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
October 17, 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
October 17, 2012
7:30 a.m.

A G E N D A

1. Approval of August 15, 2012 Minutes *(action)* – Terry Rodino (2 minutes)

2. President's Report *(information)* - Mark Murray (10 minutes)

3. Finance Committee *(action)* – Amy Kuhar Mauro (10 minutes)
   (a) Financial Statements for August and September

4. Patient Care Policies *(action)* – Amy Tribbett (5 minutes)
   (a) Communication Barriers - *revised*
   (b) Volunteer Assignments – *revised*
   (c) Volunteers – Confidentiality – *revised*
   (d) Volunteers – Orientation, Training and Supervision – *revised*
   (e) Volunteers – Patient Care Documentation – *revised*
   (f) Volunteers – Performance Evaluation – *revised*
   (g) Volunteer Recruitment – *revised*
   (h) Volunteers – Retention, Support and Education – *revised*
   (i) Vounteers – Screening and Application - *revised*

5. Foundation Update *(information)* – Catherine Hiler (11 minutes)

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

7. Board Education – Marketing Differentiation *(information)* – Amy Tribbett and Mark Murray (15 minutes)

Next meeting December 12 at 7:30 a.m.

# # #

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Center for Hospice Care
choices to make the most of life

CHAPTER TWO MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
August 15, 2012

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

Topic	Discussion	Action
1. Call to Order: 7:30 a.m.		
2. Minutes	• A motion was made to accept the minutes of the 06/20/12 meeting as presented. The motion was accepted.	B. Ansari motioned C. Hiler seconded
3. President's Report	• Compared to last year, census through July was up 5.5%, original admissions were up 5%, and ADC was up 5%. We had a meeting with EGH administrators regarding palliative care, and admitting patients to hospice while they are physically still in the hospital. We also reviewed the deaths before admission statistics. This should have a positive effect on the care patients receive and the hospital's mortality statistics. We had the same conversation with SJRMC in Plymouth and Mishawaka. We are preparing contracts for their review. • We did our first in-home blood transfusion. It was very successful. • *Okuyamba* continues to win awards and also help other hospices raise funds for their African partners through our "Event in a Box," which has been very successful. • The new HMB rates and their impact were reviewed. The new rates go into effect 10/01/12. We will receive a 2.6% rate cut in St. Joseph County, where about half our patients reside resulting in an annualized 186,000 loss in revenue based upon census case mix so far this year. Additional cuts are possible and more are definitely in store. • CHC will be the semester project for some Notre Dame marketing students on building a sustainable growth strategy. • A copy of the Succession Planning Framework is in the board packet.	

Topic	Discussion	Action
	This is an internal tool to assist the executive committee / search committee in finding the next President/CEO, especially if the transition is unexpected. This was a goal of the strategic plan for 2011-2015. • Reviewed national legislation for hospices and the HELP Hospice Act (S. 772 / H.R. 3506). • Through our employees' We Believe Fund, the Dream Foundation in Santa Barbara, and the efforts of several staff, we were able to send one of our patients to the Brickyard 400 to meet Jeff Gordon.	
4. Finance Committee	• The Finance Committee discussed the rate reductions. This could improve our market share, because of the enthusiasm of the organization. We have excellent media to inform people, and increased visibility in the community with the offices in Elkhart and the new Mishawaka campus. We believe we can turn this into a positive for us as others who are not as well positioned may fail. • June operating revenue $1.4 million, total revenue $1.7 million, YTD $9.8 million. Total expenses $1.3 million, YTD $8.1 million. June had a net gain of $391,000, YTD $1.7 million. Net without Beneficial Interest was $105,545; YTD $1.3 million. • July operating revenue was $1.5 million, YTD $11 million. Total revenue was $1.6 million, YTD $11.5 million. Total expenses $1.4 million, YTD $9.5 million. July had a net gain of $192,000, YTD $1.9 million. Net without Beneficial Interest was $124,000, YTD $1.4 million. • A motion was made to accept the June and July financials as presented. The motion was accepted. • With the rate reductions in mind, and further reductions that may or may not happen until the very end of the year, the 2013 budget will be challenging.	W. Walsh motioned B. Ansari seconded
5. Patient Care Policies	• Revisions were made in the verbiage of the "Fall Prevention" and the "Plan of Care" policies to bring them into line with regulations and practices. The Falls Prevention policy spells out the procedures for clinical staff on our expectations for safety in the home and ECFs, especially with patients at very high risk for falls.	

Topic	Discussion	Action
	• A motion was made to accept the revised policies as presented. The motion was accepted.	D. Beville motioned J. Englert seconded
6. Human Resources Policies	• The "Dress Code" policy was revised again to add, "Individual supervisors will be responsible for ensuring that staffs who wear Capri pants meet agency expectations for professional appearance." • "Steps to Follow When Government and State Agencies, Medicare/ Medicaid Contractors, and Others Makes a Request for Information" – new policy for the practices we already had in place. Staff is instructed to contact the compliance officer immediately. A short list of instructions is posted at the reception desk and Hospice House at each office. • A motion was made to accept the policies as presented. The motion was accepted.	M. Davis motioned C. Murphy seconded
7. Foundation Update	• We are seeing a nice trend from a fundraising standpoint. YTD cumulative revenue and YTD less capital campaigns, bequests and one-time major gifts is ahead of last year. • Mike W. reported on his recent visit to Uganda. During his stay, an outbreak of Ebola occurred, and one of our first two scholarship recipients, Claire Muhumuza, died after contracting it. • *Okuyamba* was shown to the Ugandan Parliament. They are very supportive of palliative care, but not financially. Most of the money spent to train health care workers comes from outside Uganda. In order to have sustainability going forward, PCAU needs to put something in their budget to fund their initiatives. For 2012-2013 we are providing scholarships for six students to go through the palliative care training program at a cost of $3,500 per student. We recently established "Road to Hope," a fund to provide schooling for children of hospice patients, which costs about $150 per child. • We will be hosting *Okuyamba Fest* on October 11 at the Center for History in South Bend. The event is in celebration of World Hospice and Palliative Care Day and our association with PCAU. Cost is $75 per person and proceeds will be directed to a fund for acquisition of a permanent home for PCAU in Kampala. • The districts in Uganda have been realigned from the original 84 to	

Topic	Discussion	Action
	137, so they include one major clinic within each district, and are around health care and schools. There are about 160 trained palliative workers in Uganda, compared to 120 when we began filming *Okuyamba*. After the next class there will be 180. One of PCAU's strategic plans is to have palliative care available for all people in Uganda within five years. • The *Gardens of Remembrance and Renewal* dedication at the Elkhart campus was held on June 7. Over 100 people attended. • Mishawaka Campus – We have completed a number of things. Wightman Petrie has finished the master plan and we closed on the real estate. DJ Construction has gotten bids for phase one. We started renovations this week on the guest house. A ground breaking event will be held in the fall.	
8. Board Education	• The status of the 2011-2015 strategic plan was reviewed. The plan has four main areas: (1) Enhance patient care; (2) Position for future growth; (3) Maintain economic strength; and (4) Continue building brand identification. Some goals have already been accomplished. We plan to do more market research to find out the needs of our customers, which include patients, families, physicians, hospitals, long-term care facilities, and assist living communities. Mark is reading Fred Lee's book, "If Disney Ran Your Hospital," which focuses on providing experiences, not just service.	
9. Chairman's Report	• Everything is being done so well and professionally.	
Adjournment	• The meeting adjourned at 8:37 a.m.	Next meeting 10/17

Prepared by Becky Kizer for approval by the Board of Directors on October 17, 2012.

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Terry Rodino, Chairman Becky Kizer, Recording Secretary

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
Hospice Foundation
President / CEO Report
October 17, 2012
(*Report posted October 11, 2012)*

This meeting takes place in Suite 200 at the AFO at 7:30 AM.
This report includes event information from August 16 – October 17, 2012.
Hospice Foundation Board meeting will begin at 8:30 AM in Room B in Suite 210.

CENSUS

At the end of September, year-to-date Average Daily Census (ADC) agency wide was running 4.71% higher than at the same time in 2011. The year-to-date total number of patients served was 3.27% higher and original admissions were 2.41% higher than July 2011. It should be noted that deaths during August were 23% higher than July (107 vs. 132) with 56% of August deaths occurring in the last 16 days (58 in first half vs. 74 in last half of the month) leaving us with a very low ADC to begin the month of September. This added to the fact that original admissions for September were down 19% from August's very robust 134 did not help mitigate the situation.

September 2012	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	413	1,486	1,439	47
Original Admissions	109	1,147	1,120	27
ADC Hospice	301.37	323.86	304.94	18.92
ADC Home Health	21.350	18.91	22.34	(3.50)
ADC CHC Total	322.87	342.77	327.35	15.42

August 2012	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	447	1,377	1,315	62
Original Admissions	134	1,038	996	42
ADC Hospice	317.81	326.63	306.75	19.88
ADC Home Health	22.77	18.59	22.68	(4.09)
ADC CHC Total	340.64	345.22	329.43	15.79

Monthly Average Daily Census by Office and Hospice House by Calendar Year

	2012 Jan	**2012** Feb	**2012** Mar	**2012** Apr	**2012** May	**2012** June	**2012** July	**2012** Aug	**2012** Sept	**2011** Oct	**2011** Nov	**2011** Dec
S.B.:	180	189	199	201	202	203	204	202	189		177	184
Ply:	73	71	67	60	60	63	61	63	62		67	76
Elk:	78	71	72	70	68	67	68	67	62		72	73
SBH:	5	7	3	3	5	4	5	5	6		4	5
EKH:	4	5	3	2	4	4	5	4	4		4	4
Total:	355	365	344	336	339	341	343	341	323	302	324	342

HOSPICE HOUSES

September 2012	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
SB House Pts Served	41	233	218	15
SB House ALOS	4.27	5.62	6.22	(0.60)
SB House Occupancy	83.33%	68.25%	71.01	-2.76%
Elk House Pts Served	24	180	172	8
Elk House ALOS	5.79	6.14	5.12	1.02
Elk House Occupancy	66.19%	57.61%	46.10%	11.51%

August 2012	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
SB House Pts Served	33	203	192	11
SB House ALOS	4.70	5.59	6.32	(0.73)
SB House Occupancy	71.43%	66.39%	71.37%	-4.98%
Elk House Pts Served	28	167	154	13
Elk House ALOS	4.71	5.78	5.10	0.68
Elk House Occupancy	60.83%	56.56%	46.15%	10.41%

PATIENTS IN FACILITIES

Of the 413 patients served in September, 164 were in facilities. The average daily census of patients in skilled nursing homes, assisted living facilities, and group homes during September was 123. Year to date through September 2012 is 131.

FINANCES

Karl Holderman, CFO, reports that the September 2012 Financials will be posted to the Board website on Friday morning, October 12th following Finance Committee approval.

August 2012 Financial Information

Center for Hospice Care					
August Overall Revenue	$	1,747,901	Year to Date Overall Revenue	$	13,286,608
August Total Expense	$	1,431,451	Year to Date Total Expense	$	10,985,464
August Net Gain	$	316,450	Year to Date Net Gain	$	2,301,144
Hospice Foundation					
August Development Income	$	64,018	Year to Date Development Income	$	643,660
August Investment Income	$	203,087	Year to Date Investment Income	$	907,917
August Overall revenue	$	268,844	Year to Date Overall Revenue	$	1,595,403
Total August Expenses	$	110,650	Total Year to Date Expenses	$	923,778
June Overall Net	$	158,194	Year to Date Overall Net	$	671,625
Combined					
August Overall Revenue	$	1,858,550	Year to Date Overall Revenue	$	14,210,386
August Overall Net Gain	$	316,450	Year to Date Overall Net Gain	$	2,301,144

At the end of August, Center for Hospice Care's Year to Date Net without the beneficial interest in the Hospice Foundation was $1,629,519.

At the end of August, CHC and HF combined had a net without investments of $1,393,227.

At the end of August, the Foundation's Intermediate Investments (formerly known as Pool Two) totaled $3,976,381. Long Term Investments (formerly known as Pool Three) totaled $10,119,837.

CHC's assets on August 31, including its beneficial interest in the Hospice Foundation, totaled nearly $30.3 million 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 we recently signed an Addendum to our Agreement with St. Joseph Regional Medical Center. It allows for the simultaneous discharge of a SJRMC terminally ill patient and the simultaneous admission of the patient into our Hospice program, while physically retaining the patient within the hospital. It is felt that this arrangement will reduce the number of DBAs and provide a higher quality of end-of-life care for SJRMC patients. Lori Price, CEO of St. Joseph Regional Medical Center in Plymouth and Ken Hall, SJRMC System Chief Nursing Officer, were instrumental in working with us to bring about this important change.

Activities continue in recruiting another Medical Director. We have had a preliminary conference call with one candidate and another candidate has expressed interest. An on-site interview with the first candidate will probably take place later this month.

Joe Banks, D.O., one of two contracted physicians helping our medical staff with face-to-face patient visits, has expressed interest in becoming board certified in Hospice and Palliative Medicine. He will be attending inter-disciplinary team meetings one day each week and will also be making rounds in the South Bend Hospice House with our physicians. This will allow him to learn more about the practice of hospice and palliative medicine and fulfill the certification board requirement of having completed 100 hours of such training.

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

DIRECTOR OF NURSING UPDATE

Donna Tieman, RN, DON, reports a second home blood transfusion was completed with a South Bend patient. The patient and family were very satisfied with the ease in which the procedure was completed. The successful completion of a second transfusion in the home is evidence that this is a value added process for our Agency.

On September 5, a nursing leadership retreat was held for all Nursing Managers. Barbara Walsh from Memorial Hospital Leadership Development led the group in developing a leadership profile. Donna Tieman has challenged the CHC Patient Care Coordinators to select two areas in their professional profile they want to improve over the next year. Barbara Walsh's services are offered free to area community non-profits.

The spouse of one of our nursing home team RNs was a CHC patient and died three days later. Her nursing co-workers stepped up to support her and picked up her visits without being asked by management. They, among themselves, developed a plan of whom and how patient care would seamlessly continue. This is evidence of how our nurses are developing into a high functioning team.

HOSPICE FOUNDATION VP / COO UPDATE

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

Fund Raising Comparative Summary

Through September 2012, the Development Department recorded the following calendar year gift totals as compared with the same period during the prior four years:

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	643,819.01
September	1,622,566.59	913,852.09	671,103.04	724,782.28	736,557.59
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 Elkhart Hospice House capital campaign, 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	64,017.65
September	32,254.39	55,710.51	85,629.27	94,000.56	92,808.58
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 4th Annual Bike Michiana for Hospice can be counted as a success on the key metrics: we exceeded our fundraising goal of $20,000 by $6,643.05 (to date); there was an increase of more than 10% in cyclists participating (974 riders in 2012 versus 866 in 2011); and survey results overall are very positive. We had one rider each from Rhode Island and New York as well as four from Pennsylvania. More than 40 cyclists came from the Chicago area, which was one of our key marketing areas.

The post-ride party included food from Corndance Café and music by Alligator Blackbird. An event of this caliber and size would not be possible without the enthusiastic leadership of our volunteer committee, so ably led for the fourth consecutive year by former board member J.V. Peacock. Their dedication and hard work are greatly appreciated. Planning is already underway for next year's event, which will be held on Sunday, September 15th.

The 27th Annual Walk for Hospice was held September 30th at Newton Park in Lakeville. Again, the event can be counted as a success; donations increased 4.88% (so far) over 2011 ($28,045.39 in 2012 versus $26,738.46 in 2011). There were 410 participants this year, compared to 416 in 2011. The 28th Annual Walk for Hospice will be held at the new Mishawaka Campus and we look forward to revamping the event to take advantage of the new location.

