine at the College of Science at the University of Notre Dame. Continue to seek opportunities for CHC-led and student performed research projects.

5.) Objective: Continue market differentiation activities and promotion

Strategy: Create Service Promises

Explanation and Expected Outcomes: Preserving and growing market share will be driven by the ability to continue to distinguish CHC's unique promises that matter to segment specific audiences. Service promises are the articulation of CHC's segment specific value propositions. Service promise driven organizations recognize their ability to define what customers want, and to communicate that fact with effective impact. This is as important as the ability to execute / deliver care.

Potential Service Promises could include:

-- Any CHC patient who rates pain at a ___ or higher receives a home visit from a _____ within __ hours.

-- Offer "Social media" as patient / family benefit with secured communication among family and friends across the country and around the world.

-- Referral source communication customization (electronic recording of preferences to insure we interact exactly as they wish).

-- "Scorecarding" explicit tools to create report cards between us and the referral source. Publishing our pain and symptom scores. Promote our own QAPI data, FEHC scores.

-- Offer "prognosticating services" for referral sources using validated ADL driven tools to provide information based upon the actual home environment.

Specific service promises could also arise from the outcomes of #4 under Goal B in this document.

6.) Objective Create key long-term initiatives that are uniquely ours to position CHC as THE leading, forward-thinking organization.

Strategy: Use our Hospice Foundation for strategic purposes.

Explanation and Expected Outcomes: Our strategy is to undertake meaningful initiatives that build a broad base of diverse, long-term loyalty and financial support from patient families and friends, colleagues, past donors, community leaders, corporations, foundations, and other organizations nationally. The key components of our strategy, and cornerstones of our Foundation, are:

- **Collaborative Partnerships**. Our success depends upon building mutually beneficial, long-term relationships with key constituent groups important to the Foundation's long-term success. These groups include: THF Board and Committee Members, CHC Board, CHC Administrative Leadership Team, NHPCO, IHPCO, FHSSA and PCAU leadership, institutions of higher learning, grant makers, patients, patient families, community leaders, CHC staff and volunteers. Additionally, strong alliances must be built with key local area professionals and centers of influence, including: funeral directors, attorneys, accountants, life insurance agents, clergy, trust and financial planning professionals. Other key constituents include area corporations, foundations and community foundations. Its long-standing reputation for quality and compassionate care is one of CHC's key strengths and provides a strong foundation for broad based community support of its programs and fundraising activities. THF and CHC may call upon its friends to take on an expanded role

as the THF extends its outreach and support to organizations with similar or complementary missions that improve the quality of living for those they serve.

- **Fund Raising**. The second component of our strategy involves delivering a pre-eminent capability in fund raising among all foundations and development programs competing for the same donor funds. This will be accomplished by employing a combination of time-tested fund raising methods (e.g. special events, direct mail, advertising, Annual Appeal, presentations to civic organizations, personal solicitation, submission of grant applications) and the vast global access opportunities available through effective use of the world wide web (e.g. THF's web presence and searchability index, viral marketing, Blackbaud's Net Communities, individual donor web pages, team fund raising and virtual events). The creation of giving societies, and associated donor cultivation, will increase annual support. Effectively marketing opportunities for donor-designated endowed funding will ensure sustainable support for otherwise unfunded niche programs, e.g. community bereavement programs through the Life Transition Center; Art Counseling programming; Camp Evergreen; community education; physician and hospice practitioner education; and support for national (NHPCO), state (IHPCO) and international (FHSSA) funding initiatives.

- **Stewardship**. Strategies include employing effective financial investment management techniques, e.g. asset allocation, risk management, manager selection, staff education and development, market opportunities, cost control, use of outside experts and establishing a strong Investments Committee that meets regularly and is capable of providing sound financial advice for both restricted and unrestricted assets. Appropriate capital investments in real estate, buildings and infrastructure will ensure that financial resources remain on the organization's balance sheet as opposed to that of its Landlords. Grant funding will be provided to non-competing not for profit organizations for programming and outreach efforts that further advance the mission of THF and CHC by delivering services in a manner that enhances or transcends those offered by THF or CHC.

- **Education**. We often hear patients and families say “if only I had known about hospice care sooner.” A key strategy to increase public awareness of the services available through CHAPC is to begin to dialogue with members of the communities we serve while they are healthy. Through sponsorship of advance planning seminars, workshops, distance learning and educational materials made available through the *Institute for Advance Care Planning*, the Foundation will endeavor to educate the community on CHC’s programs and services while they are developing their own advance care plans. An Institute Advisory Board, comprised of appropriate local area practitioners, will be invaluable in the development of curriculum, faculty selection and long-term sustainability. By offering CEU-granting seminars and workshops, we will further educate local area professionals on the goals of hospice and palliative care and the services available through CHAPC. Through collaboration with area colleges and universities, we will create a *Center for Studies in Palliative Care*, which will include residency education in Palliative Medicine as well as opportunities for internships and fellowships for professional study at various CHC facilities.

7.) Objective Continue to develop, promote, and publicize our International programming.

Strategy: Make our goal of brining palliative care to all of Uganda well known.

Explanation and Expected Outcomes: Before government redistricting, which has led to some confusion and a need for new mapping, palliative care was only available in 34 of the 80 districts of Uganda -- a country of more than 30 million people. Through its partnership with the Palliative Care Association of Uganda, CHC and its Hospice Foundation have a goal to bring palliative care to the entire county. This will be accomplished by fundraising and other efforts to enhance the training curriculum and create scholarship-based training program. This training will be targeted toward healthcare workers in non-palliative care districts. The purpose is to all them to become certified to distribute morphine and other pain and symptoms management services within the districts. From our perspective, long term goals of this partnership include a permanent home for PCAU, regionalization, and financial sustainability.

Conclusion

"Let others lead small lives, but not you. Let others argue over small things, but not you. Let others cry over small hurts, but not you. Let others leave their future in someone else's hands, but not you."

-Jim Rohn-

"When you change the way you look at things, the things you look at change."

-Wayne Dyer-

From the President/CEO

The next five years hold tremendous challenges for CHC. There will be more changes in the regulatory, public policy and healthcare landscapes that impact hospice and palliative care. CHC will need to consistently develop strategies to lead our organization through these changes. We must prepare now for additional cuts to our Medicare reimbursement for hospice care and a likely new model of payment by 2014. We must create organizational systems and processes that can adapt to changing circumstances. We must identify innovative approaches that expand the reach of hospice and palliative care and create a seamless continuum of care. We must

identify and utilize financial reporting tools to develop business plans, evaluate current and new programs and adapt to the economic environment. We will need to develop new tools for ensuring the provision of quality, evidence-based, ethical, effective and efficient end-of-life care. We will need to evaluate quality assessment and performance improvement strategies and successes while simultaneously determining best practices in advanced operations that distinguish quality programs. Executive leadership and management will need to lead a diverse and multi-generational workforce to maximize retention and productivity; and analyze strategies to engage our people to our organization. The content of this Strategic Plan contains elements of all the above. Whether or not we accomplish everything contained in this document or not, one truth is clear. We cannot wait. We must act now. As Rev. Martin Luther King, Jr. once observed, "We are now faced with the fact, my friends, that tomorrow is today. We are confronted with the fierce urgency of now. In this unfolding conundrum of life and history, there is such a thing as being too late. Procrastination is still the thief of time. Life often leaves us standing bare, naked, and dejected with a lost opportunity. The tide in the affairs of men does not remain at flood -- it ebbs. We may cry out desperately for time to pause in her passage, but time is adamant to every plea and rushes on. Over the bleached bones and jumbled residues of numerous civilizations are written the pathetic words, 'Too late.'"

