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
April 17, 2013
7:30 a.m.

BOARD BRIEFING BOOK

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Center for Hospice Care
choices to make the most of life

CHAPTER ONE

AGENDA

BOARD OF DIRECTORS MEETING
Administrative and Foundation Offices
4220 Edison Lakes Parkway, Suite 200
April 17, 2013
7:30 a.m.

A G E N D A

1. Introductions of New Board Members *(information)* – Corey Cressy (5 minutes)

2. Approval of February 20, 2013 Minutes *(action)* – Corey Cressy (2 minutes)

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

4. Finance Committee *(action)* – Wendell Walsh (15 minutes)
   (a) 2012 Audit
   (b) Financial Statements
      1.) Revised December 2012 (Post Audit)
      2.) January 2013
      3.) February 2013
      4.) March 2013

5. Professional Advisory Group *(action)* – Julie Englert (5 minutes)

6. Policies *(action)* – Donna Tieman (5 minutes)
   (a) Plan of Care
   (b) Managing Drugs and Biologicals (Home Care; Hospice House)
   (c) Medication Administration
   (d) Medication Orders
   (e) On Call Services

7. Foundation Update *(information)* – Terry Rodino (11 minutes)

8. Board Education – "Top Ten Reasons CHC is Right Choice" – Admin Team (5 Minutes)

9. Chairman's Report *(information)* – Corey Cressy (2 minutes)

Next meeting June 19, 2013 at 7:30 a.m.

# # #

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 TWO

MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
February 20, 2013

Members Present:	Amy Kuhar Mauro, Catherine Hiler, Corey Cressy, Dennis Beville, Julie Englert, Mary Newbold, Rita Strefling, Terry Rodino, Wendell Walsh
Absent:	Bilal Ansari, Carmi Murphy, Jim Brotherson, Lori Price, Melanie Davis, 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 12/12/12 meeting as presented. The motion was accepted unanimously.	R. Strefling motioned J. Englert seconded
3. President's Report	• We budgeted for an ADC of 345 in 2013. We need to have 133 original admissions a month on average to meet the budgeted 1,905 patients served in 2013, and in January we had 168 (previous record was 147 set in December 2011). However we also had a record number of deaths—157 (previous record was 142 set in October 2010). 47% of the new patients admitted in January died within the same month, and 85% died by 02/08. Patient who were admitted and died during January had an ALOS of 7 days and a median of 5 days. The January ADC should have been much higher than 345, but due to deaths, the overall ADC in January was 305. • We continue discussions with the Mayo Clinic on being a training site for their palliative care physician fellows. Dave Haley and Dr. Gifford are scheduled to attend the American Academy of Hospice and Palliative Medicine conference in March, and a meeting has been set up with the Mayo Clinic representatives while there. • New television spots were shot a few weeks ago and are being edited. They should be on the air in early April. We will be using billboards again. We will be hitting the 1-800-HOSPICE number in the outdoor campaign. • Included in the board packet is a copy of the 2012 and 2013 CHC agency goals. Many new exciting initiatives including looking at new reasons to raise money if everyone has health insurance under the	

Topic	Discussion	Action
	ACA. • The annual board self-evaluation survey was distributed. It is anonymous. Please return it in the envelope provided by the deadline. Aggregated results and representative comments will be shared with the board at the April meeting. • We don't know if sequestration will happen or not. The cuts start March 1st for services provided after that date. Our 2% hit in reimbursement begins on 4/1. Copies of news articles from around the country about hospices in crisis are in the board packet. CGS, a new fiscal intermediary for 16 states, is interpreting things differently and denying hospice claims going back as far as 2008 claims, which is causing cash flow situations for many hospices and layoffs of staff. We do not have a similar problem with our fiscal intermediary, Palmetto. • Ten staff and one community physician will be the faculty for the "Introduction to Hospice and Palliative Care" class at Notre Dame on 02/23. The class is from 8:00 a.m.–5:15 p.m. for one credit. The previous class was held in November 2011 and over 90 people signed up to attend. • A new national hospice cost savings study is coming out in March. It is much better than the Duke study from a few years ago. It shows hospice saves tax payer dollars and is the answer to end-of-life care in the country and this time around the data is irrefutable. • Elkhart flooring – No evidence a vapor barrier was installed nor purchased for below the foundation as required in the specs, so moisture came up through the concrete dissolving the glue to hold the floor in place. We had to replace nearly all the flooring in the building. We installed new carpeting in areas that used to be vinyl, which helped with sound proofing and esthetics. We will host a daily open house the week of March 18th from 7:00-9:00 a.m. to meet our new medical director, Dr. Amber Burger, and alert the Elkhart health care community that Hospice House is open. The insurance companies representing the responsible parties have not been cooperating for the last three years and we had to have the repairs performed due to worsening conditions and safety issues, so we have filed lawsuits	