The Helping Hands Award Nominating Committee selected Ann Manion as the 2013 Helping Hands Award receipt for her community service through the Women's Care Center. Planning has begun for next year's dinner, which will be held at the Hilton Garden Inn on May 1st.

Okuyamba Fest will be held on October 11th at the Center for History. This inaugural World Hospice & Palliative Care Day celebration of CHC/Hospice Foundation's partnership with PCAU will feature samplings of international foods, wines and beers as well as 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. A group of local artists exhibiting a small number of original works will be included in the event as well. They will set a minimum bid for their pieces and donate 40% of the proceeds for our efforts in support of FHSSA/PCAU.

FHSSA/PCAU

We are working with FHSSA on a crowd funding program, proceeds of which will be used to support the PCAU building fund. Crowd funding is a network of individuals who contribute and network to support a variety of causes and entrepreneurial endeavors. It has been used successfully for disaster relief and start-ups in particular. FHSSA has chosen a vendor to supply the network platform and will be coordinating the efforts of the FHSSA partners.

The film ***Okuyamba*** continues to garner awards and is being shown throughout the country. It was named an Official Selection of the Vegas Cinefest and was screened there on October 5th. On October 10th, the film was the highlight of the FHSSA World Hospice & Palliative Care Day Celebration at UCLA. The event, hosted by FHSSA and actress Torrey DeVitto, took place at the James Bridge Theater at 7 pm. Mike Wargo was on hand for post-screening Q&A sessions at both of these events.

The film will also screen at about a dozen World Hospice & Palliative Care Day events, being sponsored by various FHSSA partner hospices across the United States, during the month of October. In addition, Dr. Robert A. Carter, a medical missionary, is organizing a screening in Kijabe, Kenya this fall.

Mishawaka Campus

Site remediation is now complete and work has begun to prepare the site for laying the foundation. The Intern Suite at the Guest House has been completed and work is underway on façade improvements for both the Guest House and the former Edgewater Florist building, future site of our Palliative Care Center. Final plans for an October 16th Groundbreaking Ceremony are underway. Invitations were sent to more than 1,500 donors, dignitaries and supporters. The event will begin with a ceremonial groundbreaking ceremony at the new campus site on 603 Madison Street, Mishawaka. A reception will be held immediately following at River View 500 on Lincolway East.

Elkhart Campus

Memorial items resulting from the August mailing to donors and supporters resulted in two benches, one flowering tree, one evergreen tree, seven 8 x 8 bricks and seven 4 x 8 bricks being ordered. Once delivery and installation of the bricks is confirmed, we will set a date for a small memorial service in the Gardens of Remembrance and Renewal.

The wind sculpture, which was donated by the CHC board of directors in memory of my mother, Martha N. Murray, is now in place and looks beautiful. Again, my sincere thanks to the board member donors for this very thoughtful and touching gift.

Communications

The Summer/Fall edition of Crossroads was published in September and mailed to 36,000 households. The cover features a rendering of the Mishawaka Campus building. Other stories include a recap of this year's Helping Hands Award Dinner, a preview of Okuyamba Fest, an article on CHC Volunteer Coordinator, Valorie Eads and her pet therapy dogs.

The Foundation website continues to be updated weekly. Photo gallery images are being added to the Bike and Walk web sites as they are available.

Staffing

Denis Kidde has joined the Hospice Foundation as the International Programing Representative. His work will focus on coordination and development of various initiatives in support of our work with FHSSA and PCAU. He joins us after spending the last eight years with the African Palliative Care Association in Kampala, Uganda. Denis, along with his wife, Grace, relocated to the U.S. just last month.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

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

Outreach in August & September

During this time, our three Community Liaisons visited the offices of more than 350 physicians and made 140 visits to extended care facilities (ECFs). More than 60 visits were made to our service area hospitals.

Research

Great Lakes Research completed 300 phone surveys which were conducted to gauge shifts in the community's awareness and knowledge level of hospice in general, and CHC in particular. Results will be presented October 16. The annual research provides the basis for the following year's messaging in our paid public awareness campaigns on radio, television, print, etc.

Public Relations Coverage in Local Media

- Volunteer Recognition in the South Bend Tribune
- Feature on Annette DeGuch and her work at CHC in the South Bend Tribune
- The "Dollars of Dying" feature in the South Bend Tribune
- Volunteer feature on Pauline Pierson in the Plymouth Pilot

Much of this coverage is contained as an attachment to this report.

Notre Dame Collaboration

Anne Johnston and David McCain, MBA students at the Mendoza College of Business at the University of Notre Dame, are working with CHC for their class project in 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

Since August, Anne and David have had several meetings with Amy Tribbett, Shirley Stevens, RN, our Admissions Coordinator, along with our Community Liaisons Lisa Zollinger, Terri Stahl and Kim Lintner. The focus of the effort is to increase physician referrals from area cardiologists by 10% over a 12-month period. Market differentiation is key and the students are focusing on our specialty programs of HeartWize and Breathe Easy when they survey area physicians. Ease of the referral process is also being addressed. The development of an "app" and/or the enhancement of our website to offer online referral capability have been discussed. Anne and David are confident that Notre Dame students would welcome the opportunity to create an "app" and/or improve our website to assist with ease of referral. Everything must of course meet federal HIPAA privacy regulations which complicate good ideas like these.

Selected Provider Relations, Extended Care Facility Marketing Activities

- Lunch meeting with Midwest Cardiology in Mishawaka. Drs. Hadian and Patel were especially interested and involved in discussion.

- In discussion with West Bend Healthcare, learned that they need books for their new resident/family library. Solicited donations from CHC staff and delivered three boxes of books and a bag of magazines.
- Met with Mary Carroll, new care manager for REAL Services. Mary is going to be our guest at our October Admissions meeting.
- Met with Chris Crawley new practice manager at Michiana Hemotology Oncology – South Bend. She was very complimentary of CHC services, and reported no problems. We established that communications with physicians should go through her.
- Attended the meeting of St. Joseph Physicians Network at The Feast in Lakeville. This event included about 15 resources for the physicians, Nurse Practitioners, and clinical managers to talk with before their meeting.
- Met for more than an hour with Michael White, new Palliative Care Coordinator for Memorial Hospital. This is his first position with palliative care and we spent time educating him about our palliative care services.
- Attended the Resource Fair for employees of Memorial Home Care. More than 100 staff members/clinicians came to the booth. This was an excellent opportunity to distinguish CHC from other competitors as Heartland Hospice, Harbor Light Hospice, Ascera Care Hospice and Southern Care Hospice were present at this event. There were more hospices present than any other provider group.
- Prepared "We Honor Veteran" packets for CHC volunteers to distribute to area American Legion posts.
- Met with Community Hospital of Bremen – Andrea DON/Administrator – Discussed the administrative changes at the hospital (new CEO is Lynn Horner).
- Met with Saint Joseph Regional Medical Center discharge planners and discussed CHC's specialty programs.
- Golden Living Center Fountainview La Porte – Provided Hospice 101 to over 45 staff members. Met one on one with both the Inservice Director and Administrator.
- Met with Nurse Navigator for Dr. Stillson – talked in depth about her role and how our specialty programs will fit nicely into their goal of less calls and hospitalizations.
- Met with Oak Woods Manor administrator Chuck. Referral received.
- Met with new Director of Brentwood Manor- Mark. Referral received.
- Met with DC Planners at Woodlawn, also discussed Home Health Services
- Met with Dr. Rutherford who has relocated her practice and is seeing patients from La Porte County. Advised her of our availability in that area.
- Met with new Administrator at Wintersong. Reviewed CHC services.
- Met with Dr. Mitra in Plymouth- reminded him of our availability in the southern counties.
- Met with Dr. Deery. Discussed the Plymouth clinic – they are now going to see Medicaid patients. Dr. Deery is happy with our services. Wanted to know more information on our grief services which we supplied.
- Had several very lengthy discussions with case managers on Elkhart General Hospital Oncology floor about late referrals.
- Lakeland Rehabilitation Center – Milford – Had a luncheon in-service with Executive Director and Social Services Director. They were very impressed that we have inpatient facilities and with our bereavement services even making the comment that no one else is offering anything close to CHC.

- EGH Intern - Elkhart General Oncology utilizes Indiana University at South Bend's Social Work Masters Interns. As part of that internship they are touring Hospice House and we are meeting with them to discuss our services. The last intern also interviewed Marcia for a part of her class work.

Community Relations

Our liaisons continue to connect throughout our service area via senior networking opportunities, chamber events and health fairs. Highlights for the past two months include:

- Collaboration with Granger Community Church: presentation to church members as Part One of church series "Final Frontier." Utilized portions of the "Consider Conversation" DVD, with my own talking points. Series to be repeated in January with the same material
- Attended Elkhart County Council on Aging (Lisa Zollinger, CHC Community Liaison, elected to Executive Committee of Board)
- Presented Hospice 101 at the Senior Center in Warsaw
- Exhibited at the Hispanic Health Coalition Health Fair in Elkhart
- Participated in the FNSS (functional needs assessment) Summit at Elkhart County American Red Cross
- Attended TRIAD Board Meeting
- Attended Gerontology Consortium/Michiana Continuity of Care meeting
- Presented Hospice 101 at the Senior Center in Nappanee
- Sponsored and exhibited at the Grief Forum at Goshen College with Ryan's Place
- Speaker at Vintage Car Association and Elkhart Noon Optimists
- Michigan City – nutrition site Hospice 101
- Visited the Older Adult Services agency in Fulton Co - made contact with the facility, provided Grief Group information. Noted CHC brochures in the lobby
- Visited the Older Adult Services agency in Starke Co. and met with the Director Joan Will be participating in the Starke Co Health Initiative meeting next month
- Worked with the Older Adult Services agency in Marshall County regarding the Senior Expo
- Attended the Marshall Co United Way Kick Off Luncheon
- Participated in the Ambassador Committee meeting of the Plymouth Chamber of Commerce
- Attended the Saint Joseph Regional Medical Center Physician's Dinner
- Presented Hospice 101 in Michigan City at a nutrition site
- Attended the Starke Co. Health Circle of Care Meeting
- Attended the Oak Wood Manor Open House – Mike sang
- Attended the La Porte Co Swanson Center Health Fair
- Attended the Golden Living Starke Co Open House
- Attended the Sterling House Michigan City Open House
- Participated in the Gerontology Consortium meeting at The Waterford and Golden Living Center
- Attended the Harbor Light Hospice open house
- 90th Anniversary Celebration at Hamilton Community, sponsored by South Bend Clinic-New Carlisle. Staffed vendor booth all day Saturday to a very good turnout The visitors to

booth were at a steady pace, allowing adequate time to interact and talk about hospice care and answer their questions

- South Bend Chamber Business Expo – focus was on our veterans program, with "Pinning" of veterans that stopped by the booth
- Gerontology Consortium marketing committee meeting – Volunteered to chair group to review guidelines for us of Elder Abuse DVD. Invited Mary Jo Campbell of SJRMC and Karin Hobgood of VNA to join committee.
- Attended the open house of the new Heartland Hospice offices in Mishawaka, "welcoming" them to the neighborhood
- Presented Hospice 101 to the adult Sunday School members of Faith Methodist Church in South Bend
- Joined Family Group at Arborwood Assisted Living, and gave the presentation to the group on hospice care in the assisted living setting
- Continuing to work with Doug Germann, elder attorney, to develop a presentation to the clients of Raymond James financial.

Volunteer Update for October

New Volunteers: To date, 52 volunteers have been recruited and trained in 2012.

Training: More than 25 new volunteers have signed up for the fall training which began in October.

Collaboration: Volunteer Recruitment Coordinator, Valorie Eads, will be training 41 University of Notre Dame students who will work to grant dreams for Center for Hospice Care patients via "Dreamcatchers." The vision of Dreamcatchers is to connect local young people to their community by forging bonds between hospice patients and high school/college students.

Tuck-In: Through the end of September, 6,200 Tuck-In calls have been made and 569 needs have been met.

NEW AND REVISED POLICIES FOR THIS MEETING

We have nine policies up for approval. All eight of the volunteer related policies have changes to reflect our current practice and the communications policy is just to change a telephone number.

HOSPICE "PEPPER" REPORT INDICATES CHC NOT AT RISK FOR FRAUD AND ABUSE

We have received our PEPPER Report in late August and it is included as an attachment to this President's Report. The report is from TMF Health Quality Institute who is under contract with the Center for Medicare and Medicaid Services (CMS) to provide comparative data reports to various Medicare provider sectors and to Medicare Administrative Contractors/Fiscal Intermediaries (for us Palmetto GBA) 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, within the Palmetto jurisdiction, and nationwide. The 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. This information is intended to generally tell us if we have a problem and where we might want to look to correct it. A hospice who has a large percent of their patients alive over 180 days may have admitted patients who were not eligible for hospice care to begin with. A hospice program who has a large percent of the patients discharged alive may have enrolled patients who were not eligible to begin with and then, after reaping the revenue, discharge them right before they hit the 180 day mark. CHC appears to well below these thresholds for concern. Below are the PEPPER stats from the most recent federal fiscal year, October 1, 2010 – October 31, 2011. Again, the suggestion is that a problem may exist is a hospice program is above the 80th percentile for their peer groups.

	National 80th Percentile	Palmetto 80th Percentile	Indiana 80th Percentile	CHC Actual Percent
Percent of Patients alive over 180 Days	21%	22.6%	18.8%	12.7%
Percent of Patients Who are LIVE discharges	15.7%	20.0%	14.2%	2.7%

Since the report looked at data over three consecutive fiscal years, CHC's three-year average long LOS was 13.3% and the live discharge was 3.5%.

OIG 2013 WORKPLAN FOR HOSPICES RELEASED

The Office of Inspector General (OIG) has released their 2013 Workplan and hospice is contained within their investigations again this time around. There are three issues as follows:

NOTE: PPS = Perspective Payment System
DRG = Diagnostic Related Group
MedPAC = Medicare Payment Advisory Commission

Hospitals—Acute-Care Inpatient Transfers to Inpatient Hospice Care

The OIG will determine the extent to which acute care hospitals discharge beneficiaries after a short stay to hospice facilities. Analysis of Medicare claims data demonstrates significant occurrences of a discharge from an acute care hospital after a short stay that is immediately followed by hospice care. Medicare pays a full PPS rate to hospitals that discharge beneficiaries for hospice care. In contrast, Medicare pays hospitals a reduced payment for shorter lengths of stay when beneficiaries are transferred to another PPS hospital or, for certain DRGs, to postacute care settings, such as a skilled nursing facility. This is based on the assumption that acute care hospitals should not

receive full DRG payments for beneficiaries discharged "early" and then admitted for additional care in other clinical settings. If appropriate, the OIG will recommend that CMS evaluate its policy related to payment for hospital discharges to hospice facilities.

Hospices—Marketing Practices and Financial Relationships with Nursing Facilities

The OIG will review hospices' marketing materials and practices and their financial relationships with nursing facilities. Medicare covers hospice services for eligible beneficiaries under Medicare Part A. In a recent report, OIG found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements. MedPAC, an independent congressional agency that advises Congress on issues affecting Medicare, has noted that hospices and nursing facilities may be involved in inappropriate enrollment and compensation. MedPAC has also highlighted instances in which hospices aggressively marketed services to nursing facility residents. The OIG will focus their review on hospices that have a high percentage of their beneficiaries in nursing facilities. Previously, the OIG has indicated it considers a "high-percentage hospice" to be one which has more than two-thirds of its census as patients in nursing facilities. CHC generally has about one-third or less. This appears to target the large for-profit nursing home chains that also own their own hospice programs and serve mostly patients in their own facilities thereby gaining revenue for the nursing home per diem as well as the hospice per diem without actually making a valid attempt to serve the "community." Their hospice community is largely confined to within the walls of their owned facilities.