Beginning today, we *will* navigate the winds of change.

Respectfully submitted,

Mark M Murray
President/CEO

Center for Hospice Care
Hospice Foundation

February 2011

# # #

Center for Hospice Care
Compliance Committee Meeting Minutes
June 21, 2012

Members Present:	Amy Tribbett, Ann Cowe, Dave Haley, Donna Tieman, Gail Wind, Jon Kubley, Karl Holderman, Mark Murray, Vicki Gnoth, Becky Kizer

Topic	Discussion	Action
1. Call to Order: 3:00 p.m.		
2. ZPIC Article	• CMS has awarded a ZPIC contract for our zone effective in April. We need to know what our roles are and what we are supposed to do when/if it happens. NHPCO has recommendations on what hospices should do. Jennifer Kennedy reviewed this at the conference Donna attended last week. Hospices should be aligned with an attorney proficient in dealing with federal offices. Our health attorney is Robert Wade from Krieg DeVault. • This year Donna and Gail having been working on aligning their department for scrutiny from any audit and to make sure documentation meet regulatory requirements. The monthly and quarterly audits show there are some areas that need improvement. Nursing management is targeting and communicating the simplest ways for staff to be most compliant at the monthly nurses meeting. • It was suggested that the Compliance Committee be proactive and have a process in place to implement if auditors arrive. Mark will contact Bob Wade to determine whether there is a checklist we could adapt for our use. • We have to know who on staff would be involved in the audit. Another way to prepare is to continue to educate ourselves on what is changing and what is routine. Take advantage of webinars, read articles Mark sends out, etc. Donna and Gail are developing ways to scrutinize staff and processes. Donna tells the PCCs that staff will only do what they pay attention to, so they have to consistently be reviewing the hot topics or they will lapse. Donna has Jennifer's PowerPoint. She will also contact Marcia about doing a presentation to social workers.	
3. Duplicate Charges for Hospice Patients	• In 2010 Donna and Gail began conducting impromptu audits to see how we measure up to what the OIG is auditing. Gail picked random ECFs where we	

Topic	Discussion	Action
in an ECF	had patients and reviewed charts to make sure everything was in order in the charts. As a result of that, we changed the audit tool for ECF patients and developed several new processes so some of the required paperwork remained in the chart. • In 2012, the OIG came out with a different work plan, so Donna and Gail met with Amy and Shirley to talk about the "Hospice Manages this Patient's Care" form. It needs to be clear what meds the hospice is providing and whether they were billed to Medicare D in error. The form begins at admission and if a med is changed or added, it needs to be updated. In June Gail picked random ECFs to audit in Elkhart and South Bend. In one chart the form was missing, in one of six it was filled out correctly, and four of six the form was present but not filled out correctly. A copy of the form goes to the ECF billing office. They call us if they cannot find it. The form is important to show which meds, DME and soft supplies are billed to CHC. Another potential concern is the family getting billed in error. ECFs are also sometimes not aware when we have live discharges. Staff doesn't understand the importance of the form. It goes into a plastic sleeve at the time of admission with other forms. Ask facilities where they want the form filed. • Should QI audit it since it is an identified risk area? We have not educated staff on it yet. Staff most responsible for this is the admission nurse, primary nurse, and any nurse that does the discharge. The primary nurse does most of the live discharges. Elkhart fills out a new form each time. Alice and Shirley will get together to update the form to make it more of a working document, but don't change it too much, because ECFs are familiar with it. • What is the process to get the form to the ECF billing office? Our ECF nurses carry a portable printer. Could they use an electronic version of the form and print out a couple copies for the ECF chart and billing office? Could there be a trigger in Cerner to remind them to update the form? The active med record from Enclara is a good communication tool, but it only shows active meds and would not soft supplies or DME. ECFs already complain about the volume of paperwork we add to their chart, which they thin out so the form could be missing. • It would not be labor intensive to have a check box in the QI audit to see if the form is on the ECF chart, but they would not know whether it was accurate.	

Topic	Discussion	Action
	Should do office by office, department by department education on it and review how important it is to initiate and update the form. They could sign off on the form when it is reviewed. There should be a copy in the ECF chart and billing office. There is no consistency between ECFs on where the form is kept. Can check to make sure it is there and if missing, replace it. • Gail will look at revising the form. Need to develop an education piece, and look at sustainability through QA chart audits and Gail's audits. It will be added to the audit tool to see whether the form is present.	
4. Annual Compliance In-Service Topic	• Will do annual compliance in-service at the September staff meeting. Last year we talked about doing a general overview of the compliance program and re-educate staff on how to bring concerns to our attention, where the compliance boxes are located, and who is on the compliance committee. Could also do an overview of hot topics. Donna has slides from Jennifer Kennedy's presentation that she will share with Vicki.	
5. Top 5 Hospice Survey Deficiencies	• Reviewed NHPCO top five hospice survey deficiencies. These are things we already audit for. Jennifer Kennedy recommended free texting as much as possible in the plan of care so it is individualized. Donna will check with Marcia on how much free text the social work and SCC can do. They don't have as much to choose from, but they have the capability to pull problems/ goals/interventions that were addressed at their visit. Will continue to work on the top five list at the end of each meeting.	
Adjournment	• The meeting adjourned at 4:00 p.m.	Next meeting TBA

southbendtribune.com/news/sbt-reshaping-the-riverfront-20120804,0,3683998.story

southbendtribune.com

Reshaping the riverfront

Plans dovetail for public, private projects by Central Park

By JOSEPH DITS

South Bend Tribune

10:13 PM EDT, August 4, 2012

MISHAWAKA - "Don't touch anything, it's dirty," Lisa Grubbs warns her grandchildren before they duck into the weathered, dark brown bathroom shelter at Central Park.

"It's just damp and wet and nasty," she explains to a reporter, "and you have to go around a corner."

That creepy aura — and the way vandals have made it an easy target — is why the city plans to mow down the structure this fall, one of the first steps in reshaping the park and the open tracts of land next to it.

From her picnic table, Grubbs can see where the city plans to extend the Riverwalk and where a new, nearly five-acre campus will rise for the Center for Hospice and Palliative Care.