Topic	Discussion	Action
	against them to recover our costs for repairs and all other ancillary expenses. We hope to settle before it goes to court. We have spent over three years trying to take care of it. No staff was laid off while the work was being done.	
4. Finance Committee	• The November financial statements were reviewed. Total revenue was \$1.5 million, total expenses \$1.3 million, we had a net gain of \$128,000, and beneficial interest in the Foundation was \$56,000. We had a net gain without the beneficial interest of \$72,000. • The December financial statements were reviewed. Total revenue was \$1.9 million, total expenses were \$1.6 million, we had a net gain of \$272,000, and beneficial interest in the Foundation was \$195,000. We had a net gain without the beneficial interest of \$76,000. YTD revenue was \$19.7 million, YTD expenses were \$16.8 million, we had a YTD net gain of \$2.9 million, and beneficial interest in the Foundation YTD was \$962,000. We had a YTD net gain without the beneficial interest of \$1.9 million. • HMB patient days were up 3.8% versus budget and up 6.4% from 2011. Other hospice payers (Medicaid, commercial insurance, self-pay) were down versus budget and 2011. Total hospice days were still up versus budget and 2011. Auditors have started the process for year-end audit. The Finance Committee also reviewed the A/R Aging report. We have struggled with it since the conversion to Cerner, and staff has done a great job working on it. • A motion was made to accept the November and December financial statements as presented. The motion was accepted unanimously.	D. Beville motioned R. Strefling seconded
5. Foundation Update	• The contractors are doing a fantastic job on the Mishawaka campus and trying to meet the completion date of 06/30. At the construction meeting yesterday, they said they are only a week behind schedule. Remodeling continues on guest house and they have started on the palliative care center. An article in the South Bend Tribune yesterday referenced our project, and it was on TV as well and a couple times in January. • Overall fundraising in 2012 was up for the third straight year, excluding capital campaigns, bequests and one time major gifts.	

Topic	Discussion	Action
	• Ann Manion is the 2013 recipient of the Helping Hands Award. We already have $120,000 committed to the dinner. The Fifth Annual Bike Michiana for Hospice early bird registration is 04/30 for $35.00. We will be hosting Circle of Caring luncheons on 02/27 in Goshen, 02/28 in Plymouth and 04/11 in Mishawaka as a thank you to our donors. The 2012 Annual Appeal has raised about $75,000, so we are within $20,000 of our goal. The campaign ends in May. • The crowd funding initiative is coming up. This is a means through which to get people looking at a particular issue that needs to be addressed and raise money towards it in a defined period of time, such as 30 or 60 days. Our goal is to raise $4,000 for a full scholarship for a health care worker to go through the palliative care program at Hospice Africa Uganda. *Okuyamba* will be in its last film festival in Long Island NY this Sunday. • We are working on developing an e-newsletter.	
6. Recognition of Outgoing Board Members	• The following board members were recognized for years of service: Dennis Beville – 6 years, Bilal Ansari – 3 years, Sara Miller – 3 years, Rita Strefling – 5 years, Catherine Hiler – 11 years. Catherine Hiler will serve two more years on the Hospice Foundation board as immediate past chair. Terry Rodino was recognized as chair of the CHC board for two years. He will become the CHC immediate past chair, and will also become chair of the Hospice Foundation board.	
7. Election of Officers and Members	• The slate of officers and election of new board members for the period April 2013 through April 2014 was presented as follows: Chairman – Corey Cressy Chairman-Elect – Amy Kuhar Mauro Treasurer – Wendell Walsh Secretary – Julie Englert Immediate Past Chairman – Terry Rodino A motion was made to accept the slate of officers as presented. The motion was accepted unanimously. • New Board Members – Francis Ellert and Tim Yoder. Brief bios were included in the board packet. A motion was made to accept the election of the new board members as presented. The motion was accepted unanimously. • As we try to fill new board vacancies, if know someone who would be a good	R. Strefling motioned C. Hiler seconded C. Cressy motioned A. Mauro seconded