Hospices—General Inpatient Care

The OIG will review the use of hospice general inpatient care. They will also assess the appropriateness of hospices' general inpatient care claims by reviewing hospice medical records to address concerns that this level of hospice care is being misused. This level of care is commonly used for billing at our two Hospice Houses. Since CHC is unfortunately below the national average on the percent of days billed at the general inpatient level of care, we do not believe we have a systemic risk in this area.

Hospice Services—Compliance with Medicaid Reimbursement Requirements

The OIG will determine whether Medicaid payments by States for hospice services complied with Federal reimbursement requirements. Medicaid may cover hospice services for individuals with terminal illnesses. Hospice care provides relief of pain and other symptoms and supportive services to terminally ill persons and assistance to their families in adjusting to the patients' illness and death. An individual, having been certified as terminally ill, may elect hospice coverage and waive all rights to certain otherwise covered Medicaid services. This is simply a work in process.

2011 IRS FORM 990 TO BE INCLUDED AS PASSWORD PROTECTED .PDF FILE ON FLASH DRIVE TO BE MAILED TO BOARD ON 10/25/2012

The CHC Executive Committee and HF Board will meet with a representative from David Culp and Co, LLP on Wednesday, October 24th for a summary review of the Form 990s (the IRS non-profit "tax" return) for CHC and for the Hospice Foundation – two separate Form 990s. The CHC Form 990 will be mailed on a flash drive to the 2011 CHC Board and likewise the HF Form 990 will be

mailed to the HF board on 10/25/2012. This allows us to answer "yes" to the question on whether the board(s) received a copy of the 990 prior to its filing. The filing deadline is November 15. The 44-page 990 is not a document the board reviews and approves, but it is distributed to the board. This 1GB CHC logo flash drive is yours to keep. We would highly recommend you delete the 990 before putting the flash drive into personal use. Because it is our tax return, it will be password protected. The password for the CHC 990 .pdf will be " 2011_C4HC990f! " without the quotation marks.

If you have any questions about the 990 or the flash drive, please directly contact Karl Holderman, CFO, or myself. Karl and I are the only two staff employed by both corporations and the only staff members involved with these documents. Within the 40+ pages of documentation, the method of reporting certain data as required by the IRS leaves some figures inflated and in some places the requisite calculations defy any reasonable and intuitive accounting standards. Again, if you have questions, please directly contact Karl or myself.

NATIONAL LEGISLATIVE UPDATE

These are the current national legislative priorities for the hospice industry as communicated to Congress:

1.) Require all hospice programs to be surveyed by Medicare no less frequently than every three years.

2.) By [one year after enactment], all Medicare hospices will be required to have an operational corporate compliance plan consistent with the Office of Inspector General's Compliance Program Guidance for Hospices.

3.) Disclosure to the patient and family of ownership interests between the referral source and hospice.

4.) Require that owners of a provider that ceases operations with an outstanding balance due to the Medicare program not be permitted to participate in the ownership and/or management of another hospice unless they are current on the outstanding obligation.

5.) Direct the Centers for Medicare and Medicaid Services (CMS) contracted Medicare Administrative Contractors (MACs) to issue notices of cap liability within 12 months of the end of the cap year.

6.) Allow physician assistants and clinical nurse specialists to perform the face-to-face encounters, bringing them in alignment with nurse practitioners, and mandate that the face-to-face encounter occur not later than seven calendar days after the individual's election of hospice, in order to address concerns of small and rural providers in meeting their compliance obligations.

7.) Require nursing homes to make a good faith effort to enter into contracts, with at least two certified hospices in their service area, if they exist. The proposal would make the

requirement of a good faith effort to have the contracts in place a condition of certification.

8.) Require that as part of a hospital discharge planning process any patient referred for possible admission to hospice be informed of all Medicare certified hospice programs in the service area, who ask to be included, as well as noting those with whom the hospital has an ownership relationship.

9.) CMS should fully evaluate the impact of the face-to-face requirement on patients with longer lengths of stay to determine if the regulation has had the intended effect.

Please contact me with any specific questions or is you would like further information.

NATIONAL HOSPICE EXECUTIVE ROUNDTABLE MEETING

The eleven members of the National Hospice Executive Roundtable met the evening of October 8, all day on the 9th and the first half of the 10th in Colorado Springs, CO. We toured the new 40,000 square foot headquarters of Pike's Peak Hospice and Palliative Care, home to their residential home care hospice program, bereavement services and foundation offices. We also toured their new 16-bed inpatient unit housed on the entire sixth floor of the Penrose-St. Francis Hospital. We heard guest speaker Kimbery McKay discuss healthcare reform and trends in the industry for hospitals, nursing homes, assisted living facilities, hospice and home care. Kim is a CPA and partner at BKD CPAs and Advisors and has more than 18 years of experience in the health care industry and is actively involved in all aspects of health care services, including accounting and audit services, third-party reimbursement consulting and Medicare/Medicaid cost report preparation. She serves on the American Institute of Certified Public Accountants (AICPA) Health Care Expert Panel and AICPA Health Care Audit Guide Committee. She is a frequent speaker for the Healthcare Financial Management Association, state associations and other organizations. We also had a lively discussion on the pros and cons of hospice programs owning and operating their own pharmacy and had a presentation regarding such by the pharmacist, chief medical officer, consulting pharmacist, and director of pharmacy services for Pikes Peak hospice.

OUT AND ABOUT

Several CHC and HF staff attended the annual Center for History dinner honoring the University of Notre Dame on September 26.

Dave Haley, Donna Tieman, Amy Tribbett, and our three Community Liaisons attended the Indiana Hospice and Palliative Care Organization / LeadingAge Indiana conference in Indianapolis October 8 and 9. Additionally, Mike Wargo was a presenter at the conference and presented a session on international palliative care and screened "Okuyamba."

I attended the National Hospice Executive Roundtable meeting in Colorado Springs, CO, October 8 – 10.

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

CHC's PEPPER Report.

Newspaper articles regarding:
- Volunteer Recognition in the South Bend Tribune
- Feature on Annette DeGuch and her work at CHC in the South Bend Tribune
- The "Dollars of Dying" feature in the South Bend Tribune
- Volunteer feature on Pauline Pierson in the Plymouth Pilot
- 27th Annual Walk for Hospice, in Senior Life

2013 CHC Board Meeting Dates

Dave Haley's Census Charts

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

September 2012 Financials including year-to-date information.

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, December 12, 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 .

# # #

TMF
Health Quality Institute

Bridgepoint 1, Suite 300
5918 West Courtyard Drive, Austin TX 78730-5036

August 24, 2012

Chief Executive Officer
Center For Hospice & Palliative Care Inc, The, 151501
111 Sunnybrook Ct
South Bend, IN 46637

RE: **Program for Evaluating Payment Patterns Electronic Report (PEPPER)**

Dear Chief Executive Officer/Administrator,

The Centers for Medicare & Medicaid Services (CMS) is pleased to provide the comparative data report, known as PEPPER, for hospices. PEPPER can be used to support internal auditing and monitoring activities with the goal of preventing improper Medicare payments and protecting the Medicare Trust Fund. CMS has contracted with TMF Health Quality Institute to develop and distribute PEPPER and to support facilities with its use. **Please forward your Hospice PEPPER to those in your facility who would most benefit from the data provided in the report.**

What is PEPPER? It is a report containing hospice-specific data statistics for claims for services identified as potentially vulnerable to improper Medicare payments. It identifies where the hospice is at greatest risk for improper payments as compared to all other hospices in the nation. This is Hospice PEPPER version RY2011, containing statistics for claims for services occurring November 1, 2008 through October 31, 2011.

Interpreting PEPPER: Hospices are encouraged to review the reports and focus on areas in which they are at greatest risk for improper payments (at or above the 80th percentile). PEPPER cannot identify the presence of improper payments. These can only be confirmed through a review of medical record documentation, although PEPPER data identifies where billing practices differ from the majority of other hospices in the nation.

Training and Support: At PEPPERresources.org, access the Hospice PEPPER User's Guide and a recording of a Hospice PEPPER training session (to be posted September, 2012), located on the Training and Resources page in the Hospice section. Questions regarding the Hospice PEPPER may be submitted at any time through the website Help Desk (Help/Contact Us tab).

Sincerely,

Kimberly Hrehor

Kimberly Hrehor, MHA, RHIA, CHC
Project Director

PEPPER

Definitions for Hospice PEPPER Target Areas

PEPPER

Hospice Target Area	Hospice Target Area Definition
Live Discharges	Numerator (N): count of beneficiaries discharged alive with occurrence code "42" (date of termination of hospice benefit) and with a length of stay (LOS) < 25 days Denominator (D): count of all beneficiaries discharged (by death or alive) with a LOS < 25 days excluding discharge patient status code "30" (still a patient)
Long Length of Stay	N: count of beneficiaries receiving hospice services whose combined days of service at the hospice during the cap year (November 1 through October 31) is greater than 180 days (obtained by considering all claims billed for a beneficiary during the cap year) D: count of all beneficiaries receiving hospice services at the hospice at any point during the cap year (beneficiaries must have at least one claim for service from the hospice)

PEPPER

Hospice PEPPER

Visit PEPPERresources.org

Compare Targets Report, 12 Months Ending 10/2011

151501, CENTER FOR HOSPICE & PALLIATIVE CARE INC, THE

The Compare Targets Report displays statistics for target areas that have reportable data in the most recent cap year. To prioritize Compare Worksheet findings, hospices should consider their target area percentile values for the nation, jurisdiction and state. Percentile values at or above the 80th percentile indicate that the hospice is at risk for improper Medicare payments. Percentile values should be evaluated in the priority order of 1) nation, 2) jurisdiction and 3) state. The higher the percentile, the greater the risk of improper payments. Hospices should also consider the number of target claims (third column below) and the sum of payments in prioritizing their findings to maximize potential impact of their efforts.

Target	Description	Target Count	Percent	Hospice National %ile	Hospice State %ile	Hospice Jursidict. %ile	Sum of Payments
Live Discharges	Proportion of beneficiaries discharged alive with occurrence code "42" (date of termination of hospice benefit) and with a LOS < 25 days, to all discharges with a LOS < 25 days excluding discharge patient status code "30" (still a patient)	21	2.7%	3.6	12.0	2.8	$77,595
Long LOS	Proportion of beneficiaries receiving hospice services whose combined days of service is greater than 180 days (obtained by considering all claims billed for a beneficiary during the cap year), to total number of beneficiaries receiving hospice services at any point during the cap year (beneficiaries must have at least one claim for service from the hospice)	188	12.7%	42.2	48.3	33.6	$8,054,473

Note: State and Jurisdiction %tiles are not reported when there are fewer than 11 hospices or when there are no hospices with at least 11 target claims.

Source: Medicare PPS Inpatient Discharge Data

Worksheet: Compare

File: 151501_11001_HSPCPEPP_RY2011_CENTER_FOR_HOSP.xls

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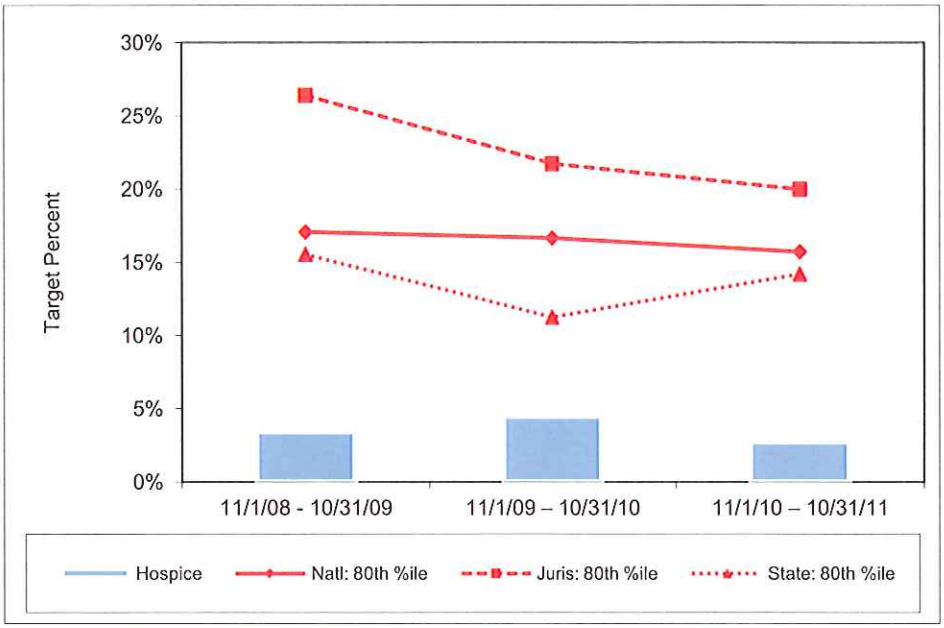
Live Discharges

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile



YOUR HOSPICE	11/1/08 - 10/31/09	11/1/09 – 10/31/10	11/1/10 – 10/31/11
Target Percent	3.4%	4.5%	2.7%
Target Count (Numerator:count of beneficiaries discharged alive with occurrence code "42" (date of termination of hospice benefit) and with a length of stay (LOS) < 25 days)	24	34	21
Denominator Count (see Definitions worksheet for complete definition)	698	759	769
Target Average Length of Stay	13.5	11.9	13.4
Denominator Average Length of Stay	8.6	7.8	7.7
Target Average Payment	$4,141	$3,154	$3,695
Target Sum of Payments	$99,382	$107,227	$77,595

*Data not available when numerator count less than 11

COMPARATIVE DATA			
National 80th Percentile	17.1%	16.7%	15.7%
Jurisdiction 80th Percentile	26.4%	21.7%	20.0%
State 80th Percentile	15.6%	11.3%	14.2%

Note: State Percentiles are zero when there are fewer than 11 hospices in the jurisdiction's state or when there are no hospices with at least 11 target claims.

SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE: This could indicate that beneficiaries are being enrolled in the Medicare Hospice Benefit who do not meet the hospice eligibility criteria. Medical record documentation should be reviewed to determine if enrollment in the hospice benefit was appropriate and in accordance with Medicare policy. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility criteria. It is recognized that beneficiaries could be discharged alive due to the beneficiary requesting to revoke the hospice benefit, or the beneficiary moving out of the hospice service area.