A dump truck driver, she even hauled off rubble from one of three houses torn down for the new hospice campus.

Photo provide

An artist's rendering shows the first two buildings, connected in the middle, to be built on the new Mishawaka campus of the Center for Hospice and Palliative Care.

This will change the panorama on a key, northern bank of the St. Joseph River, across the water and a few blocks from downtown.

The city will build a new access road here, too, as public and private projects converge. The city's Redevelopment Commission has approved the cooperative plans, including land swaps between the city and the Center for Hospice's foundation.

The hospice plans have been in the works for almost three years, but they came to light a year ago when the Hospice Foundation started buying land at the site. The foundation and its Center for Hospice is just one of a handful of hospice organizations in Michiana aiding patients with end-of-life care.

To clear some final hurdles, the Mishawaka Common Council will vote Monday on measures to vacate an east-west alley north of Madison Street and to rezone land on Fish Ladder Lane.

Foundation officials plan to give a brief presentation of their campus plans at the council meeting at 7 p.m. in City Hall, 600 E. Third St.

Digging will begin this month.

On Pine Street, which is at the opposite edge of the projects from Central Park, Everett Rich points to the scratches on the

door of the truck he uses in his towing business — $1,000 worth of damage, he says, not unlike the paint thinner that was thrown on the truck door almost two years ago.

"I can't watch it 24-7," he says as bicyclists and pedestrians filter down Madison and Pine to the park. "We have too many people going by here all the time."

Rich plans to be out of here in a couple of years. Forty-nine years has been long enough. Four bedrooms are too many for a man living alone. And he asks his grandchildren and great-grandchildren not to go to the park because "there are so many things going on there."

On this day, police quietly talk with kids in the open lots that Rich's house faces — apparently about a minor infraction.

Next door, Pat Goeller often lets her grandchildren play in the park. But her German shepherd, whom she hopes to train as a therapy dog, won't let them go alone. The dog insists on riding the merry-go-round with them and sliding down the slide.

Goeller and her husband live in a century-old house that, they've heard, once served as boarding house for European workers at the old Uniroyal plant. The small neighborhood here has old but well-kept homes.

"I miss my neighbors," Goeller says of the homes that were scrapped, noting that her front porch will look out on the new Center for Hospice parking lot. Then again, she says it's been quieter since two time-worn Moose lodge buildings were torn down this year — another
deal to furnish land for the Center for Hospice.

Park plans

New playground equipment — on the order of Kids Kingdom at South Bend's Potawatomi Park — should be a hit at the park, too. The equipment now sits in storage, and the city plans to install it next year, said city planner Ken Prince.

Grubbs and neighbors were excited to hear that. Central Park is "nothing fancy, but it gets the job done," says Grubbs, watching her 8-year-old son and three grandchildren play. The children prefer their weekly visits to Kids Kingdom and Potawatomi's zoo.

Beyond that, most improvements at the park are just proposals for now.

In the Central Park master plan, the city proposes to dress up the concrete fish ladder by adding a more decorative walking platform and railings and metal sculptures that a local artist would make of heron, a bird often seen on the river.

The city proposes new bathrooms with four doors to individual bathrooms, three of which could be locked at a time to thwart vandals during quiet times. Until that's built, the city may have to put up portable potties, Prince said.

Other proposals call for shade awnings — maybe small versions of the new white canopy at South Bend's Century Center — along with an oval walkway.

The tennis courts and softball field would stay.

But new parking lots will definitely be built this fall just north and south of the tennis courts. That should help with safety around the bathrooms by making them more visible, Prince said.

Hospice campus blend

Also this fall, the city will build a new access road angling in from Cedar Street and linking to the Center for Hospice campus and the park's new parking. It will go through vacant lots where the city tore down two commercial buildings a block north of Madison Street last year. The street's tentative name is Comfort Place, a nod to hospice.

The Hospice Foundation will acquire .64 acres along the new road and use it for green space and for building one home that it will sell.

The city originally thought of building three new homes there. But, once the road was designed, it left room for just one home, Prince said. Meanwhile, the Hospice Foundation didn't want to leave that space to chance. So, in acquiring the land, the foundation agreed to fulfill the city's intent to build a house there.

Chief Operating Officer Mike Wargo said the foundation will work with a real estate agent to first find an interested buyer, then build the home, he said.

"We're not interested in being real estate developers," he said. "We like the idea of having some control of what our main entrance to campus looks like."

Borders between the park, Riverwalk and hospice campus should all blend together naturally, say architects.

"It will appear like the (hospice) campus is accessible," Prince says. "But when you cross that line, you'll know you're there. It's a delicate balance."

The Hospice Foundation sees the Riverwalk and the river itself as a place for clients to find peace, as well as a staging area for the foundation's annual Walk for Hospice and other events.

In Phase I, the hospice campus will start off with a pair of office buildings conjoined by a lobby for a total of 22,000 square feet, plus a 98-space parking lot. Architects say it will have a warm exterior with stones, ribbed steel siding, broad overhangs and large wooden trusses that support balconies.

They'd aim for landscaping that's "contemplative," possibly with a water feature and a 9-foot-tall "wind harp" that makes sound as the wind hits it.

The goal is to finish the building and move in next June, Wargo says.

The agency plans to vacate its leased space on Edison Lakes Parkway and Red Coach Drive in Mishawaka. But the Hospice Foundation doesn't have plans to leave its Hospice House with inpatient beds in Roseland nor its sites in Plymouth and Elkhart, he says.

Also this fall, it will renovate a former floral shop at Cedar and Madison streets to serve as a palliative care center, serving like an outpatient clinic where patients visit physicians for exams.

Across Madison, the agency will renovate a home to serve as a guest house, mostly for out-of-town families who are visiting Hospice patients. Wargo says its exterior will gain a "new skin" to match the neighborhood's historical character.

He says the Hospice Foundation won't start on the other buildings in the campus, or Phase II, until it raises the money for that, a campaign to begin late this year or early next year.

Staff writer Joseph Dits:
jdits@sbtinfo.com
574-235-6158

New campus, upgrades by river

Here are plans for the new Center for Hospice and Palliative Care campus and improvements around it by the city of Mishawaka.

Legend

1. New buildings for Center for Hospice and Palliative Care, to be finished June 2013.
2. New parking for Center for Hospice.
3. Future buildings of Center for Hospice, to be built when money raised.
4. Extension of Riverwalk, to be built next year.
5. Former floral shop, to be renovated as Palliative Care Center.
6. Existing home to be renovated as hospice guest house.
7. Existing neighborhood.
8. Land to be used for Center for Hospice as green space and to build/sell one house.
9. New access road to be built by city this fall.
10. Central Park, where the city proposes new playground equipment, shelters, bathrooms, shade structures, water feature and walkways.
11. Parking to be built by city this fall for Central Park.
12. Veterans memorial proposed by city.
13. Fish ladder, which city proposes to dress up with a new platform and sculptures.