Topic	Discussion	Action
	member or has mentioned they would be interested, pass the name on to Mark. The bylaws call for 12-21 members, and with the addition of the two new members above, we will be at 12. We would like to add one or two more.	
8. Chairman's Report	• Reminder to complete the board self-evaluation survey and return it. • The executive committee completed the annual review of the CEO. They had asked for input from the board, and received very favorable responses. Thank you for your participation. Mark thanked the board for their comments, support and leadership. Mark said have a tremendous administrative team and a remarkably dedicated staff who care very much about our mission.	
9. Board Education	• Year in review of 2012.	
Adjournment	• The meeting adjourned at 8:30 a.m.	Next meeting 04/17

Prepared by Becky Kizer for approval by the Board of Directors on 04/17/13

Julie Englert, Secretary

Becky Kizer, Recording Secretary

Center for Hospice Care
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CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
Hospice Foundation
President / CEO Report
April 17, 2013
(*Report posted April 11, 2013*)

This meeting takes place in Suite 200 at the AFO at 7:30 AM.
This report includes event information from February 21 – April 17, 2013.
Hospice Foundation Board meeting will begin at 9:00 AM in the same room, Suite 200.

CENSUS

Average daily census (ADC) has been increasing from January's 305 to 330 in March. The number of patients served during the first quarter of this year is running nearly 9% ahead of last year. The number of admissions of new patients is running nearly 24% ahead of last year. March 2013 had the highest number of new admissions in history at 169, breaking the previous record set two months ago at 168. March also had a record number of deaths at 158 breaking the previous record of 157 also set in January slowing potential growth in ADC. Of the more than 450 patients who expired in Q1 2013 (a small sample) the average length of stay was 66 days and the median was 11 days compared to 75/16 respectively for all of calendar year 2012. Based upon the 2012 case mix of payor sources, the CHC budgeted post sequester cut break even ADC is 313.

March 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	486	793	730	63
Original Admissions	169	482	390	92
ADC Hospice	309.16	295.23	339.85	(44.62)
ADC Home Health	21.19	21.60	14.41	7.19
ADC CHC Total	330.35	316.83	354.56	(37.43)

February 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	453	624	610	14
Original Admissions	145	313	271	42
ADC Hospice	292.32	287.92	344.20	(56.28)
ADC Home Health	22.71	21.81	15.40	6.41
ADC CHC Total	315.03	309.73	359.60	(49.87)

Monthly Average Daily Census by Office and Hospice Houses

	2013 Jan	**2013** Feb	**2013** Mar	**2013** Apr	**2013** May	**2013** June	**2013** July	**2013** Aug	**2012** Sept	**2012** Oct	**2012** Nov	**2012** Dec
S.B.:	181	188	193						189	186	181	186
Ply:	58	54	59						62	64	66	64
Elk:	59	63	68						62	65	64	61
SBH:	6	6	6						6	5	6	4
EKH:	1	4	4						4	4	3	4
Total:	305	315	330						323	324	320	319

HOSPICE HOUSES

March 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
SB House Pts Served	41	115	29	33
SB House ALOS	4.76	4.57	6.10	(0.89)
SB House Occupancy	89.86%	83.49%	71.00%	13.20%
Elk House Pts Served	27	60	73	(13)
Elk House ALOS	4.67	4.63	4.67	(0.04)
Elk House Occupancy	58.06%	44.13%	56.00%	-11.87%

February 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
SB House Pts Served	43	83	59	24
SB House ALOS	3.56	3.99	5.95	(1.96)
SB House Occupancy	78.06%	80.15%	83.57%	-3.42%
Elk House Pts Served	33	37	54	(17)
Elk House ALOS	3.55	4.11	4.80	(0.69)
Elk House Occupancy	59.69%	36.80%	61.67%	-24.87%

PATIENTS IN FACILITIES

Of the 486 patients served in March, 163 were in facilities and of the 453 patients served in February, 155 resided in facilities. The average daily census of patients in skilled nursing homes, assisted living facilities, and group homes during March was 114; February was 113.