Hospice PEPPER

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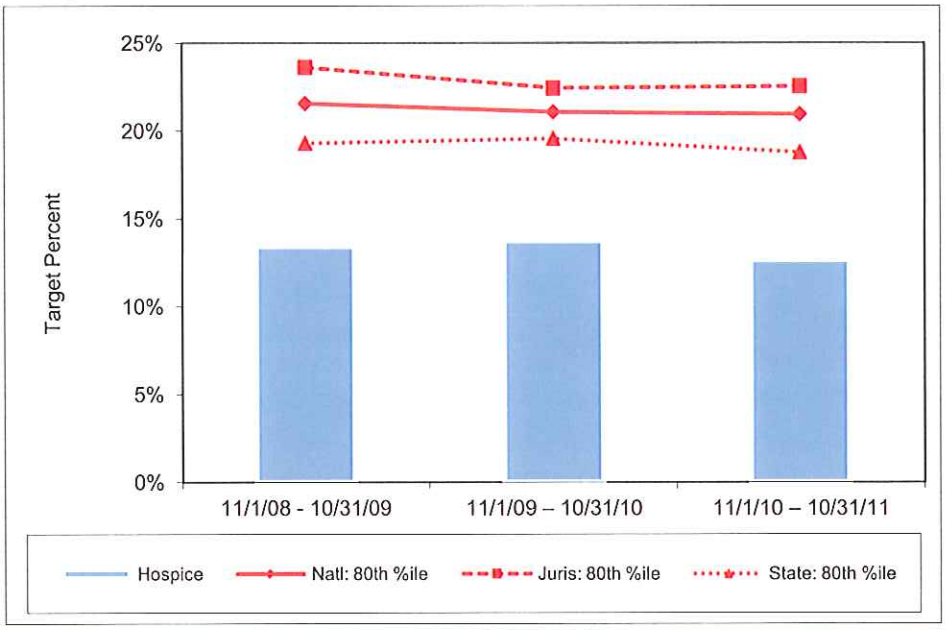
Long Length of Stay

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile



YOUR HOSPICE	11/1/08 - 10/31/09	11/1/09 – 10/31/10	11/1/10 – 10/31/11
Target Percent	13.4%	13.7%	12.7%
Target Count (Numerator: count of beneficiaries receiving hospice services whose combined days of service at the hospice during the cap year (November 1 through October 31) is greater than 180 days (obtained by considering all claims billed for a beneficiary during the cap year)	196	212	188
Denominator Count (see Definitions worksheet for complete definition)	1,459	1,543	1,486
Target Average Length of Stay	280.9	290.5	292.6
Denominator Average Length of Stay	67.7	69.3	65.4
Target Average Payment	$40,504	$42,221	$42,843
Target Sum of Payments	$7,938,804	$8,950,798	$8,054,473

*Data not available when numerator count less than 11

COMPARATIVE DATA			
National 80th Percentile	21.6%	21.1%	21.0%
Jurisdiction 80th Percentile	23.6%	22.4%	22.6%
State 80th Percentile	19.3%	19.6%	18.8%

Note: State Percentiles are zero when there are fewer than 11 hospices in the jurisdiction's state or when there are no hospices with at least 11 target claims.

SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE: This could indicate that beneficiaries are being enrolled in the Medicare Hospice Benefit who do not meet the hospice eligibility criteria. Medical record documentation should be reviewed to determine if enrollment in the hospice benefit was appropriate and in accordance with Medicare policy. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility criteria.

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Top Terminal Conditions

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Hospice Top Terminal Conditions, Most Recent Cap Year

In Descending Order by Total Decedents

Terminal Condition Description	Total Decedents for Each Condition	Proportion of Decedents for Each Condition to Total Decedents	Hospice Average Length of Stay for Condition
Blood/lymph CA	42	3.8%	14.8
Chronic kidney disease	30	2.7%	19.9
Pancreatic CA	29	2.7%	7.3
Breast CA	26	2.4%	36.8
Other heart disease	21	1.9%	56.9
Prostate CA	20	1.8%	21.6
Bladder CA	19	1.7%	13.1
Chronic liver disease	16	1.5%	20.9
Ovarian CA	14	1.3%	9.1
Parkinson's	12	1.1%	74.5
Top Conditions	229	25.1%	26.9
All Conditions	1,093		32.0

Note: This report is limited to the top terminal conditions (up to 10) for which there are a total of at least 11 decedents (for the respective terminal condition) during the most recent cap year. Terminal conditions are identified using the final claim. Average length of stay is calculated by dividing the total number of days decedents received services from the hospice by the total number of decedents with that terminal condition that received services from the hospice.

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Hospice for J11 Palmetto GBA (11001)

Top Terminal Conditions

Jurisdiction Top Terminal Conditions, Most Recent Cap Year

In Descending Order by Total Decedents

Terminal Condition Description	Total Decedents for Each Condition	Proportion of Decedents for Each Condition to Total Decedents	Jurisdict. Average Length of Stay for Condition
NonAlzheim dementia	43,618	10.7%	59.6
Lung & other chest cavity CA	39,032	9.6%	23.0
Congestive heart failure	29,144	7.2%	39.3
Failure to thrive	28,393	7.0%	50.8
Debility NOS	28,086	6.9%	49.2
Non-infectious respiratory	26,297	6.5%	47.7
CVA/stroke	24,246	6.0%	25.7
Other heart disease	21,327	5.3%	43.1
Alzheimer's disease	18,170	4.5%	69.0
Pneumonia	13,238	3.3%	15.6
Top Conditions Jurisdiction-wide	317,192	78.1%	40.3
All Conditions Jurisdiction-wide	406,206		37.2

Note: This report is limited to the top terminal conditions (up to 10) for which there are a total of at least 11 decedents (for the respective terminal condition) during the most recent cap year. Terminal conditions are identified using the final claim. Average length of stay is calculated by dividing the total number of days decedents received services from the hospice by the total number of decedents with that terminal condition that received services from the hospice.

Hospice center honors volunteers

Carole Moats, Larry Brucker receive Krueger Award

Kathy Borlik
Namely News

Two honorable people. **Carole Moats** and **Larry Brucker**, both of South Bend, recently received the John E. Krueger Hospice Caring Award from the Center for Hospice Care.

Carole and Larry have been involved in every capacity in the agency. They currently provide patient care, do tuck-in calls and conduct fundraising.

Kathy Borlik writes this weekly column about people.

Debra Mayfield, volunteer coordinator, said they have exceptional talents and add so much to the agency. "They have impacted the lives of hundreds of patients and families, raised thousands of dollars in fundraising and enhanced our marketing efforts."

Brucker

Moats

They have helped with the competition of the CHC 30th anniversary cookbook, trained volunteers and written articles for the volunteer newsletter. They probably will always bring brownies when asked.

They also have been members of the 11th Hour Team, being with people at the very end of life when family members need a break or when there is no family at all.

Of the 11th Hour group, Carole said it's very rewarding to be there for people as they transition. It is a way to offer comfort.

She said the award is more of a reward for the work. "I got involved after a friend had hospice care. I believe that it is the finest of volunteer work."

She also got her longtime friend Larry to come along and volunteer as well. They are entering their 13th year of service. Quite the versatile pair.

The Center for Hospice Care also honored some long-standing volunteers. In the 15-year group: **Becky Donahue, Therese Greer, Elizabeth Robinson, Irma Slack, Marlene Taylor** and **Janice Wilson.**

Now to those who have served 10 years. They are: **Joan Fitt, Denise Johnson, Hubert Kuzmich, Sandra Maichen, Larry Olson, Dan Shuppert, Vera Tiani** and **Nancy Whipple.**

The five-year volunteers are: **Sharon Calahan, Denise Conery, Isabel Dequesada, Loir Fisher, Herbert Gundt, Kathleen Hojnacki, Mary Kerby, Rebecca Lanning, Susie Mahler, Jim Rahilly** and **Anna Riblet.**

Officer's widow helps others

South Bend Tribune SAT 2012

South Bend Tribune/SANTIAGO FLORES

Annette Deguch educates people about grief in her role as a bereavement counselor at the Center for Hospice Care in Mishawaka.

Annette Deguch serves as bereavement counselor for agency that once assisted her

When Annette Deguch remodeled her basement last year, she came across the three large boxes of letters and notes she received after her husband, Paul, a South Bend police officer, was gunned down 15 years ago.

"I wanted to read all of them again," she says. "I couldn't thank everyone who sent them but, even now, I want them to know how much I appreciated them."

That support helped her deal with the grief ... the loneliness ... and all the other raw emotions she felt.

"When you lose someone you love, you start wondering if life is ever going to get better, if you're always going to be sad," Annette says.

She sought professional help right away. "Someone at the emergency room (where her husband had been transported) suggested I contact the Center for Hospice Care," she says. "I did and Carolyn Pritchard, a bereavement counselor, really helped me."

And so five years ago, Annette Deguch came full circle. She became a bereavement counselor herself.

She works for the Center for Hospice Care in Mishawaka — the very place that helped her put her life back together and find the courage to face every day.

It was often a struggle. She was left with two young boys and an infant daughter when her husband was shot on a porch by a South Bend teenager, who is now serving a life sentence.

Annette went on to earn two degrees at Indiana University South Bend, including a master's in social work, so she could become a bereavement counselor. "Sometime after the first year when I was trying to find a direction and rebuild my life, I decided I wanted to help people who have had a loved one die," she says.

She counsels people of all ages — children who have lost parents, parents who have lost children, individuals who have lost their spouses. The services offered by the Center for Hospice Care are free.

Moor or Less

Bill Moor

"I rarely bring up what happened to me," she says. "It's not about me. But sometimes, my name registers with them and they may say something. I'll share my own story if I think it will help."

And mostly it does. "But there have been a couple times it has been a disadvantage," Annette admits. "A client might think what happened to me was worse than what they are experiencing. That can make it a little more difficult. But all I want to do is to help them any way I can."

See MOOR/F2

Her job is to educate them about grief. She talks about how forgetfulness or a lack of concentration is par for the course. She lets them know that their life will get better and their heart less heavy. She stresses that they need to get a medical checkup to make sure they are OK physically after sometimes spending every waking hour attending to a loved one.

She also facilitates both monthly and bi-monthly support groups of young widows/widowers, a women's tea and a men's breakfast.

Annette encourages her clients to find a hobby or a passion to help give them purpose. She goes to the gym three times a week and has become an avid bicycle rider. "You can also find something in music, the arts, meditation or by volunteering. You just need to find something."

Her life continues to revolve around her children. Theo is a high school senior and Mackenzie a high school freshman

while David is in the cadet program at an Indianapolis college, hoping to follow his father's footsteps. "I'm so proud of all of them," she says.

She also has a special relationship with Mike Suth, a South Bend police officer. He is there to give her children fatherly advice if they need it.

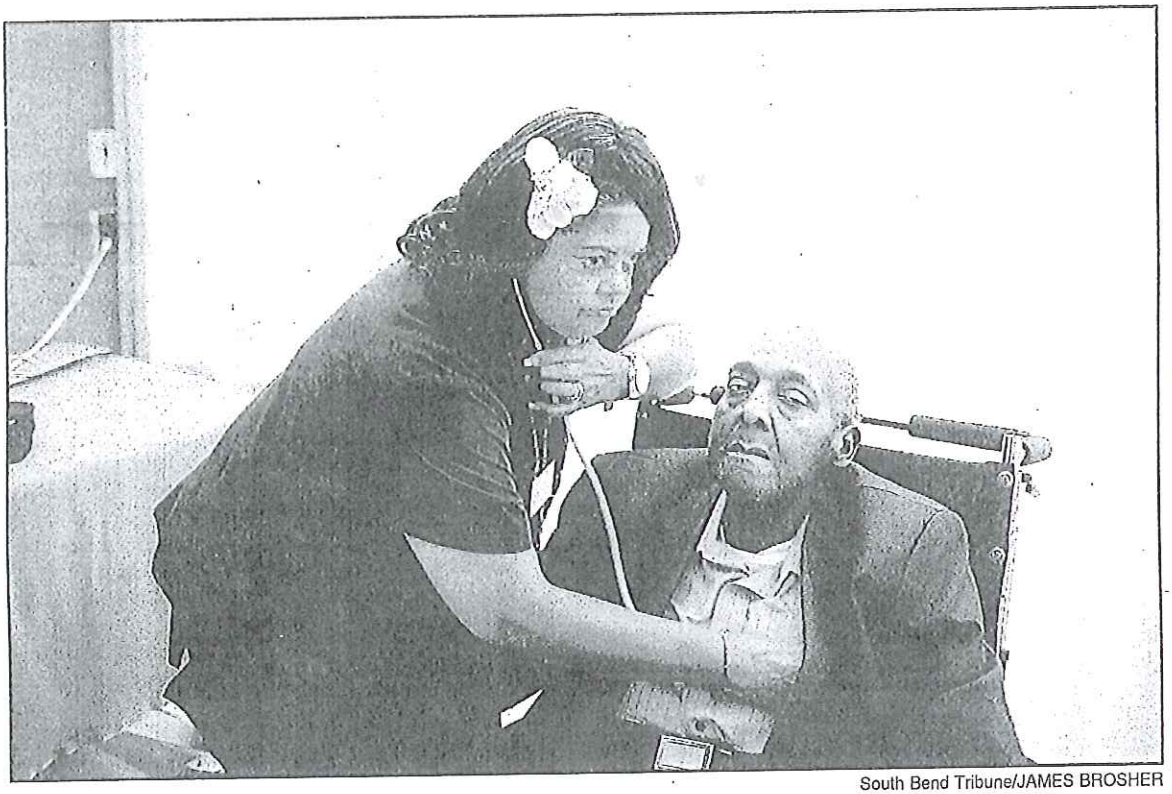
Annette knows how important it is to have people like that in everyone's lives - especially for those who have suffered a loss.

It's the way Annette Deguch makes a living - and makes living a little better for those who follow her healing words and ways.

Retired Tribune columnist Bill Moor writes a weekly column for Community. Contact him at ern14est@yahoo.com.

SB Tribune 9-16-12

The dollars of dying



South Bend Tribune/JAMES BROSHER

Helen Ursery, a registered nurse with Center for Hospice Care, listens to the heartbeat of 68-year-old George Long, a hospice patient with end-stage congestive heart failure, last month at West Bend Rehabilitation Center in South Bend. Ursery has been a hospice caregiver for six years.

Aging patients spur for-profit firms to compete for sometimes-lucrative hospice business

Adele Durham was in the hospital when she learned her husband, Bruce, had been told to seek hospice care.

By the time he died in October 2011, a few days after his 71st birthday, the South Bend man's liver was failing. Among other things, carcinomas had been discovered in his bladder and urethra and a lesion found on his pancreas.

Adele and Bruce had both lost spouses before they married in 1999, and she says they agreed on how they wanted things to go at the end of their lives.

They had not counted on Adele, who is 73, enduring medical problems at the same time. So when two hospice employees arrived at her hospital bedside to enroll Bruce in their program, she remembers being taken aback.

"To put it quite bluntly, it was like a 100 percent used-car sales pressure," Adele recalls now.

Among other things, she says, they said her husband would not see a doctor again unless he lived past the 90 days prescribed for hospice reimbursement.

"Let's just say I was lied to a whole lot," Adele says angrily nearly a year later.

Once she was back home, too, a worker argued with her about where to set up Bruce's hospital bed, Adele says, and nurses gave family members conflicting advice, including how to adjust medications and what her husband's prognosis was.

"One said, 'This could last for weeks.' Another said, 'He's going to be in screaming pain,'" Adele recalls. "We had been told everything under the sun."

South Bend Tribune/SANTIAGO FLORES

Adele Durham holds a photo of her with her husband, Bruce, who grew up in Kokomo but lived in Mishawaka most of his life. Bruce, who died last fall, was "very sweet and lovable," Adele says. After the family's disappointments with one hospice agency, she says they called the Center for Hospice Care two days before Bruce died, and "at least they were very nice people we dealt with those two days."

Virginia Black

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Watchdog

southbendtribune.com/news/sbt-the-dollars-of-dying-20120916,0,5426926.story

southbendtribune.com

The dollars of dying

Aging patients spur for-profit firms to compete for sometimes-lucrative hospice business

By VIRGINIA BLACK

South Bend Tribune

5:21 AM EDT, September 16, 2012

Adele Durham was in the hospital when she learned her husband, Bruce, had been told to seek hospice care.

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Once she was back home, too, a worker argued with her about where to set up Bruce's hospital bed, Adele says, and nurses gave family members conflicting advice, including how to adjust medications and what her husband's prognosis was.

"One said, 'This could last for weeks.' Another said, 'He's going to be in screaming pain,'" Adele recalls. "We had been told everything under the sun."

Bruce wound up with bedsores, and Adele began having difficulty with a particular nurse, she says. For

clarification of conflicting advice or to complain, she was directed to call a phone number in another city.

Perhaps like many of us, the Durhams believed "hospice" referred to one local, not-for-profit agency, in this area the Center for Hospice Care based in St. Joseph County but serving eight counties in northern Indiana.

The family discovered the hard way, she says, that other hospice organizations exist, including many owned by investors or large companies.

"I know why we're getting for-profit hospices popping up," Adele says. "With the graying of America, hospice is probably going to be one of the fastest-growing organizations in the country."