Source: City of Mishawaka, Center for Hospice and Palliative Care

Tribune Graphic/JOHN STUMP

Land swaps

■ The Hospice Foundation is selling a .21-acre parcel to Mishawaka's Redevelopment Commission for $425,230, which includes $315,182 to remove debris underground that apparently had been used to stabilize the riverbank decades ago. The city will use that land on the St. Joseph River to extend the Riverwalk.

■ The Redevelopment Commission is selling seven parcels totaling 2.69 acres to the Hospice Foundation for a total of $147,351.

■ The Hospice Foundation is acquiring another 0.64 of an acre along the new access road from Cedar Street as green space and for one new home that it will build/sell. The foundation will buy the land from the Redevelopment Commission for $10.

■ Nearly a quarter acre of the Central Park's eastern edge will be carved off it — land that has been vacant and in the Redevelopment Commission's hands for decades. From that same vacant land, another 1.19 acres will go to the Center for Hospice campus.

Other costs

■ $5 million: what the Hospice Foundation will spend on Phase I of its new Center for Hospice campus.

■ $3 million-plus: the city's extension of the Riverwalk from Central Park to Madison Street, erosion control on riverbank, construction of new access road from Cedar Street, demolition of park bathrooms and (a major part of costs) improvements to water and wastewater utilities at the location. To be paid for with the city's tax increment financing.

■ $150,000: new playground equipment for Central Park, a 45 percent discount.

— Source: City of

South Bend Tribune

Opinion
Voice of the People

July 24, 2012

Downtown Hospice not the right fit

Instead of building a sprawling Center for Hospice Care near downtown Mishawaka, which by the way will encroach into Central Park, why not relocate the project to a vacant 30-acre parcel on Main Street at Douglas Road?

Think about it. Saint Joseph Regional Medical Center is nearby and there are restaurants, hotels and shopping.

If you'll excuse me for saying so, we need something more lively and upbeat to attract folks downtown, not a place people will go to spend their final days.

Put a center for combined arts downtown, theater, music, fine arts, fine woodworking, etc. Use that wasted building in Beutter Park to house working artisans who could teach classes, possibly in lieu of rent. Allow them to put on exhibitions and hold seminars. Build an indoor/outdoor theater to showcase multi-talents and call it Tivoli Gardens in memory of our sorely neglected and, hence, demolished theater.

The open air park concerts are great, up to a point, but we need to attract visitors of all ages, all year long.

All of our wonderful restaurants and other existing businesses would benefit greatly from such a diverse educational entertainment venue.

Also, I appreciate the beautiful hot pink roses planted in the median of the Main Street underpass and other places. They are gorgeous.

Susan K. Bradford
Mishawaka

South Bend Tribune

Opinion
Voice of the People

August 5, 2012

Hospice

The Center for Hospice and **Palliative Care** Inc. moving to a soon-to-be-constructed facility near downtown Mishawaka speaks volumes for what the city and its citizens have to offer any business entity that is entertaining moving within our boundaries. The partnership between hospice, Mishawaka Parks and the Mishawaka Redevelopment Commission is going to benefit all three parties.

Hospice will move its operation over a few phases to a location that will have both a tranquil feel overlooking the river and a vibrant feel with the park and riverwalk that will be extended beyond its banks. The park will, according to the architectural renderings, have a magnificent face-lift that will rival any of our current park facilities. Hospice will also bring several hundred employees to our downtown area who can enjoy the riverwalk, many lunchtime offerings and the activities surrounding Beutter Park and Kamm Island.

Maybe hospice will plant beautiful hot pink roses near its entrance so that Susan Bradford (Voice, July 24) will then appreciate having hospice as part of our community.

M. Wayne Troiola
Mishawaka Redevelopment Commission

Center for Hospice Care

choices to make the most of life

August 3, 2012

Circle of Life Award
c/o AHA Office of the Secretary
155 North Wacker Dr., Suite 400
Chicago, IL 60606

To Whom It May Concern:

It is with great excitement that I recommend the Veterans Health Administration's Hospice and Palliative Care (HPC) Program for the 2013 Circle of Life Award.

As chair of the National Hospice and Palliative Care Organization's (NHPCO) Board of Directors, President and CEO of Center for Hospice Care, and a ***We Honor Veterans*** Partner, I can directly speak to the impact of the partnership and collaboration between NHPCO and VA's HPC Program which began in 2001.

On a national level, NHPCO is very proud to help support and promote services and resources that enable our nations' hospice programs to more effectively care for all Veterans. Several key accomplishments include:

- "Reaching Out" grants were awarded to community hospices to improve access to hospice and palliative care for homeless and rural Veterans through developing models that have been disseminated to other hospices across the country for implementation.
- The ***We Honor Veterans*** Partners campaign (www.WeHonorVeterans.org), now joined by over 1,400 hospices, was established to encourage and recognize hospices across the country in their efforts to educate staff, community members **and** Veterans about available end-of-life benefits and services.
- Hospice-Veteran Partnerships (coalitions of VA facilities, hospices and other community healthcare providers) were launched and are now active in over 40 states.

As a ***We Honor Veterans*** Partner, Center for Hospice Care is:

- Using the Military History Checklist for all our patients/families intake process
- Providing formal recognition of military service to our Veteran patients

centerforhospice.org
800.413.9083

111 Sunnybrook Court
South Bend, IN 46637
574.243.3100
fax: 574.243.3134

112 South Center Street
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

Life Transition Center
215 Red Coach Drive
Mishawaka, IN 46545
574.255.1064
fax: 574.255.1452

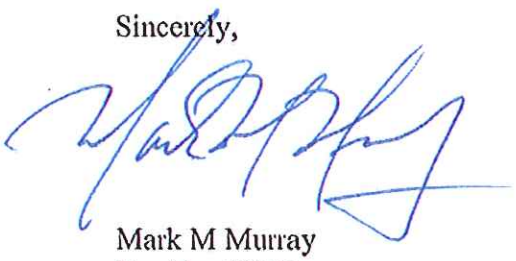
- Establishing a Veteran-to-Veteran volunteer program which was featured on our local CBS News affiliate
- Integrating Veteran-specific content into our staff and volunteer orientations
- Actively participating the Indiana Hospice-Veteran Partnership

From my experience, the results of the partnership at the national level are helping Veterans and their families at very vulnerable times in our community and others across the country. All of this would not have been possible if not for the collaboration and support from the VA's HPC Program.

I strongly recommend the VA HPC Program's Circle of Life application, as this and other efforts reflect its innovative approaches to enhancing end-of-life care for the large and diverse population of Veterans.

Please contact me should you have any questions.