FINANCES

Karl Holderman, CFO, reports that the March and year-to-date 2013 Financials will be posted to the Board website on Friday morning, April 12th following Finance Committee approval. First quarter 2013 financials will be covered at April 17 board meeting. The non-approved February 2013 financials are below.

February 2013 Financial Information

Center for Hospice Care

(Numbers include CHC's beneficial interest in the Hospice Foundation)

February Overall Revenue	$	1,339,056	Year to Date Overall Revenue	$	3,135,901
February Total Expense	$	1,275,598	Year to Date Total Expense	$	2,602,900
February Net Gain	$	63,458	Year to Date Net Gain	$	533,001

Hospice Foundation

Feb. Development Income	$	82,890	Year to Date Development Income	$	166,510
February Investment Income	$	57,049	Year to Date Investment Income	$	409,713
February Overall revenue	$	139,960	Year to Date Overall Revenue	$	576,520
Total February Expenses	$	150,245	Total Year to Date Expenses	$	232,097
February Overall Net	$	(15,277)	Year to Date Overall Net	$	334,149

Combined

February Overall Revenue	$	1,494,243	Year to Date Overall Revenue	$	3,378,271
February Overall Net Gain	$	63,458	Year to Date Overall Net Gain	$	533,001

At the end of February 2013, Center for Hospice Care's Year to Date Net without the beneficial interest in the Hospice Foundation was $198,851.

At the end of February, CHC and HF combined had a net without investments of $123,287.

At the end of February 2013, the Foundation's Intermediate Investments (formerly known as Pool Two) totaled $3,991,651. Long Term Investments (formerly known as Pool Three) totaled $10,917,253.

CHC's assets on February 28, 2013, including its beneficial interest in the Hospice Foundation, totaled $31.8MM.

2012 AUDITED FINANCIAL STATEMENTS

The 2012 audited financial statements are on the Board Agenda. They are scheduled to be reviewed by the Finance Committee on Friday April 12 when they meet with the auditors from David Culp and Co., LLP. The audit, along with the post-audit December 2012 financial statements, will be posted to the board website on Friday morning following the Finance Committee meeting for those wishing to review the materials prior to Wednesday's board meeting. Hard copies of the 2012 audited financial statements will be distributed to all board members at the Wednesday meeting.

CHC VP/COO UPDATE

Dave Haley, VP/COO, reports that he and CHC CMO, Greg Gifford M.D., attended the annual assembly of the American Academy of Hospice and Palliative Medicine in New Orleans on March 13 -16. While there, they met with Drs. Elise Carey and Molly Feely of the Mayo Clinic in Rochester, Minnesota to discuss the possibility of having Fellows from the Mayo Clinics' Palliative Medicine Fellowship program rotate through our agency, probably starting in the spring of 2014. There was definite interest on their part and a site visit for Dr. Feely was scheduled for April 8. The site visit went extremely well. While here, Dr. Feely attended an Interdisciplinary Team meeting, toured both Hospice Houses, the Life Transition Center, viewed the plans for Palliative Care Center building and the Guest House residence -- which could house Fellows -- and visited the new Mishawaka Campus under construction. Dr. Feely was so impressed with our bereavement program that she will recommend that their Fellowship rotation be extended two weeks for specific training with our bereavement department. This would make a total Fellowship rotation of six weeks. The next step is that Dr. Feely will present what she has learned to the Mayo Clinic graduate medical studies committee. This is the group which will make the final decision on CHC's involvement in their Fellowship program. Dr. Feely said she did not feel it would take them long to make a decision. She also said that she will recommend that this rotation be a required rotation, as opposed to an elective one, with the only exception for opting out being married Fellows with children. She was very optimistic that the Fellowship rotation through CHC would be approved.

We have received interest from area hospitals in discussing CHC contracting with them to provide a Medical Director for their Palliative Care Services. Discussions are in the very early exploratory stage.

For the first quarter, our non-formulary drug expenses averaged 18 cents per patient day. This matches the low expense level we experienced during last year. Our drug shipping costs for the first quarter were 9 cents per patient day. This is slightly above the average level of 2012, which was 7 cents per patient day. We continue to strive to maintain excellence in these metrics.