She is right. And the proliferation of for-profit hospice agencies worries some who believe a focus on the bottom line might affect those considered among our most vulnerable: the dying and their families.

'Some money to be made'

When the concept of hospice care began about four decades ago, the idea of helping patients die with as much peace at home as possible -- and helping their families through the experience -- grew through the efforts of volunteers and like-minded medical professionals.

In 1978, fewer than 60 American hospices existed. By 1981, that number had expanded to more than 400 and now tops 3,300, according to a study released last year by an Indiana University business law professor and a Bloomington doctor.

The study -- "In the Business of Dying: Questioning the Commercialization of Hospice" -- points out the ballooning numbers of both for-profit and not-for-profit agencies competing for the Medicare hospice benefit of $155 a day.

That hospice "per diem" is meant to provide pain and symptom relief, therapeutic services and other types of support to patients and their families. Hospice agencies typically offer such equipment as a hospital bed, a bedside commode, nurse visits as needed, a massage therapist or even cleaning help.

That the benefit is a flat daily rate not dependent on what services are actually provided that day, if any, can open the door to abuse, says study co-author Dr. Robert Stone.

"There's always a potential to cut corners and send nurses out less often" or even hire less experienced and less educated staff, Stone says.

"The story that you're telling me sounds very, very much like one I hear too often," Stone says of Adele Durham's description of what happened with her husband. "They're surprised to hear there are a number of other hospices in town."

It was difficult to quantify the differences in care between for-profit and not-for-profit hospices for the study, he says, calling for more investigation.

A person qualifies for hospice care if a doctor believes the patient is not likely to improve or recover from a condition, says Stone, who spent 28 years as an emergency room doctor before moving into end-of-life care a couple of years ago.

'The sweet spot'

Typically, a patient's admittance into hospice spikes intense activity as an agency arranges equipment and services. Initial visits with a family to assess needs and devise a plan for care are made. As a patient grows nearer to dying, activity increases again, with more nursing care and attention.

The typically less-involved time between enrollment and death is what Stone calls "the sweet spot" of hospice profitability.

Although the average patient spends only a few weeks in hospice care, the doctor notes that some for-profit companies have been accused of taking only patients with relatively longer predicted outcomes or conditions that might be less costly to treat.

"In the Business of Dying" refers to a Yale study on the topic.

"While correlations to adverse impact on quality of care were not proven," the 2011 study says, "the (Yale) study did find that for-profit hospice facilities typically employ less expensive labor, including fewer registered nurses, fewer medical social workers, and fewer clinicians."

Especially concerning, Stone says, are lawsuits and criminal cases that have emerged accusing such companies of failing to dismiss a lingering patient from hospice, instead continuing to collect the lucrative per diem, or of recruiting nursing home patients into hospice who are already receiving 24-hour care.

In the face of such controversy, Medicare laws tightened a bit last year to require face-to-face visits from doctors or licensed practitioners with patients who survive their initial six months in hospice.

"Initially there wasn't a whole lot of need to put the burden of reporting work behind hospice. You can call it 'burdensome regulation' or 'accountability,'" Stone says of the volunteer beginnings of the hospice philosophy. "As time went on, it became obvious there was some money to be made here."

Learning the differences

As the CEO of the not-for-profit Center for Hospice Care, Mark Murray is well aware of the proliferation of hospice organizations in this area. At least 22 competitors have sprung up here over the years, 12 of them for-profit agencies.

It's no accident that you're seeing and hearing much more advertising these days for Center for Hospice Care, he says.

"We frequently have people who think they're with us and they're not," Murray says. "We're fighting this 'Kleenex,' 'Coke,' 'Hospice' thing. We're seeing people be more educated about the choices they have with every year that goes by."

Among Medicare providers, in 1991, about 10 percent of all hospices were for-profit. In 2010, about 58 percent were for-profit companies.

Murray points out the main differences: Profits for not-for-profit agencies, which are tax-exempt, go back into services. For-profit firms pay taxes, and those profits benefit owners or shareholders.

Center for Hospice Care relies on Medicare and other insurance plans to help pay for care, Murray says, but it also depends on volunteers (to help with additional services such as respite care); memorial gifts; and its foundation to raise money to cover those costs not met by any type of insurance.

The CEO points out that by supporting the locally run Center for Hospice Care, patients also nurture the local economy rather than an out-of-town venture.

Profitability has been "a hot issue" in the industry, Murray acknowledges, but both types of agencies have good and bad providers. Stone, too, says he's aware of some for-profit agencies that also provide top-notch care.

"The main concern is that everybody gets the care they're entitled to," Murray says. "I think that people should be aware of choices that they have and be aware of who they want to go with."

Looming cuts to Medicare should inspire all in the industry to work together to ensure that patient care isn't compromised, he says, and consumers should check out state licensing and accreditations and ask questions when choosing a hospice.

Understanding options

Indeed, Jennifer Edwards, director of professional services since June for the local office of for-profit Heartland Hospice, points out the advantages of consumer choice.

"People do not understand there are options in this area," Edwards says. "You have the right to talk with hospices and find the best fit for you."

When agencies are regulated by Medicare and certified by the Community Health Accreditation Program, as hers is, she says they are well scrutinized and required to provide certain services and levels of staff training.

She says her agency, a satellite office in Mishawaka, includes staff as competent as those employed by not-for-profit agencies. The local Heartland office has cared for more than 100 patients in its 14 months of operating here, and visits to medical staffs and senior groups have helped spread the word.

Edwards says she has not experienced pressure from upper management to cut corners in patient care, although she's seen that "a little bit" with other hospice providers she's worked for, in other parts of the state.

"Everyone has to be fiscally responsible," she says, pointing out her agency, too, serves indigent patients. But "if we feel like (something is) right for that patient, we're going to try to do what we can to meet their needs."

Stone, the Bloomington doctor, says he entered the hospice field after seeing so many patients in the ER who could have benefited from a hospice approach to dying.

"Hospice patients are so vulnerable," Stone says. "They're in such great need."

Edwards, too, says that although more of the population is using hospice to manage the dying process, too many patients and doctors don't understand the hospice benefit or are even comfortable discussing options.

Adele Durham says her husband, Bruce, "definitely wanted to die at home." He had even donated to the Center for Hospice Care after he had been so impressed with how it had treated his first wife as she died.

"My complaints are irrelevant in the big picture. I just hope nobody gets treated the way we were," she says. "I think we the people need to be informed in layman's terms what hospice is."

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South Bend Tribune/JAMES BROSHER

Kelly Holder, the West Bend Rehabilitation Center's executive director, back right, conducts a caregiver meeting Aug. 23 at the center in South Bend.

Bruce Durham

southbendtribune.com/news/sbt-checking-out-hospice-information-online-20120916,0,453999.story

southbendtribune.com

Checking out hospice information online

Indiana database not comprehensive, but it's a place to start.

By VIRGINIA BLACK

South Bend Tribune

5:30 AM EDT, September 16, 2012

Like other health providers, hospice providers are licensed and regulated by Indiana health officials.

Randy Snyder, division director for acute care with Indiana's Department of Health, says 88 providers are licensed to operate in the state.

Those that qualify to bill for Medicare benefits are inspected on a six-year cycle, Snyder says, and complaints about facilities are investigated. It's fairly rare for a complaint to lead to decertification, he says.

Survey reports and substantiated complaints about licensed agencies are on the department's Web site, www.state.in.us/isdh/20124.htm. Also included is a link to consumer information, which includes a list of what services each agency offers.

Indiana is way ahead of other states, including Michigan, when it comes to making such information so easily available, Snyder says.

But when you seek out the lists of hospices operating in various counties, those county-specific lists do not include all hospices operating. St. Joseph County's includes only three agencies, including the large not-for-profit Center for Hospice Care -- which, for example, is not listed with neighboring Elkhart County, where it also operates.

Snyder says his staff is aware of that limitation, which is "under review internally," and hopes to be able to remedy that soon.

Although the health department offers general consumer advice, the state agency can't recommend certain hospices over others, he says.

"I think there's sometimes some confusion in the private sector when it comes to profit or not-for-profit," he says, but noting, "for-profits and not-for-profits are all in the business to make money. Otherwise, they cease operations."

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Marshall County, Indiana's community news source since 1851
Pilot News
Published on *The Pilot News* (http://www.thepilotnews.com)

Plymouth woman shares experiences of longtime volunteering for Hospice

By *editor*
Created *09/17/2012 - 8:36am*
By Lydia Beers, Staff Writer
lbeers@thepilotnews.com [1]
PaulinePierson.jpg [2]
Pauline Pierson

PLYMOUTH — It's been 27 years since Pauline Pierson, of Plymouth, first heard about volunteering for the Center for Hospice Care.

She knew right away that Hospice would be a good fit for her.

"A friend of mine was telling me that Hospice would be coming to South Bend," said Pierson, adding that she lived in South Bend at the time. "I asked her, 'What is Hospice?' She told me, and I knew that was something I might be interested in doing."

Pierson took volunteer training and started out with patient care and helping with office work. Later, she moved on to bereavement calling — counseling those who had lost a loved one.

"I guess you could say I've done several different things in Hospice," said Pierson. "I've always been so impressed with Hospice and it's been a blessing to know the people involved and the patients."

Pierson continued to work with Hospice even after the office moved to Plymouth. Coincidentally, Pierson and her husband moved to Plymouth around the same time.

"I never missed one meeting," said Pierson, smiling. "I just stepped right in to (working in) Plymouth."

An experience that Pierson will always remember is dealing with one patient, a woman who didn't understand much English.

"She was the longest duration patient we've ever had, about two years," said Pierson. "I learned music therapy, foot massage therapy…to help her. She always insisted on being next to the garage door when her husband came home from work, and her head was always cold because she didn't have hair."

Pierson decided to make the woman a hat to keep her head warm.

"She was so pleased with that, as simple as it was," remembered Pierson.

Pierson visited the woman in the hospital as she drew close to the end of her life. Shortly before her death, the woman placed a necklace around Pierson's neck herself, although she was too weak to speak.

"That was so emotional for me — I knew it was from her heart and it was her way of saying goodbye, and thank you," said Pierson.
Pierson thinks that working with Hospice is one of the most rewarding volunteer opportunities available.
"You have the opportunity to be with a person during a very critical time in their life," said Pierson. "You should be a good listener, because the patient will share all kinds of things with you, that maybe they think they can't share with their family."
Opportunities at Center for Hospice Care include: patient care, companionship, bereavement callers, office support, massage therapy, veteran to veteran counseling, and hair stylist or barber services. Fall training — 15 total hours — is coming up October 15, 17, 23, 25, and 30 from 5:30 to 8:30 p.m. No previous medical experience is necessary to volunteer. To register for fall training sessions, contact Valerie Eads at 574-286-1198 or email her at eadsv@centerforhospice.org [3]
Center for Hospice is located at 112 S. Center Street in Plymouth.

Plymouth, IN
Staff Writer
The Pilot News


Pauline Pierson

Join the 27th Annual Walk for Hospice Sept. 30

The 27th Annual Walk for Hospice will take place Sunday, Sept. 30, at Newton Park, 801 N Michigan St., (US 31) in Lakeville. Check-in begins at 11:30 a.m. with a Celebration of Remembrance taking place at 12:30 p.m. The walk will step off at 1 p.m. and concludes at 3:30 p.m. Walkers choose their total distance, using the one mile scenic route. The day includes free snacks and water, entertainment and family-friendly activities. Teams, families, and individuals are all welcome.

Walk for Hospice is a wonderful way to celebrate the life of a loved one and give back by supporting community members currently in need of hospice care, grief counseling, Camp Evergreen — a grief camp for children and teens — and innovative programs such as "We Honor Veterans." Walkers may use an online donation form to raise funds for Hospice Foundation (available at the walk website or contact Lisa Kelly at Hospice Foundation). All funds raised will go to support the Center for Hospice Care's mission to provide quality, compassionate care for anyone in need of hospice or palliative care services, regardless of their ability to pay.

Participants can register online at www.WalkMichianaForHospice.org. There is no cost to register and participants who raise more than $35 to support Center for Hospice Care will receive a T-shirt.

Sponsors WSBT, Recycled New Pallets, The Tire Rack, Veldman's Auto Parts Inc. and Patrick Industries invite you to join in supporting Center for Hospice Care's mission to improve the quality of living for families and patients facing life-limiting illness.

Volunteers for the event are needed. For more information regarding the event, volunteering or registration, contact Lisa Kelly at (800) 413-9083.

www.seniorlifenewspapers.com

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Senior Life
September
2012

Center for Hospice Care

2013 BOARD OF DIRECTORS MEETINGS
Administrative and Foundation offices
4220 Edison Lakes Parkway, Suite 200, Room E
Wednesdays, 7:30 a.m.

Date	Topic of Focus
February 20	Year in Review Election of new members and officers Board Self-Evaluation
April 17	Review of Audit New members' first meeting
June 19	Annual Professional Advisory Group report Review of Personnel Policies Manual (every other year) Review of Bylaws (as needed; at least every three years)
August 21	Foundation Update Strategic Plan update
October 23	Quality Assurance Performance Improvement updates
December 18	Budget for 2014

111 Sunnybrook Court
South Bend, Indiana 46637
(574) 243-3100
Fax: (574) 243-3134

112 South Center St, Suite C
Plymouth, Indiana 46563
(574) 935-4511
Fax: (574) 935-4589

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

Life Transition Center
215 Red Coach Drive
Mishawaka, Indiana 46545
(574) 255-1064
Fax: (574) 255-1452