Sincerely,



Mark M Murray
President/CEO
Center for Hospice Care

Chair, Board of Directors
National Hospice and Palliative Care Organization

CHAPTER FOUR

AVERAGE DAILY CENSUS CHARTS

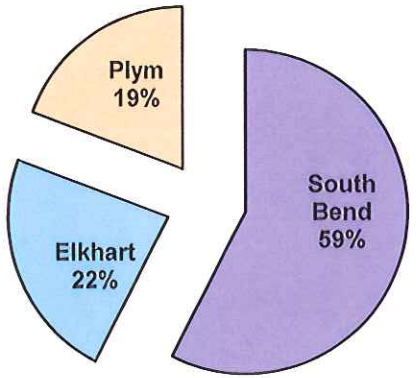
Center for Hospice Care

2012 YTD Average Daily Census (ADC)

(includes Hospice House and Home Health)

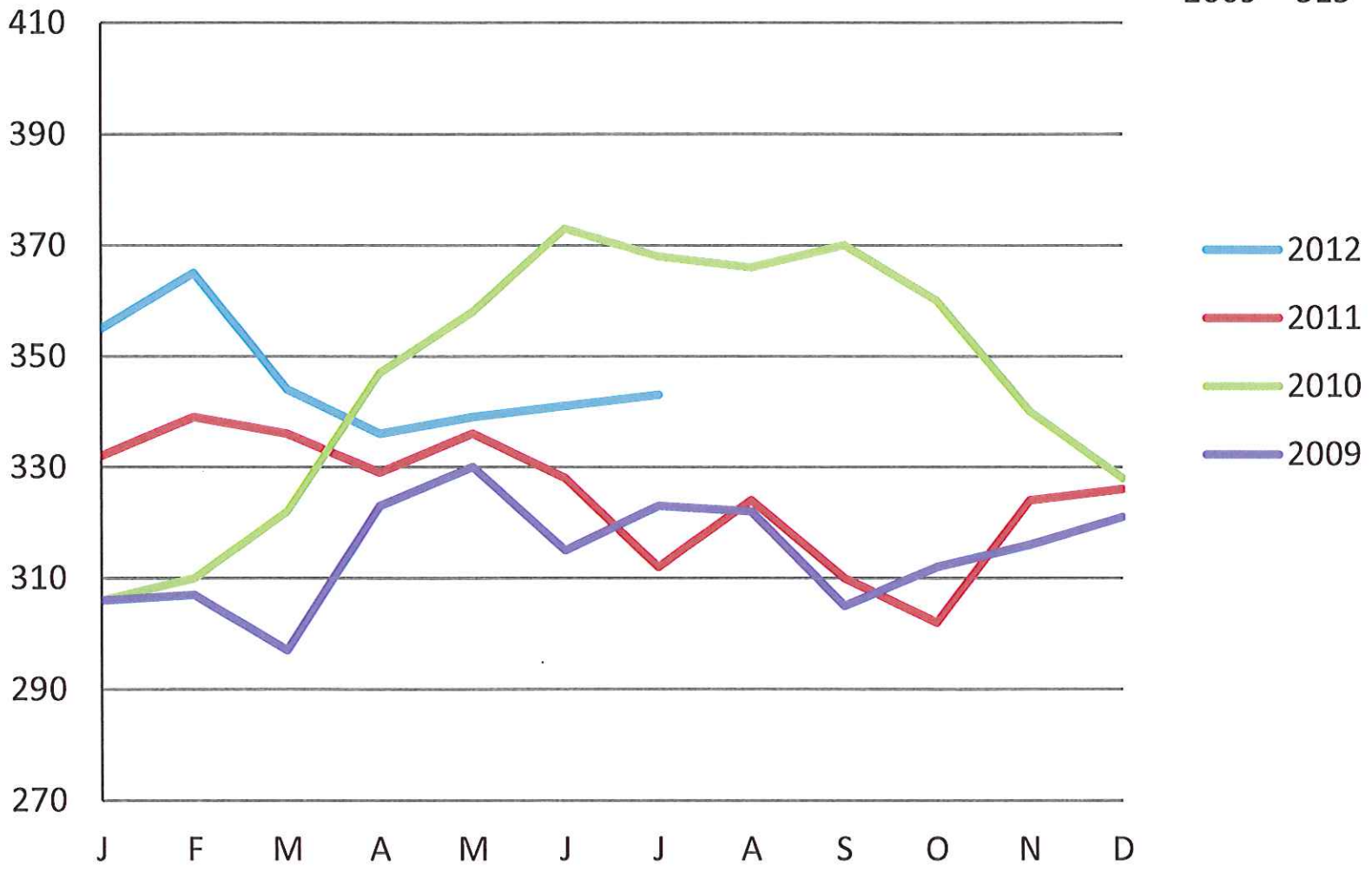
	All	South Bend	Elkhart	Plymouth
J	355	196	84	74
F	365	207	85	72
M	344	202	75	67
A	336	204	72	60
M	339	207	72	60
J	341	207	70	63
J	343	208	73	61
A				
S				
O				
N				
D				
2012 YTD Totals	2423	1431	531	457
2012 YTD ADC	**346**	**204**	**76**	**65**
2011 YTD ADC	330	194	75	60
YTD Change 2011 to 2012	16	10	1	5
YTD % Change 2011 to 2012	**4.9%**	**5.4%**	**1.1%**	**8.8%**