We recently received our second perinatal hospice referral. This is a result of our efforts to form a community perinatal hospice service in partnership with area hospitals.

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

DIRECTOR OF NURSING UPDATE

Donna Tieman, RN, DON, reports recent nursing education has focused on Valuing the Attending Physician as Part of the IDT and Medication Orders Error Risk: Reduction Strategies. Our goal is to strengthen our relationships with our community referral sources, improve quality patient care, and reduce risk exposure.

Work has begun on a Nursing Preceptor Development program that will enhance orientation of new nursing staff and strengthen the clinical expertise of the nursing department by ensuring consistent best practice mentoring. The ultimate goal of this program is to ensure the best possible care for our patients while creating job satisfaction for our nursing staff.

The DON and ADON recently participated in a webinar entitled "Increasing the Sample Size for the Family Evaluation of Hospice Care Surveys." Information gleaned from this webinar applies to implementation of CHC's newly developed Caregiver Confidence tool. These efforts are directed at building caregiver confidence for patients at the end of life

HOSPICE FOUNDATION VP / COO UPDATE

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

Fund Raising Comparative Summary

Through March 2013, 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)

	2009	2010	2011	2012	2013
January	70,808.77	64,964.45	32,655.69	36,775.87	83,619.96
February	114,791.61	108,025.76	64,530.43	88,893.51	166,563.17
March	156,227.15	231,949.73	165,468.92	194,345.35	264,625.29
April	265,103.24	354,644.69	269,676.53	319,818.81	
May	358,108.50	389,785.41	332,141.44	416,792.85	
June	739,094.00	477,029.89	427,098.62	513,432.22	
July	782,028.00	532,913.52	487,325.01	579,801.36	
August	831,699.47	585,168.77	626,466.72	643,819.01	
September	913,852.09	671,103.04	724,782.28	736,557.59	
October	1,249,692.64	992,743.37	1,026,728.58	846,979.95	
November	1,294,948.93	1,043,750.46	1,091,575.65	895,164.28	
December	1,415,554.25	1,178,938.91	1,275,402.38	1,027,116.05	

Year to Date Monthly Revenue

(Less Elkhart Hospice House capital campaign, bequests and one-time major gifts)

	2009	2010	2011	2012	2013
January	36,382.10	52,442.49	32,110.69	32,309.58	82,300.18
February	33,816.42	41,364.37	30,644.74	43,783.64	82,943.21

March	34,722.57	65,886.51	99,796.42	102,351.84	98,212.12
April	105,621.19	104,544.96	97,332.61	123,998.46	
May	92,613.21	33,768.72	51,753.98	90,909.04	
June	94,353.52	74,084.48	90,718.18	92,036.89	
July	43,103.73	55,278.63	53,536.39	62,069.43	
August	48,215.45	51,240.25	83,202.86	64,017.65	
September	55,710.51	85,629.27	94,000.56	92,808.58	
October	78,996.22	66,061.97	47,779.09	65,904.80	
November	45,136.29	49,247.09	48,284.08	46,674.33	
December	113,640.59	115,188.45	133,617.73	111,236.77	
Total	**782,331.80**	**794,737.19**	**862,777.33**	**928,101.01**	

Special Events & Projects

Final preparations are underway for this year's Helping Hands Award Dinner, honoring Ann Manion, founder and volunteer president of the Women's Care Center, and themed "Celebrating Life." In mid-March approximately 1,700 invitations were sent. As of April 3rd, gross revenue for the event was $188,200 with 462 RSVPs in hand. The event will be held May 1 at Hilton Garden Inn. Cocktails begin at 6 pm, with dinner at 7 pm.

Bike Michiana for Hospice has once again received a Convention and Visitors Bureau grant for $5,000 to promote the upcoming 5th Annual Bike Michiana for Hospice. Early registration opened on January 15th and been promoted through social media, e-blasts, website advertising and postcards. To date, 125 cyclists had already registered for the September 15th event, which is 10% of our ridership goal for this year.