Center for Hospice Care

choices to make the most of life

CHAPTER FOUR

AVERAGE DAILY CENSUS CHARTS

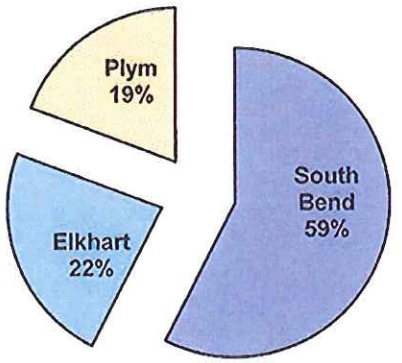
Center for Hospice Care

2012 YTD Average Daily Census (ADC)

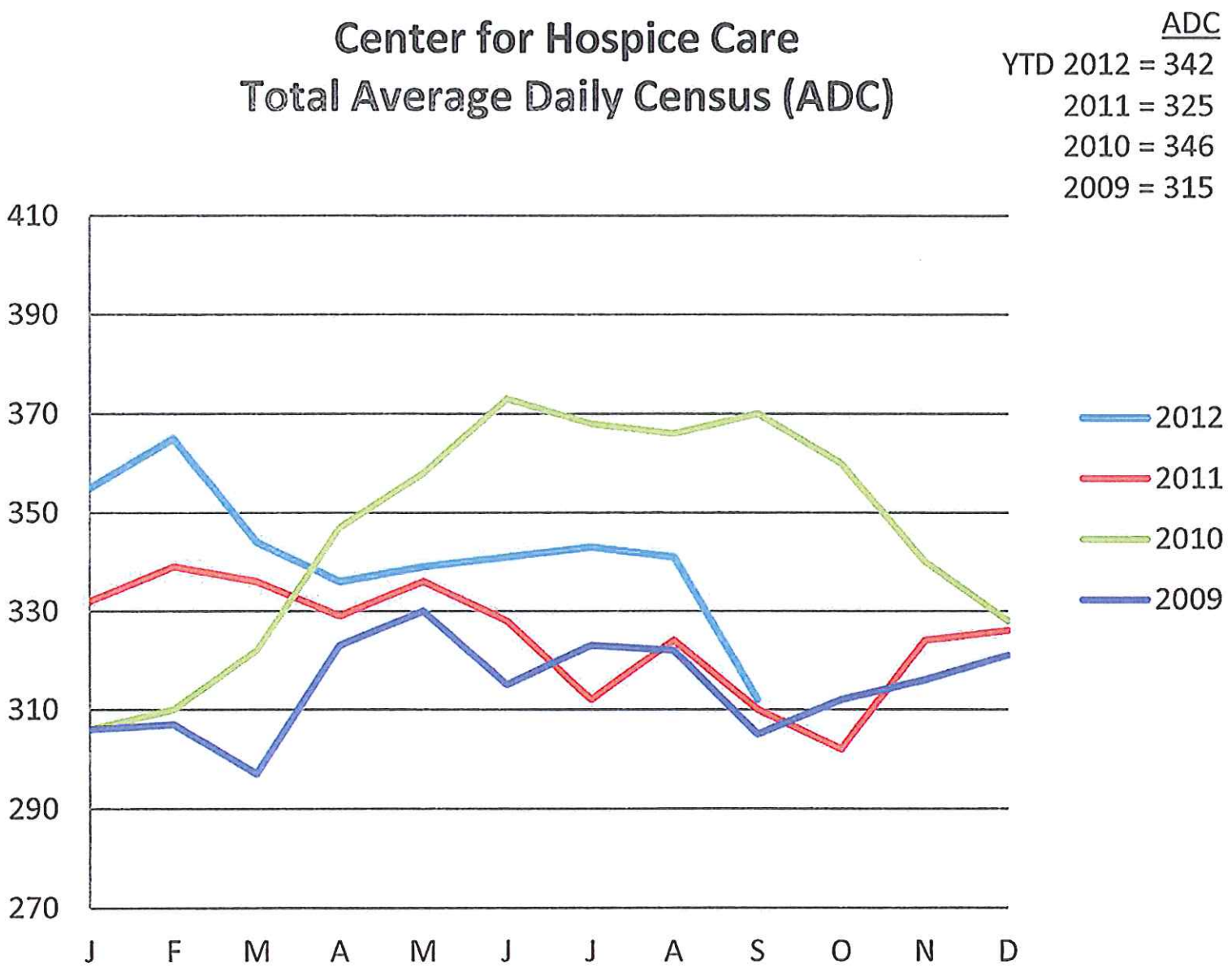
(includes Hospice House and Home Health)

	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	341	207	71	62
S	312	195	66	62
O				
N				
D				
2012 YTD Totals	3076	1833	668	581
2012 YTD ADC	**342**	**204**	**74**	**65**
2011 YTD ADC	327	193	74	59
YTD Change 2011 to 2012	15	11	0	6
YTD % Change 2011 to 2012	**4.5%**	**5.5%**	**0.0%**	**9.4%**

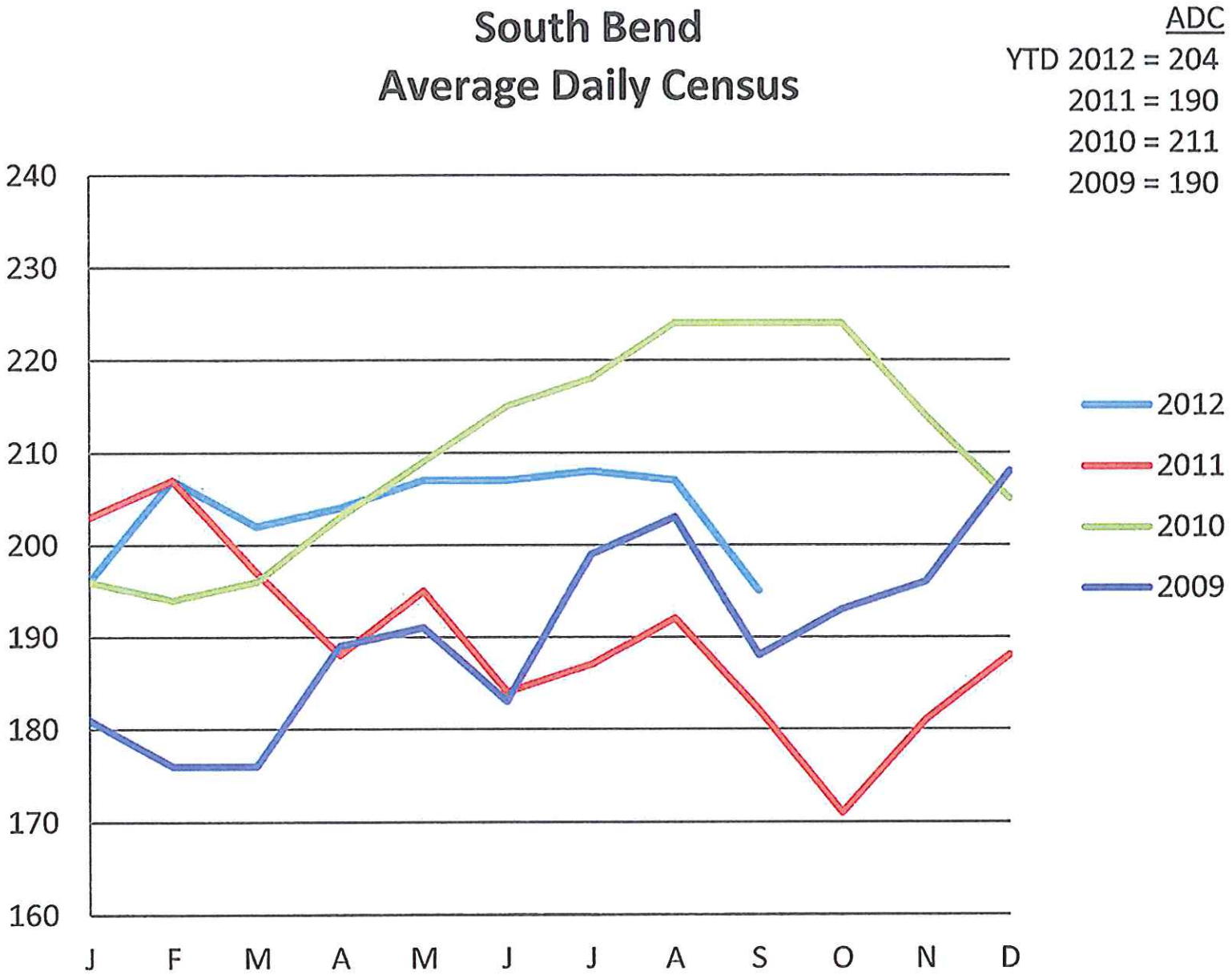
2012 YTD ADC by Branch	
South Bend	59.6%
Elkhart	21.7%
Plymouth	18.9%
All	100%



Center for Hospice Care
Total Average Daily Census (ADC)



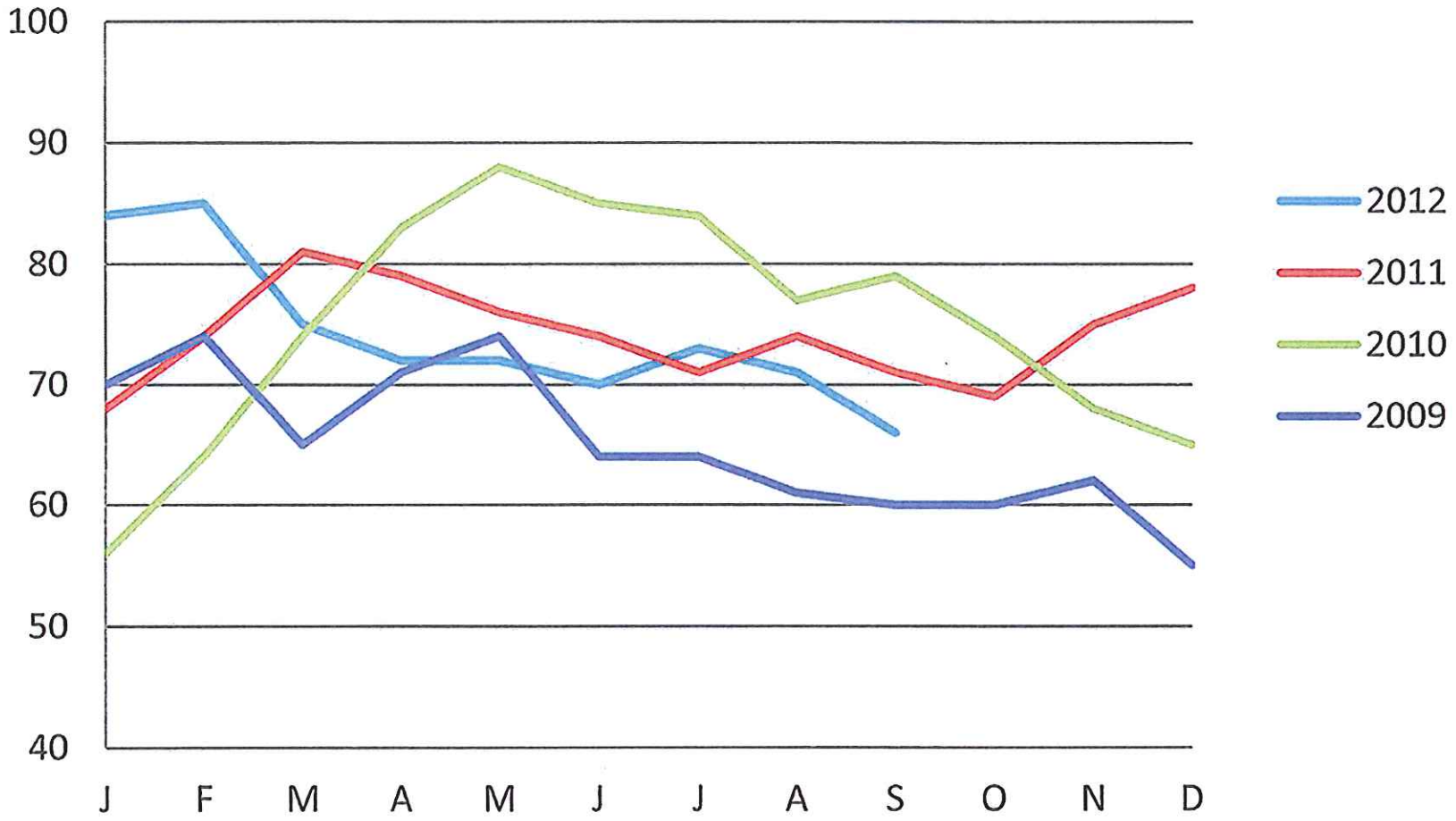
South Bend
Average Daily Census



Elkhart
Average Daily Census

ADC

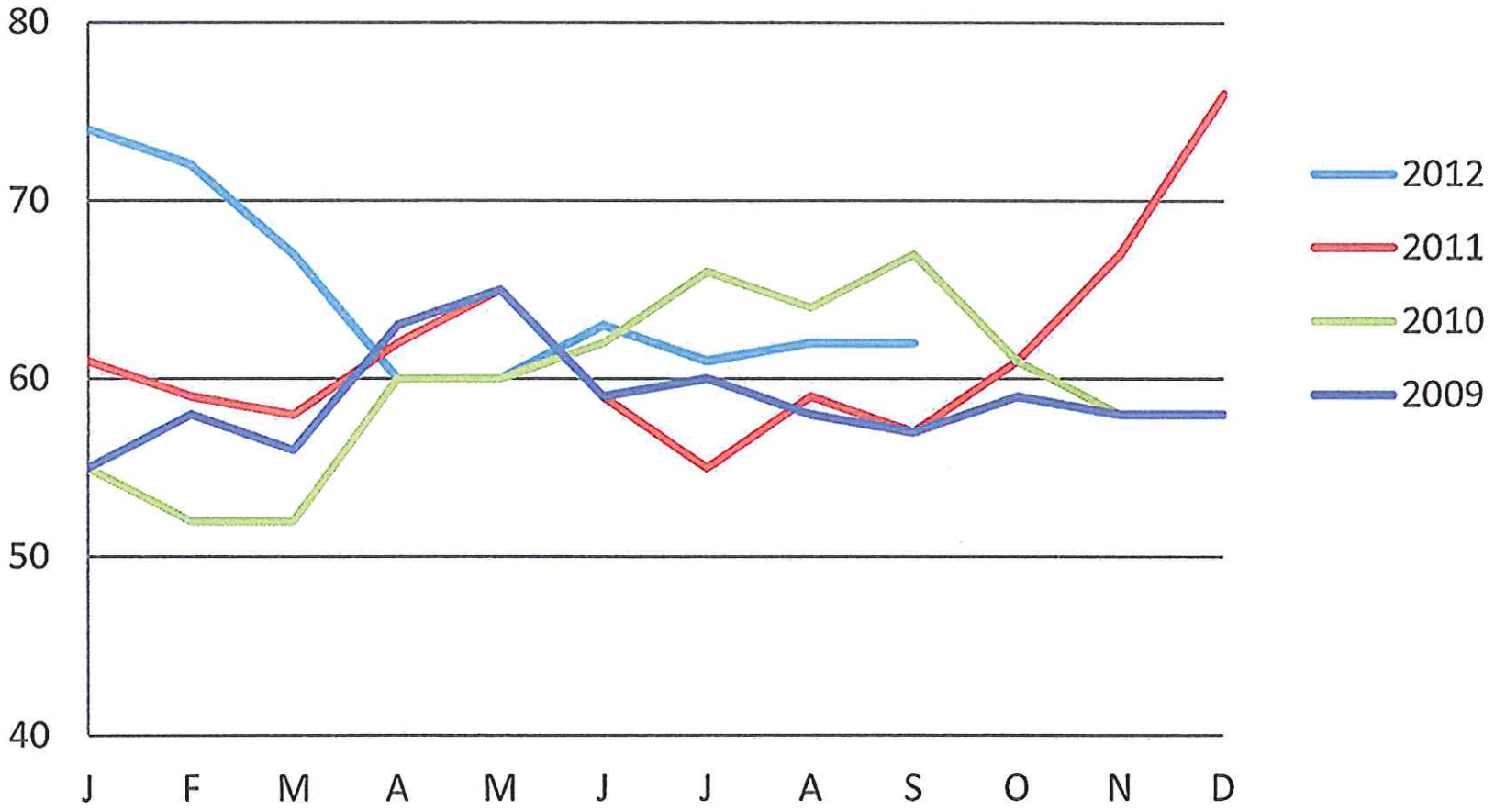
YTD 2012 = 74
2011 = 74
2010 = 75
2009 = 65



Plymouth
Average Daily Census

ADC

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



CHAPTER FIVE

FINANCIAL STATEMENTS

Center for Hospice Care
August 31, 2012
Financial Statements

The total checking balance of $4,974,655 is down $882,712 from the prior month.

Assets now total nearly 30.3 million. Our only significant liabilities are our trade accounts payable, accrued payroll, and accrued payroll taxes.

	Current Month	Year to Date	Prior Year to Date	YTD Change	Pct Change
Patients Served	447	1,377	1,315	62	4.71%
Original Admissions	134	1,038	996	42	4.22%
ADC Hospice	317.87	326.63	306.75	19.88	6.48%
ADC Home Health	22.77	18.59	22.68	(4.09)	-18.03%
ADC CHC Total	340.64	345.22	329.43	15.79	4.79%
Census High	350	371	347	24	6.92%
Census High Date	08/02/12	02/16/12	03/12/11	----------	----------
Census Low	331	329	301	28	9.30%
Census Low Date	08/29/12	04/28; 04/30	07/26/11	----------	----------
SB House Pts Served	33	203	192	11	5.73%
SB House ALOS	4.70	5.59	6.32	(0.73)	-11.55%
SB House Occupancy	71.43%	66.39%	71.37%	-4.98%	-6.98%
Elk House Pts Served	28	167	154	13	8.44%
Elk House ALOS	4.71	5.78	5.10	0.68	13.33%
Elk House Occupancy	60.83%	56.56%	46.15%	10.41%	22.56%

Due to the type of controlling interest between CHC and Hospice Foundation (HF), accounting rules require that CHC reflect its "Beneficial Interest" in HF. The Beneficial Interest is defined as the net worth (HF assets minus HF liabilities). It is shown on CHC's Balance Sheet in the "Other Assets" section...much like an investment or a subsidiary organization. As HF generates net gains (losses), the value of CHC's "asset" increases (decreases). This is reflected on CHC's Income Statement as "Change In Beneficial Interest" in the "Interest & Other Income" section. When the financial statements of the two organizations are combined, these transactions are "eliminated" or "zeroed out". In past years, this has been reflected as one year-end adjustment; beginning in 2012, it will be reflected on a monthly basis.