2012 YTD ADC by Branch	
South Bend	59.1%
Elkhart	21.9%
Plymouth	18.9%
All	100%



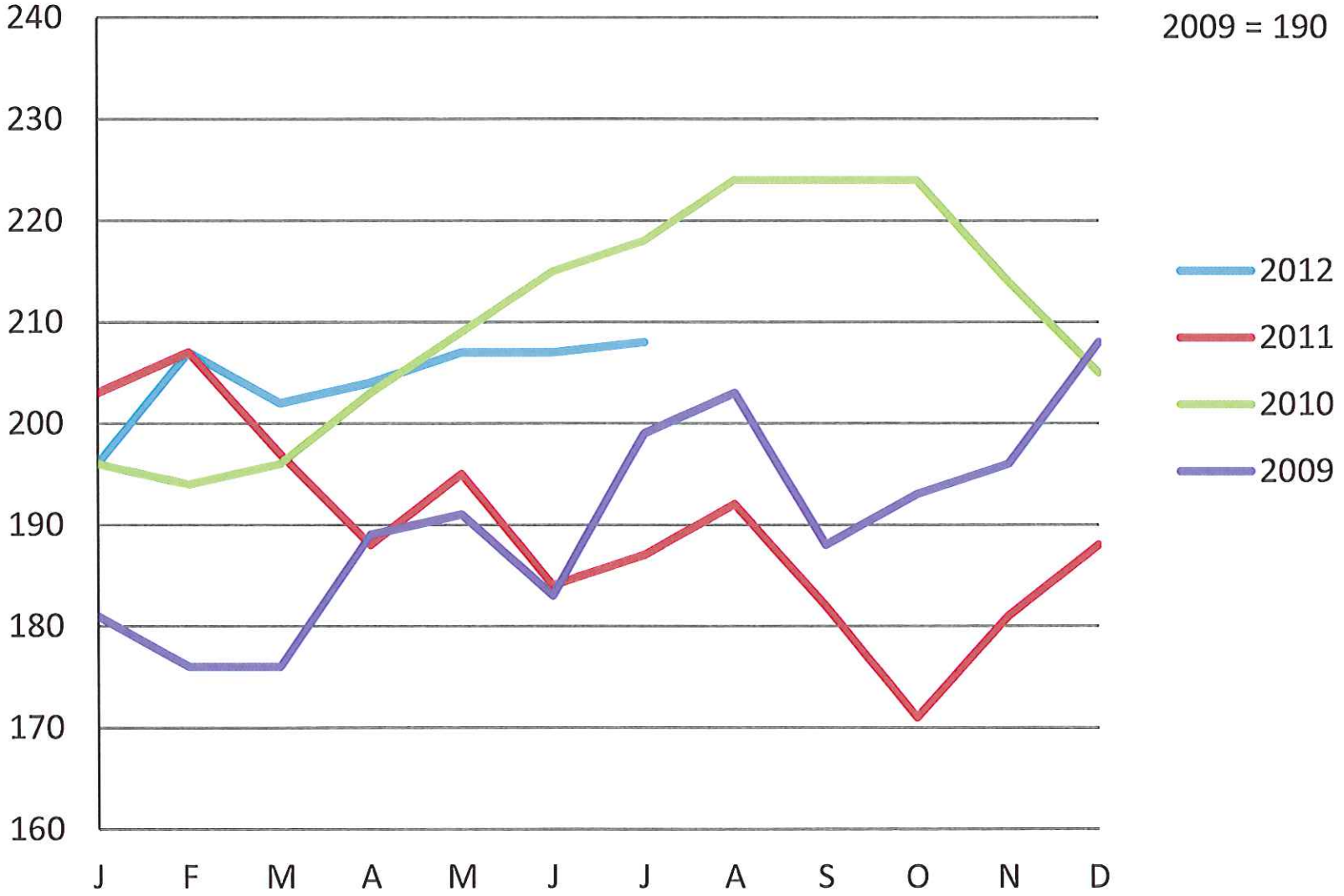
Center for Hospice Care
Total Average Daily Census (ADC)

ADC
YTD 2012 = 346
2011 = 325
2010 = 346
2009 = 315



South Bend
Average Daily Census

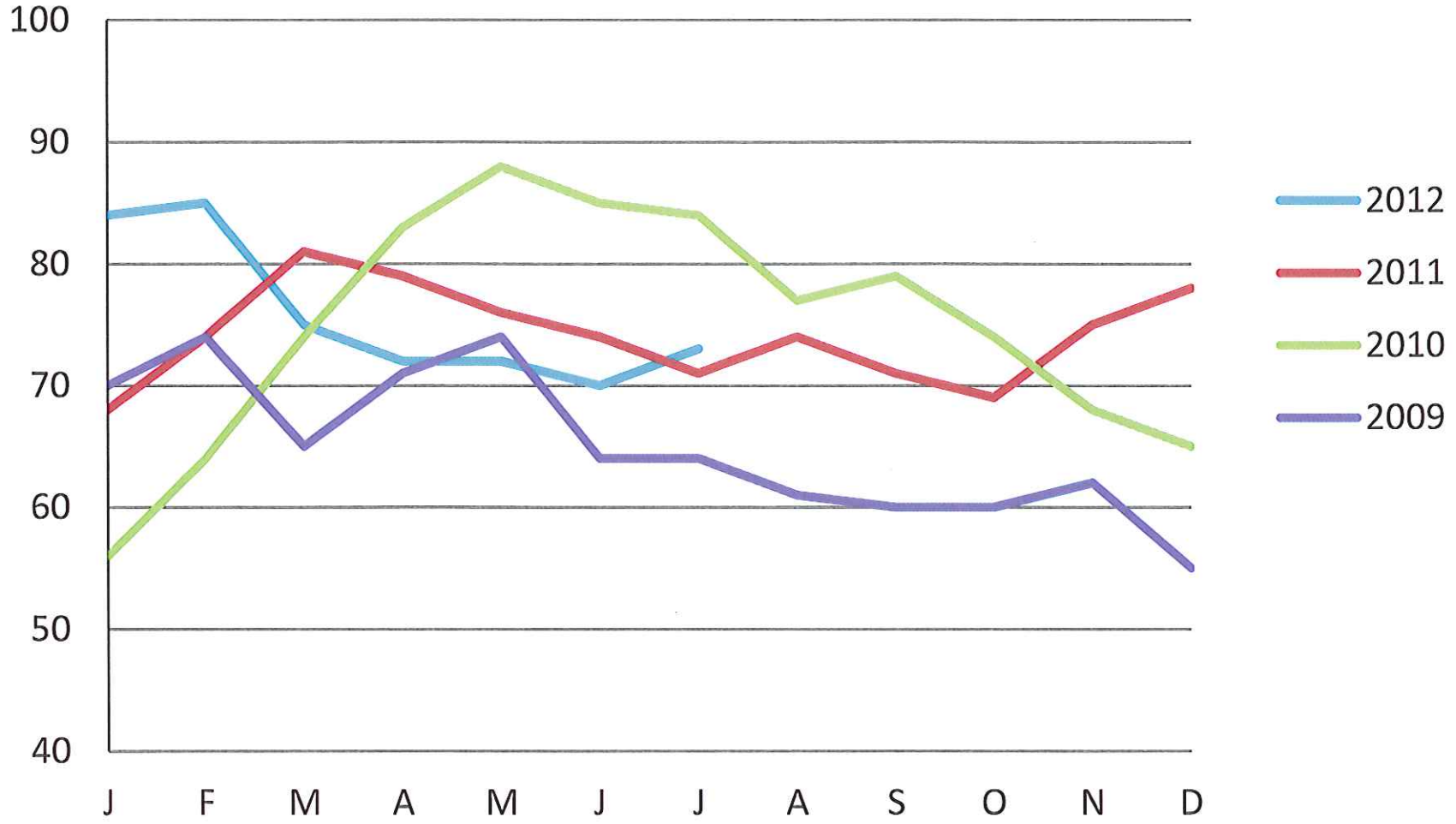
ADC
YTD 2012 = 204
2011 = 190
2010 = 211
2009 = 190



Elkhart
Average Daily Census

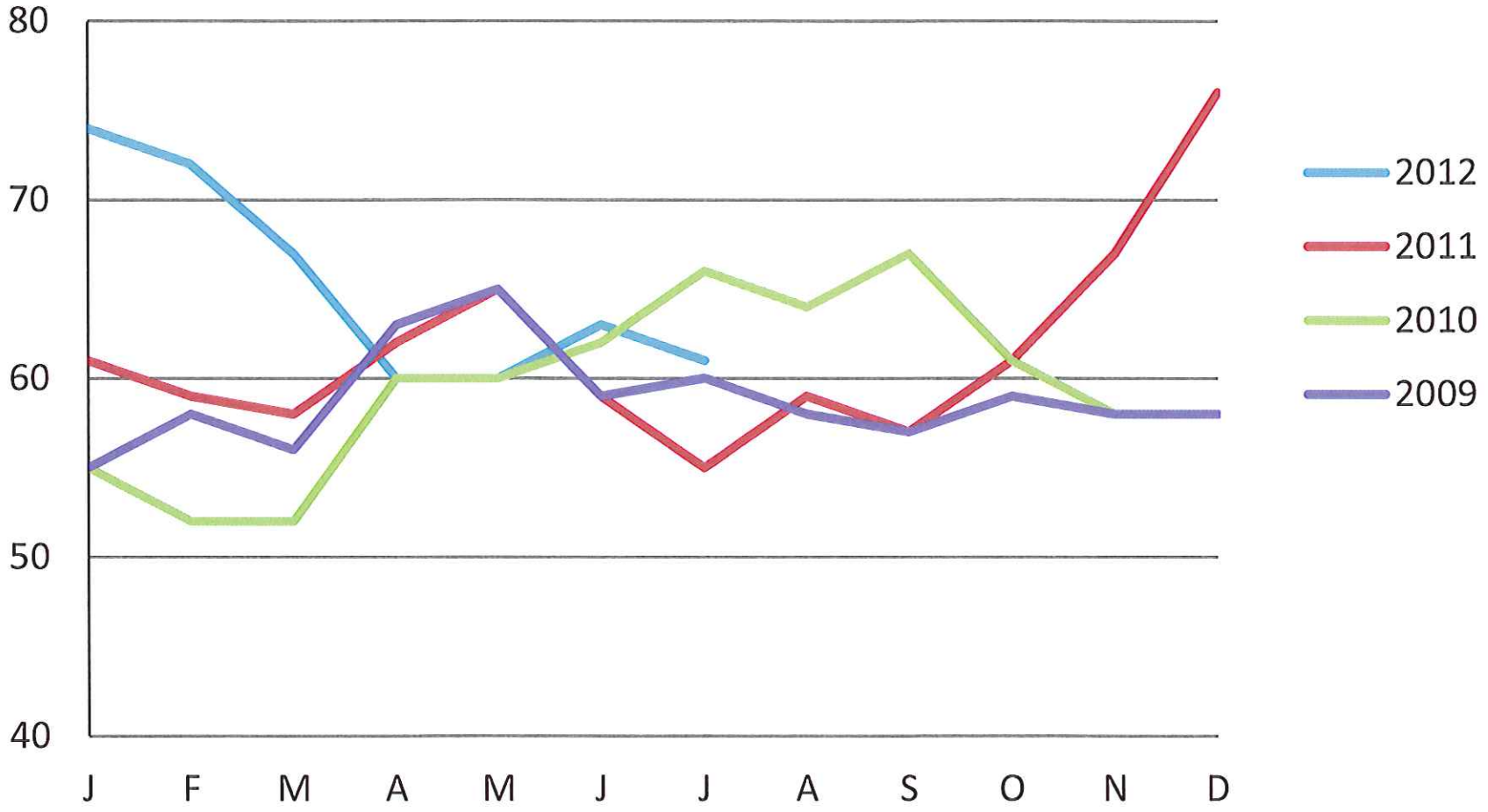
ADC

YTD 2012 = 76
2011 = 74
2010 = 75
2009 = 65



Plymouth
Average Daily Census

ADC
YTD 2012 = 65
2011 = 62
2010 = 60
2009 = 59



CHAPTER FIVE

POLICIES

Center for Hospice Care
FALL PREVENTION
Section: Patient Care Policies Category: Hospice Page: 1 of 1

REGULATION: 42 CFR 418.52 – Patient's rights
42 CFR 418.58 – Quality Assessment and Performance Improvement

PURPOSE: To prevent and reduce fall related injuries.

POLICY: Center for Hospice Care will evaluate patients for fall risk and educate patients/ families on safety and fall prevention throughout the course of the patient's care. The Agency will have a fall reduction process that is appropriate to the population, settings, and services provided. The process will include interventions that will reduce the patient's fall risk factors, and educates the patient and family, as needed, about fall risks and any individualized fall reduction strategies.

PROCEDURE:

1. ~~All p~~Patients will have a Falls Risk Assessment completed at the initial assessment.

2. A basic home environment inspection will be completed at the initial assessment with suggestions for environmental changes in the home if obvious fall risks are present.

~~2.~~3. Safety in the Home, Preventing Falls ~~in the Family Handbook~~ will be covered at the time of the initial assessment, and as needed throughout the course of the patient's care.

~~3.~~4. The patient and family will be educated on the identification of risk factors, contributing factors to falls, prevention, and responses to falls utilizing the Agency's "Teaching Tool."

5. When indicated, the ~~IDT~~nurse will use teaching points from the safety section of the Family Handbook. ~~Safety in the Home section of the Family Handbook.~~Emphasis will be placed on wearing safe footwear, use of adaptive equipment, commodes at the bedside, and postural safeguards such as sitting versus standing during certain activities.

~~4.~~6. An Enclara Pharmacy pharmacist analyzes risks versus benefits of medications with high risk for sedating side effects. The pharmacist will be utilized as a resource by the nurse of fall potential from these medications. There may be times that multiple medication regimes can be simplified.

~~5.~~7. The care plan will include safety and fall prevention interventions that are developed in conjunction with the patient and family/caregiver when falls are anticipated or repeated. A safety evaluation or safety teaching by an occupational

Signature:

therapist or physical therapist can be obtained by referral upon agreement of the Interdisciplinary Team (IDT). This process will be used for more complex cases.

~~6.~~8. Each discipline~~staff member~~ is to ask about falls at each visit. If a fall has occurred, the primary nurse is to be contacted so appropriate interventions can be developed with the family and patient.

~~7.~~9. The above interventions may need to be modified if the patient is residing in a facility, respecting the protocols that the facility may have.

10. An incident report will be completed following every reported or observed fall. These incident reports will be reviewed by the Falls Committee ~~quarterly~~ to evaluate the Agency's fall prevention efforts.

~~8.~~11. Falls resulting in significant injury will be tracked over time to evaluate the effectiveness of the fall prevention efforts. Significant injury is defined as falls resulting in sutures, fracture or probable fracture, a permanent change in level consciousness, a permanent change in level of function including becoming bedbound, and death.

Effective Date: 07/11	Revised Date: 07/12	Board Approved: 08/17/11
Reviewed Date:		Signature Date: 08/17/11

Signature:

REGULATION: 42 CFR 418.56(b)(d) – Interdisciplinary Team, care planning, and coordination of services

PURPOSE: To provide a written plan of care for each individual admitted to the Agency and to ensure that the care provided to an individual is in accordance with the plan. The plan of care shall be reviewed and updated accordingly.