Year to Date Summary	Center for Hospice Care	Hospice Foundation	Combined
CHC Operating Income	12,608,612		12,608,612
Development Income (Net)		643,660	643,660
Donated Services			0
Investment Income (Net)		907,917	907,917
Interest & Other	6,371	43,826	50,197
Beneficial Interest in Foundation	671,625	[redacted]	
Total Revenue	**13,286,608**	**1,595,403**	**14,210,386**
Total Expenses	**10,985,464**	**923,778**	**11,909,242**
Net Gain	**2,301,144**	**671,625**	**2,301,144**
Net w/o Beneficial Interest	*1,629,519*	[redacted]	
Net w/o Investments	[redacted]		*1,393,227*

Reviewed

Karl Holderman, CFO — Date 10-02-12

Mark Murray, President / CEO — Date 10/2/2012

Summary Balance Sheet
Center for Hospice Care
August 31, 2012

Assets	June 30, 2012	July 31, 2012	August 31, 2012	August 31, 2011	Net Change
Cash and Equivalents	5,517,928.78	5,857,367.13	4,974,655.41	5,432,885.47	(458,230.06)
Intermediate Cash	0.00	0.00	0.00	0.00	0.00
Long Term Cash	0.00	0.00	0.00	0.00	0.00
Other Investments	0.00	0.00	0.00	0.00	0.00
Accounts Receivable	1,748,153.34	1,787,553.91	2,223,995.71	1,966,413.74	257,581.97
Due from Affiliate	2,318,532.80	2,393,390.96	2,469,701.94	2,398,143.54	71,558.40
Prepaid Assets	201,658.30	177,147.70	155,671.10	257,853.37	(102,182.27)
Plant, Property & Equipment	7,821,507.54	7,829,249.04	7,832,326.03	7,807,132.34	25,193.69
Accumulated Depreciation	(2,373,733.33)	(2,413,177.81)	(2,452,622.29)	(2,161,605.09)	(291,017.20)
Other Assets	14,854,514.07	14,922,312.98	15,080,507.86	14,701,415.37	379,092.49
Total Assets	**30,088,561.50**	**30,553,843.91**	**30,284,235.76**	**30,402,238.74**	**(118,002.98)**
Liabilities					
Accounts Payable	437,461.66	635,899.58	355,678.85	702,055.55	(346,376.70)
Due to Affiliate	28,560.00	(2,685.28)	(2,725.28)	1,766,518.33	(1,769,243.61)
Accrued Payroll	757,011.68	855,807.13	558,641.82	839,965.11	(281,323.29)
Payroll Taxes	0.00	0.00	0.00	0.00	0.00
Payroll Deductions	(295.02)	6,803.75	(1,829.90)	172.68	(2,002.58)
Other Liabilities	0.00	0.00	0.00	0.00	0.00
Long Term Liabilities	0.00	0.00	0.00	0.00	0.00
Total Liabilities	**1,222,738.32**	**1,495,825.18**	**909,765.49**	**3,308,711.67**	**(2,398,946.18)**
Fund Balance					0.00
Unrestricted Funds	27,073,326.73	27,073,326.73	27,073,326.73	26,278,057.93	795,268.80
Temporarily Restricted Funds	0.00	0.00	0.00	0.00	0.00
Permanantly Restricted Funds	0.00	0.00	0.00	0.00	0.00
Retained Earnings					0.00
Year to Date Net Income	1,792,496.45	1,984,692.00	2,301,143.54	815,469.14	1,485,674.40
Total Fund Balance	**28,865,823.18**	**29,058,018.73**	**29,374,470.27**	**27,093,527.07**	**2,280,943.20**
Total Liabilities and Fund Balance	**30,088,561.50**	**30,553,843.91**	**30,284,235.76**	**30,402,238.74**	**(118,002.98)**

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Center For Hospice Care
Monthly Income Statement

	August Actual	August Budget	August Variance	YTD Actual	YTD Budget	YTD Variance
Operating Revenue						
Hospice Medicare Benefit	1,431,564	1,407,809	23,755	11,640,623	10,718,128	922,495
Medicaid Hospice Benefit	55,324	61,159	(5,835)	347,009	465,635	(118,626)
Private Ins Hospice Benefit	87,114	85,532	1,582	502,221	651,179	(148,958)
Self-Pay Hospice Benefit	1,203	1,265	(62)	6,944	9,627	(2,683)
Hospice House R&B		54	(54)		409	(409)
Medicare Home Health	10,168	6,680	3,488	88,030	50,849	37,181
Medicaid Home Health	4,105	446	3,659	18,205	3,392	14,813
Private Ins Home Health	(1,564)	2,386	(3,950)	4,472	18,160	(13,688)
Self-Pay Home Health		158	(158)	1,108	1,209	(101)
Cost Report			0			0
Total Operating Revenue	**1,587,914**	**1,565,489**	**22,425**	**12,608,612**	**11,918,588**	**690,024**
Development Income						
Contributions & Fundraising			0			0
Planned Giving			0			0
Total Development Income	**0**	**0**	**0**	**0**	**0**	**0**
Other Income						
Donated Services			0			0
Investment Income			0			0
Interest & Other Income	159,987	1,100	158,887	677,996	8,700	669,296
Total Other Income	**159,987**	**1,100**	**158,887**	**677,996**	**8,700**	**669,296**
Total Revenue	**1,747,901**	**1,566,589**	**181,312**	**13,286,608**	**11,927,288**	**1,359,320**
Operating Expenses						
Salary & Wages	745,809	760,413	14,604	5,770,972	5,960,654	189,682
Temporary Staff	7,620	750	(6,870)	20,302	7,000	(13,302)
Employment Expenses	166,143	172,258	6,115	1,160,883	1,368,686	207,803
Education	7,246	5,396	(1,850)	45,638	43,168	(2,470)
Travel	38,569	35,884	(2,685)	296,405	281,284	(15,121)
Supplies Inventory	18,983	10,000	(8,983)	101,146	80,000	(21,146)
HMB Direct Care	224,360	212,103	(12,257)	1,695,286	1,614,808	(80,478)
MHB Direct Care	8,753	9,256	503	60,112	70,465	10,353
PHB Direct Care	15,475	13,880	(1,595)	103,180	105,699	2,519
SHB Direct Care	1,861	6,942	5,081	33,295	52,851	19,556
Hospice House Expenses	1,333	1,566	233	12,462	12,528	66
Hospice Outreach	1,820		(1,820)	14,431		(14,431)
Office Costs	10,957	19,874	8,917	136,259	158,992	22,733
Dues	2,676	2,823	147	25,612	22,584	(3,028)
Insurance	19,562	16,875	(2,687)	118,196	135,000	16,804
Public Awareness	38,122	26,500	(11,622)	265,565	212,000	(53,565)
Professional Fees	18,501	20,083	1,582	153,383	226,564	73,181
Software Maintenance	7,162	8,142	980	53,696	65,136	11,440
Volunteer Awards & Expenses	92		(92)	4,884	24,000	19,116
Building & Grounds	33,789	29,311	(4,478)	204,594	263,488	58,894
Telephone	21,118	21,333	215	155,836	170,664	14,828
Depreciation	35,570	35,513	(57)	284,557	284,104	(453)
Bad Debt		23,482	23,482	212,062	178,779	(33,283)
Miscellaneous	5,890	6,250	360	56,668	50,000	(6,668)
Interest			0			0
Total Operating Expenses	**1,431,411**	**1,438,634**	**7,223**	**10,985,424**	**11,388,454**	**403,030**
Fundraising Expenses	**40**		**(40)**	**40**		**(40)**
Total Expenses	**1,431,451**	**1,438,634**	**7,183**	**10,985,464**	**11,388,454**	**402,990**
Net Gain	**316,450**	**127,955**	**188,495**	**2,301,144**	**538,834**	**1,762,310**
Beneficial Int in Foundation	**158,195**		**158,195**	**671,625**		**671,625**
Net w/o Beneficial Interest	**158,255**	**127,955**	**30,300**	**1,629,519**	**538,834**	**1,090,685**

Center for Hospice Care
September 30, 2012
Financial Statements

The total checking balance of $4,980,122 is up $5,527 from the prior month.

Assets now total nearly 30.8 million. Our only significant liabilities are our trade accounts payable, accrued payroll, and accrued payroll taxes.

	Current Month	Year to Date	Prior Year to Date	YTD Change	Pct Change
Patients Served	413	1,486	1,439	47	3.27%
Original Admissions	109	1,147	1,120	27	2.41%
ADC Hospice	301.37	323.86	304.94	18.92	6.20%
ADC Home Health	21.50	18.91	22.41	(3.50)	-15.62%
ADC CHC Total	322.87	342.77	327.35	15.42	4.71%
Census High	332	371	347	24	6.92%
Census High Date	09/02/12	02/16/12	03/12/11	----------	----------
Census Low	313	313	299	14	4.68%
Census Low Date	09/30/12	09/30/12	09/30/11	----------	----------
SB House Pts Served	41	233	218	15	6.88%
SB House ALOS	4.27	5.62	6.22	(0.60)	-9.65%
SB House Occupancy	83.33%	68.25%	71.01%	-2.76%	-3.89%
Elk House Pts Served	24	180	172	8	4.65%
Elk House ALOS	5.79	6.14	5.12	1.02	19.92%
Elk House Occupancy	66.19%	57.61%	46.10%	11.51%	24.97%

Due to the type of controlling interest between CHC and Hospice Foundation (HF), accounting rules require that CHC reflect its "Beneficial Interest" in HF. The Beneficial Interest is defined as the net worth (HF assets minus HF liabilities). It is shown on CHC's Balance Sheet in the "Other Assets" section...much like an investment or a subsidiary organization. As HF generates net gains (losses), the value of CHC's "asset" increases (decreases). This is reflected on CHC's Income Statement as "Change In Beneficial Interest" in the "Interest & Other Income" section. When the financial statements of the two organizations are combined, these transactions are "eliminated" or "zeroed out". In past years, this has been reflected as one year-end adjustment; beginning in 2012, it will be reflected on a monthly basis.

Year to Date Summary	Center for Hospice Care	Hospice Foundation	Combined
CHC Operating Income	14,114,291		14,114,291
Development Income (Net)		736,398	736,398
Donated Services			0
Investment Income (Net)		1,120,340	1,120,340
Interest & Other	7,073	44,033	51,106
Beneficial Interest in Foundation	854,951	[redacted]	
Total Revenue	**14,976,315**	**1,900,771**	**16,022,135**
Total Expenses	**12,328,858**	**1,045,820**	**13,374,678**
Net Gain	**2,647,457**	**854,951**	**2,647,457**
Net w/o Beneficial Interest	*1,792,506*	[redacted]	
Net w/o Investments	[redacted]		*1,527,117*

Reviewed

Karl Holderman, CFO — Date 10-11-12

Mark Murray, President / CEO — Date 10/11/12

Summary Balance Sheet
Center for Hospice Care
September 30, 2012

Assets	July 31, 2012	August 31, 2012	September 30, 2012	September 30, 2011	Net Change
Cash and Equivalents	5,857,367.13	4,974,655.41	4,980,182.22	4,815,224.82	164,957.40
Intermediate Cash	0.00	0.00	0.00	0.00	0.00
Long Term Cash	0.00	0.00	0.00	0.00	0.00
Other Investments	0.00	0.00	0.00	0.00	0.00
Accounts Receivable	1,787,553.91	2,223,995.71	2,439,414.33	1,788,699.08	650,715.25
Due from Affiliate	2,393,390.96	2,469,701.94	2,539,677.78	1,571,040.96	968,636.82
Prepaid Assets	177,147.70	155,671.10	134,674.50	215,083.99	(80,409.49)
Plant, Property & Equipment	7,829,249.04	7,832,326.03	7,891,068.98	7,872,126.90	18,942.08
Accumulated Depreciation	(2,413,177.81)	(2,452,622.29)	(2,492,066.77)	(2,199,878.67)	(292,188.10)
Other Assets	14,922,312.98	15,080,507.86	15,263,834.35	14,701,415.37	562,418.98
Total Assets	**30,553,843.91**	**30,284,235.76**	**30,756,785.39**	**28,763,712.45**	**1,993,072.94**
Liabilities					
Accounts Payable	635,899.58	355,678.85	427,735.72	240,758.26	186,977.46
Due to Affiliate	(2,685.28)	(2,725.28)	(2,728.53)	913,972.26	(916,700.79)
Accrued Payroll	855,807.13	558,641.82	612,724.57	527,007.26	85,717.31
Payroll Taxes	0.00	0.00	0.00	0.00	0.00
Payroll Deductions	6,803.75	(1,829.90)	(1,732.75)	(704.49)	(1,028.26)
Other Liabilities	0.00	0.00	0.00	0.00	0.00
Long Term Liabilities	0.00	0.00	0.00	0.00	0.00
Total Liabilities	**1,495,825.18**	**909,765.49**	**1,035,999.01**	**1,681,033.29**	**(645,034.28)**
Fund Balance					0.00
Unrestricted Funds	27,073,326.73	27,073,326.73	27,073,326.73	26,278,057.93	795,268.80
Temporarily Restricted Funds	0.00	0.00	0.00	0.00	0.00
Permanantly Restricted Funds	0.00	0.00	0.00	0.00	0.00
Retained Earnings					0.00
Year to Date Net Income	1,984,692.00	2,301,143.54	2,647,459.65	804,621.23	1,842,838.42
Total Fund Balance	**29,058,018.73**	**29,374,470.27**	**29,720,786.38**	**27,082,679.16**	**2,638,107.22**
Total Liabilities and Fund Balance	**30,553,843.91**	**30,284,235.76**	**30,756,785.39**	**28,763,712.45**	**1,993,072.94**

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Center For Hospice Care
Monthly Income Statement

	September Actual	September Budget	September Variance	YTD Actual	YTD Budget	YTD Variance
Operating Revenue						
Hospice Medicare Benefit	1,331,269	1,330,044	1,225	12,971,892	12,048,172	923,720
Medicaid Hospice Benefit	71,294	57,782	13,512	418,303	523,417	(105,114)
Private Ins Hospice Benefit	71,250	80,806	(9,556)	573,470	731,985	(158,515)
Self-Pay Hospice Benefit	687	1,194	(507)	7,631	10,821	(3,190)
Hospice House R&B		50	(50)		459	(459)
Medicare Home Health	24,345	6,311	18,034	112,375	57,160	55,215
Medicaid Home Health	310	421	(111)	18,515	3,813	14,702
Private Ins Home Health	5,575	2,254	3,321	10,047	20,414	(10,367)
Self-Pay Home Health	950	150	800	2,058	1,359	699
Cost Report			0			0
Total Operating Revenue	**1,505,680**	**1,479,012**	**26,668**	**14,114,291**	**13,397,600**	**716,691**
Development Income						
Contributions & Fundraising			0			0
Planned Giving			0			0
Total Development Income	**0**	**0**	**0**	**0**	**0**	**0**
Other Income						
Donated Services			0			0
Investment Income			0			0
Interest & Other Income	184,029	1,100	182,929	862,024	9,800	852,224
Total Other Income	**184,029**	**1,100**	**182,929**	**862,024**	**9,800**	**852,224**
Total Revenue	**1,689,709**	**1,480,112**	**209,597**	**14,976,315**	**13,407,400**	**1,568,915**
Operating Expenses						
Salary & Wages	715,126	735,883	20,757	6,486,098	6,696,537	210,439
Temporary Staff	59	750	691	20,361	7,750	(12,611)
Employment Expenses	105,442	170,383	64,941	1,266,326	1,539,069	272,743
Education	8,883	5,396	(3,487)	54,521	48,564	(5,957)
Travel	34,300	34,726	426	330,706	316,010	(14,696)
Supplies Inventory	8,237	10,000	1,763	109,383	90,000	(19,383)
HMB Direct Care	215,753	200,389	(15,364)	1,911,039	1,815,197	(95,842)
MHB Direct Care	8,273	8,742	469	68,385	79,207	10,822
PHB Direct Care	10,782	13,116	2,334	113,961	118,815	4,854
SHB Direct Care	811	6,560	5,749	34,107	59,411	25,304
Hospice House Expenses	2,000	1,566	(434)	14,463	14,094	(369)
Hospice Outreach	2,704		(2,704)	17,135		(17,135)
Office Costs	13,975	19,874	5,899	150,234	178,866	28,632
Dues	2,541	2,823	282	28,152	25,407	(2,745)
Insurance	17,412	16,875	(537)	135,608	151,875	16,267
Public Awareness	44,826	26,500	(18,326)	310,391	238,500	(71,891)
Professional Fees	22,041	17,583	(4,458)	175,424	244,147	68,723
Software Maintenance	6,068	8,142	2,074	59,764	73,278	13,514
Volunteer Awards & Expenses	30		(30)	4,913	24,000	19,087
Building & Grounds	25,231	29,311	4,080	229,825	292,799	62,974
Telephone	19,750	21,333	1,583	175,586	191,997	16,411
Depreciation	35,570	35,513	(57)	320,127	319,617	(510)
Bad Debt	37,500	22,185	(15,315)	249,562	200,964	(48,598)
Miscellaneous	6,119	6,250	131	62,787	56,250	(6,537)
Interest			0			0
Total Operating Expenses	**1,343,433**	**1,393,900**	**50,467**	**12,328,858**	**12,782,354**	**453,496**
Fundraising Expenses	**(40)**		**40**			**0**
Total Expenses	**1,343,393**	**1,393,900**	**50,507**	**12,328,858**	**12,782,354**	**453,496**
Net Gain	**346,316**	**86,212**	**260,104**	**2,647,457**	**625,046**	**2,022,411**
Beneficial Int in Foundation	**183,326**		**183,326**	**854,951**		**854,951**
Net w/o Beneficial Interest	**162,990**	**86,212**	**76,778**	**1,792,506**	**625,046**	**1,167,460**

Center for Hospice Care

choices to make the most of life

CHAPTER SIX

POLICIES

Center for Hospice Care

COMMUNICATION BARRIERS

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

REGULATION: 42 CFR Part 418.52 – Patient's Rights

PURPOSE: To provide a mechanism for communication with patients who possess communications barriers.

POLICY: Sensory Impaired patients are covered in the policy entitled, "Services to Sensory Impaired Terminally Ill Persons" in the Patient Care Policies.

When other communication barriers exist, such as non-English speaking patients, patients with expressive aphasia, and patients with limited formal education, Agency utilizes the following mechanism:

For ***non-English speaking patients:***
Use a staff person or volunteer who speaks the primary language.

Investigate the use of translators from another resource (e.g., local hospitals) through which Agency has an agreement when deemed appropriate for a situation.

Call ~~AT&T~~ Language Line Services (1-800-~~874-9426~~996-8808), which provides over-the-phone interpretation from English to 140 languages, 7 days a week, 24 hours a day. For emergencies dial 1-800-523-1786.

- ~~Identify your organization as the Center for Hospice Care, regardless of the county/office you're from.~~
- Provide Client ID #: 221113~~Follow the instructions for use on the Quick Reference Guide.~~
- Identify language needed.
- ~~You must have your client ID number before AT&T will complete your call.~~
- ~~Identify your personal code (your name).~~

If no telephone is available in the home setting and telephone translation services are necessary, the Agency employee shall use the cellular telephone supplied by the Agency for these services.

The use of family members and/or significant others for translation purposes should be used only when there is no other resource available.

The Agency will maintain brochures for non-English speaking patients in languages for which translation is available.

For patients with expressive aphasia or patients with limited formal education, the Agency shall use appropriate family members or its contracted speech therapist.

Effective Date: 12/95	Revised Date: 09/12~~09/08~~	Board Approved: 09/16/08
Reviewed Date: 08/11		Signature Date: 09/16/08

Signature:

REGULATION: 42 CFR Part 418.78 – Volunteers

PURPOSE: Hospice volunteers are assigned in a timely and appropriate manner.

POLICY:

1. A hospice team member provides the patient/caregiver with information regarding the services provided by volunteers. This information may be provided verbally or in writing.

2. If the patient/caregiver is interested in having a volunteer, the team member completes a Volunteer Request and Plan of Care e-forms on the staff website. ~~that are given to the Volunteer Coordinator.~~

3. Alternatively, the Volunteer Coordinators may initiate contact with the patient if, based on information gathered at the interdisciplinary team meeting, it appears likely the patient or caregivers could benefit from volunteer services. This is done in consultation with other members of the interdisciplinary team.

4. Volunteer assignments are made by the Volunteer Coordinator in a timely manner based on patient/caregiver request and availability of volunteers.

5. The Volunteer Coordinator describes the patient situation to an appropriate volunteer. The volunteer may either accept or decline~~reject~~ the assignment.

6. If the volunteer accepts the assignment, the Volunteer Coordinator provides the volunteer with the information needed to make contact with and provide services to the patient and his or her caregivers.

7. The volunteer is informed the patient will be reviewed~~discussed~~ every 14 days at interdisciplinary team meetings and is invited to attend if possible.

8. Upon the death of a patient, the volunteer is notified as soon as possible by the Volunteer Coordinator or another designated staff member.

REGULATION: 42 CFR Part 418.78 – Volunteers

PURPOSE: To address the importance of confidentiality and right of privacy of the Agency patient and family.

POLICY: Volunteers are expected to maintain confidentiality as per the Agency's Confidentiality Agreement. Each volunteer will sign the Confidentiality Agreement, which is completed in Volunteer Training, and a copy ~~of which~~ will be kept in the~~at~~ volunteer's file.

REGULATION: 42 CFR Part 418.78 – Volunteers

PURPOSE: To provide appropriate orientation and training prior to placement as a volunteer.

POLICY: Volunteers will provide at least 5% of the total of both travel time and patient care hours of all paid employees and contract staff. Volunteers will be used in defined roles under supervision of a designated Agency employee after they have received proper orientation and training.

Plan for orientation and training:

- All individuals are interviewed before training for purposes of screening and to determine the volunteer's interests and skills.
- Two reference checks are obtained, as well as a limited criminal history check on all potential volunteers.
- Volunteers who have any opportunity for patient contact will have a signed statement from their physician that they are free from communicable disease and will comply with any Agency drug screening policies.
- New patient care volunteers are required to have an initial two-step testing method of the Mantoux TB Test and an annual test thereafter. Office volunteers that provide services in buildings that have a Hospice House must also have an initial two-step Mantoux TB Test, followed by an annual TB Test.
- A training program is prepared by the Volunteer Recruitment Coordinator and is presented throughout~~at least three times per~~ the year.~~ or as otherwise determined necessary to train volunteers.~~ The program consists of, but is not limited to:
  1. ~~Patient Care Volunteers:~~
     - Their duties and responsibilities
     - The persons to whom they report
     - The person(s) to contact if they need assistance and instructions regarding the performance of their duties and responsibilities
     - Hospice goals, services and philosophy
     - Confidentiality and protection of the patient's and family's rights
     - Family dynamics, coping mechanisms, and psychological issues surrounding terminal illness, death and bereavement
     - Procedures to be followed in an emergency, or following the death of the patient
     - Guidance related specifically to individual responsibilities

~~2. Bereavement Volunteers:~~
- ~~Individual training by Bereavement Coordinator designed to volunteer needs and background~~
- ~~Hospice concept and philosophy~~
- ~~Communication skills~~
- ~~Grief cycle, female grief, male grief, children's grief~~
- ~~Videos as a teaching tool~~

- ~~3.Office and Specialty Volunteers Hospice philosophy and concept of care~~
- ~~Individual training by assigned staff as to the jobs they perform~~

~~4. Hospice House Volunteers~~
- ~~Additional training by Hospice House staff or Volunteer Coordinator is received on all aspects of food preparations (see policies under Food Preparations: Chemical Storage, Dishwashing, Food Handler, Frozen Food Storage, Hair Restraints, Hand Washing, Leftovers, Non-food Storage, and Non-perishable Food Storage).~~

- Volunteers will receive and sign copies of their position description related to their specific volunteer duties and a copy of a Volunteer Policies Manual.
- An orientation check list will be completed by the volunteer for specific duties he/she may be asked to perform.
- The signed and dated orientation checklist will be maintained in the volunteer's record.
- Volunteers are directly supervised by the Volunteer Coordinator at the office to which they are primarily assigned. ~~or a staff person designated by the Coordinator of Volunteers, and is available to them for training concerns and needs related to specific tasks.~~
- Volunteers are evaluated annually.

Center for Hospice Care

VOLUNTEERS – PATIENT CARE DOCUMENTATION

REGULATION: 42 CFR Part 418.78 – Volunteers

PURPOSE: All volunteers are required to provide timely, accurate and appropriate documentation of any patient-related contact.

POLICY:

1. Hospice patient care volunteers use the Patient Care Volunteer Report/Time Sheet for documentation of any and all contact with hospice patients and their caregivers, including visits and telephone calls.

2. Volunteers are required to keep a supply of forms available for their use.

3. Upon completion of a patient/caregiver visit or phone contact, the volunteer completes the Patient Care Volunteer Report/Time Sheet and brings or mails the completed documentation to the Volunteer Coordinator.

4. All volunteer documentation is submitted within three days~~one week~~ of the patient contact for incorporation into the patient's clinical record.

5. The Volunteer Coordinator reads all Patient Care Volunteer Report/ Time Sheets and follows up with the volunteer or patient/caregiver as needed.

Effective Date: 11/08	Revised Date: 09/12	Board Approved: 11/05/08
Reviewed Date: 08/11		Signature Date: 11/05/08

REGULATION: 42 CFR Part 418.78 – Volunteers

PURPOSE: The Volunteer Coordinator evaluates the performance of all volunteers who have completed its volunteer trainingorientation program and/or orientationspecific training to their in his/her assigned area and are considered to have "active" volunteer status.

POLICY:

1. Each active volunteer is evaluated annually in the following areas:
   (a) Functioning in accordance with hospice policies and procedures
   (b) Appropriate communication with:
      (1) Patient/caregivers, if applicable
      (2) Hospice Interdisciplinary Team members, if applicable
      (3) Volunteer Coordinator
   (c) Providing appropriate documentation in a timely fashion
   (d) Participation in continuing education programs to develop/strengthen skills
   (e) Maintaining confidentiality
   (f) Performance of assignments as requested

2. The evaluation is presented to the volunteer by the Volunteer Coordinator either in person, by telephone, or via mail.
   a) If the volunteer does not return the signed evaluation, and documented attempts to obtain it are unsuccessful, a copy without the volunteer's signature is placed in their file and the volunteer enters "inactive" status.

Center for Hospice Care

VOLUNTEER RECRUITMENT

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

REGULATION: 42 CFR Part 418.78 – Volunteers

PURPOSE: CHC makes a consistent and concerted effort to recruit qualified, appropriate and competent people~~men and women~~ willing to volunteer their services to the hospice program. Volunteers are selected regardless of race, color, national origin, ancestry, age, sex, religious creed, sexual orientation, or disability.

POLICY:

1. The ~~Volunteer Department, in conjunction with the Marketing and Access Department, maintains a list of potential sources for volunteers that is updated on a regular basis.~~Volunteer Recruitment Coordinator is responsible for the recruitment of new volunteers throughout the Agency's service area, identifies recruitment opportunities and follows through with a plan of action. Volunteers are recruited for the following opportunities:
   a) Level One:
      - Office Volunteers
      - Bereavement Volunteers
      - Tuck-In Callers
      - Community Relations / Fund Raising Volunteers
   b) Level Two:
      - Extended Care Facility Volunteers
      - Specialty Areas Volunteers
      - 11th Hour Volunteers
      - Complementary Comfort Care (CAM) Volunteers
   c) Level Three:
      - Patient Care Volunteers
      - Hospice House Volunteers

2. Prior to a scheduled volunteer training program, ~~a mailing is sent to resources announcing the program and requesting assistance with posting announcements of the training. In addition,~~ press releases are sent to various area publications and/or other venues either by mail or~~,~~ e-mail.~~, or facsimile.~~

3. All staff members are aware of their roles in the recruitment of volunteers and to actively seek to promote the Agency's volunteer opportunities as they speak formally and informally to family members, friends, places of worship~~church~~ and community groups. ~~they actively seek to promote the Agency's volunteer opportunities.~~

4. Family members and other caregivers of the hospice's patients are encouraged to wait at least a year after the patient's death before serving as a patient~~direct~~ care volunteer.

5. All efforts to recruit hospice volunteers are documented and maintained by the Volunteer Recruitment Coordinator~~s~~.

Effective Date: 11/08	Revised Date: 09/12~~06/06~~	Board Approved: 06/20/06
Reviewed Date: 08/11		Signature Date: 06/20/06

Center for Hospice Care

VOLUNTEERS – RETENTION, SUPPORT AND EDUCATION

REGULATION: 42 CFR Part 418.78 – Volunteers

PURPOSE: In order to retain qualified, competent volunteers, CHC provides on-going support and continuing education opportunities.

POLICY:

1. Support is provided to hospice volunteers through:
   (a) A formal Volunteer Recognition event held annually
   (b) Regular and consistent contact with the Volunteer Coordinator and other members of hospice's Interdisciplinary Team
   (c) Attendance at Interdisciplinary Team meetings, when possible
   (d) ~~Volunteer newsletter (Gazette) published six times a year~~.

2. Continuing education opportunities for volunteers include:
   (a) Specialized in-services on topics relevant to volunteers
   (b) Annual volunteer in-service day

Effective Date: 11/08	Revised Date: 09/12	Board Approved: 11/05/08
Reviewed Date: 08/11		Signature Date: 11/05/08

REGULATION: 42 CFR Part 418.78 – Volunteers

PURPOSE: To ensure the highest quality of volunteers available, volunteers for CHC are screened for appropriateness and are asked to complete a volunteer application and provide two (2) references.

POLICY:

1. When an applicant for a hospice volunteer position inquires regarding the volunteer training program, the Volunteer Recruitment Coordinator conducts a ~~brief~~ phone interview to determine interest and appropriateness.

2. If appropriate, based on the telephone screening, the applicant is scheduled for an in-person interview. The applicant is either given, completed on the CHC website, or mailed a Volunteer Application and information packet.

3. Once an applicant has been screened and accepted, he or she is invited to attend the next available volunteer training program. If a training program is not scheduled for the near future, the volunteer may, at the discretion of the Volunteer Recruitment Coordinator, participate in an individualized training program.

4. The Volunteer Recruitment Coordinator or designee obtains two ~~(2)~~ references for individuals who apply for volunteer positions at hospice.

5. A criminal background check is obtained on the applicant during the volunteer training program.