POLICY: Hospice care and services provided to patients and their families are in accordance with an individualized, written plan of care established by the hospice interdisciplinary team (IDT) in collaboration with the patient's attending physician (if any), and, if appropriate, the patient or representative and the primary caregiver.

PROCEDURE:

1. The patient's plan of care specifies the care and services necessary to meet the needs of the patient/caregiver as identified in the initial, comprehensive and updated assessments of the patient.

2. Each patient and his/her primary caregiver(s) receive education and training from the hospice as appropriate to their responsibilities for the care and services provided in the plan of care.

3. Efforts to involve the patient's attending physician (if there is one) in the development and updating of the hospice plan of care and the results of those efforts are documented in the patient's clinical record. A copy of the Plan of Care is sent to the attending physician within seven (7) days of the patient's election of the hospice benefit ~~admission to the Agency~~ and at every recertification period.

4. When the patient, representative or primary caregiver declines to be involved in actively developing the plan of care, this is documented in the patient's clinical record.

5. The plan of care is reviewed and updated by the IDT every 15 days or more frequently if needed.

6. Revisions to the plan of care are based on information from the patient's updated comprehensive assessment and the patient's progress toward outcomes specified in the plan.

7. Reviews of and changes to the plan of care are documented in the plan and communicated to members of the IDT.

DRESS CODE

Our organization's image is reflected by our employees. We ask that all employees take pride in their professional appearance, and that everyone is clean, well groomed, and appropriately dressed for their position.

Employees who come in contact with patients and families should be aware as professionals that attention to details in appearance will help instill confidence in patients and families. Project a professional appearance; projects professional care.

CHC has established the following guidelines, which include, but are not limited to:

- Identification must be worn at all times by patient care staff.
- Fingernails should be clean, well-trimmed, and not interfere with duties. Based on CDC and OSHA guidelines to reduce the risk of healthcare acquired infection, artificial nails (including acrylics, gels, wraps, overlays, etc.) are not to be worn by anyone with patient contact or patient food preparation. Nail polish may be worn on natural nails by patient care staff, but it should not be chipped.
- Perfume/cologne should be worn with discretion.
- Hair should be clean and neatly fashioned. Patient care staff must keep long hair tied back when performing patient care. Hospice House staff must do so at all times.
- Jewelry can be worn sparingly, for example, rings, watches, short necklaces, and small earrings. Jewelry may not be worn on visible pierced body parts (excluding ears).
- Clothing should not be form fitting (spandex, Lycra) or reveal lines/color of undergarments.
- Clothing cannot display questionable wording or graphics; this includes, but is not limited to, alcohol or tobacco logos.
- Non-canvas athletic shoes may be worn by direct patient care staff, if they are appropriate to dress. They must also be solid in color. Nurses and Aides providing patient care must wear closed toe shoes.

- Bib overalls, sweat pants, shorts, and denim pants are not permitted.
- Individual supervisors will be responsible for ensuring that staff who wear Capri pants meet agency expectations for professional appearance.
- Skirts or dresses should not be more than two inches above the knee.
- Patient care staff is required to wear CHC issued scrubs or jackets when going into ECF's or Assisted Living Facilities.

Individual supervisors are responsible for ensuring that the appearance of their employee is appropriate, and may, at his/her discretion, in consultation with the Director of Human Resources, implement and define appearance standards which are more restrictive than those listed above, but never less restrictive. Employees who appear for work inappropriately dressed may be sent home and directed to return to work in proper attire. Under such circumstances, hourly employees will not be compensated for the time away from work. Dress Code policy violations will be handled in accordance with the Progressive Discipline policy.

Revised 07/12; Reviewed 06/10

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STEPS TO FOLLOW WHEN GOVERNMENT AND STATE AGENCIES, MEDICARE / MEDICAID CONTRACTORS, AND OTHERS MAKE A REQUEST FOR INFORMATION

Telephone Requests

Any Staff who receives a Request for Information by telephone from any person who claims to represent a Government Agency, State Agency, Medicare / Medicaid Contractor (hereafter "Government Agency") should take the caller's full name and contact information, write it down and advise them that their call will be promptly returned. The caller's information should be delivered to the Compliance Officer promptly so that the Compliance Officer, or in the Compliance Officer's absence, such other person(s) designated below, can arrange for prompt follow up, as appropriate. No Staff should schedule an appointment or otherwise furnish information to the caller without the Compliance Officer's prior express approval.

If the Compliance Officer is unavailable, present the information to the following staff in the following order of availability: VP/COO, CFO, President / CEO or any other member of the Administrative Team (hereafter simply referred to as "Compliance Officer.")

In Person Requests

Any Staff who receives a Request for Information from a person who physically presents in the office and claims to represent a Government Agency should take the person's full name and their business card (if available) and any written materials that they wish to present in support of their Request and ask the person to have a seat in the waiting room. Staff shall immediately contact the Compliance Officer. Staff shall deliver the person's information and any written materials to the Compliance Officer immediately (by email scan or FAX as necessary) so that the Compliance Officer can review same and meet with the person. NOTE: Any Request that appears to be a subpoena or search warrant requires the immediate attention not only of the Compliance Officer but also of designated legal counsel who will be contacted by the Compliance Officer. As before, no Staff should furnish any information to the person without the Compliance Officer's prior express approval.

Out-Of-Office Requests

It is possible that Staff may be approached by a person who claims to represent a Government Agency outside the business office after normal business hours, either at their home, shopping mall or other location within the community. Although Staff are permitted to speak with the person, please note that they have the legal right to choose not to speak to the person at that time and to have their own attorney present before the interview is conducted at a later time. As before, any such Request should be reported to the Compliance Officer immediately so that the Compliance Officer can arrange for prompt follow up, as appropriate.

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Compliance Officer Response to Requests

Upon receipt of any Request for Information, the Compliance Officer shall obtain additional information regarding the nature of the Request, as appropriate, and confer with the President / CEO or his/her designee, before disclosing any information in response to the Request. Because certain Requests may require immediate attention, as in the case of search warrants, grand jury subpoenas and other lawful processes, the Compliance Officer should contact designated legal counsel immediately.

Absolutely No Obstruction of Justice or Interference with Investigations

Center for Hospice Care has a firm policy against obstructing or interfering with any audit, investigation or enforcement action that may be the subject of a Request for Information. Therefore, no Staff shall, under any circumstances:

Destroy or alter any records, documents, emails, or other information in anticipation of a request for the document or record by a Government Agency;

Lie or make false or misleading statements to any person who claims to represent a Government Agency; or,

Attempt to persuade any other person to provide false or misleading information in response to a Request or to otherwise refuse to cooperate with an investigation conducted by a Government Agency.

Reviewed 07/12