The first two of three Circle of Caring lunches were held in Goshen and Plymouth in February. The luncheon series wrapped up in Mishawaka on Thursday, April 11 at Riverside Terrace in The St. Joseph River Room and Patio. Those in attendance received a set of notecards featuring art from the Hospice Foundation-funded *After Images Art Counseling Program*.

A kick-off Walk for Hospice committee recruitment event was held on the evening of March 26th at Doc Pierce's restaurant in Mishawaka. A total of 32 people attended, including 13 "new" volunteers; in addition, eight people who were unable to attend called to sign up for the committee.

FHSSA/PCAU

"You Can Okuyamba," our first crowd funding initiative, went live in March and has raised $485 of the $4,000 goal. The objective of this particular campaign is to raise enough money to provide a full scholarship for a healthcare worker to attend the year-long CPCC Diploma course at Hospice Africa Uganda. The online crowd funding campaign features a short video clip from Okuyamba, photos of PCAU patients and nurses, as well as information on the CPCC course. Crowd funding is a fundraising concept through which a network of individuals 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. The initiative has been publicized via social media, emails to PCAU supporters and CHC/HF staff. It was also the subject of a recent press release issued via PRWeb.

Okuyamba

Okuyamba continues to serve as a fundraising platform for other hospice organizations working to raise funds for their partners in Sub-Saharan Africa as well. In March, we produced promotional materials for two upcoming screenings, one hosted by Providence Hospice in Portland, OR. The other is being hosted by Kaiser Oakland Hospice in Oakland, CA. Other organizations with fundraisers in the planning stages include Vitas Innovative Hospice Care in Newark, DE; a health forum organization in Sun City, CA; and Hinds Hospice in Fresno, CA.

Mishawaka Campus

Phase I construction is on schedule with work scheduled to conclude by the end of June. Staff will begin moving in early July. Through the end of March, windows were installed, roofing was underway and drywall was placed throughout the interior. As of this writing, some areas of the west building are already beginning to see ceramic tile and paint. WNDU featured a progress report on the campus at the end of March (http://www.wndu.com/home/headlines/New-Hospice-headquarters-to-open-this-summer-200651301.html) and the South Bend Tribune provided a photographic update on the front page of its Business Section in early April (attached to this Report).

Annual Giving

As of the end of March, the total given to this year's Annual Appeal "Circle of Caring – Start a Ripple" is $82,448.97, within $12,551.03 of the $95,000 goal. The 2012 goal is a $10,000 increase from 2011; the campaign will run through Memorial Day.

Communications

The first Hospice Foundation e-newsletter was sent to 1,028 recipients on March 1. Articles in first issue included information on the Circle of Caring luncheons, early registration for Bike Michiana for Hospice, "You Can Okuyamba" and the Annual Appeal. The mailing list includes donors and other supporters for whom we have verifiable e-mail addresses.

The Spring 2013 issue of Crossroads will be published in April and features stories about the Helping Hands Award Dinner, the *After Images Art Counseling Program*, the ND/CHC Intro to Hospice Class, "You Can Okuyamba," the bike and walk events as well as a donor profile featuring the employee giving program at Gates Automotive Group.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

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

Outreach in February & March

During this time, our three community liaisons visited the offices of nearly 200 Physician Practices and made 114 visits to assisted living and other extended care facilities. More than 90 visits were made to our service area hospitals. The liaisons also completed 59 patient pre-assessments during this time as well.

CHC hosted an Open House at the Elkhart office and Hospice House the week of March 18. From 7 – 9 a.m., area physicians, social workers and administrators were invited to come and tour the Elkhart office and Hospice House. It was not well attended, but it alleviated any misconceptions that our Elkhart office was closed.

Year Three Campaign Update

"The Right Choice," marketing campaign debuted the week of April 8. The Right Choice campaign is multi-faceted and includes television spots, print ads, online banner ads, and an outdoor billboard component. (See attached ad campaign packet).

Senior Networking and Speaking Engagements

- Participated in the Gerontology Consortium monthly Marketing and Membership meeting
- Attended open house Reception at Tanglewood to meet new administrator
- Lunch and Learn at St. Paul's
- Elkhart Chamber of Commerce Annual Meeting
- Courtyard Healthcare Advisory Meeting
- Elkhart County Council on Aging Board of Directors Meeting
- Greenleaf Healthcare Advisory Meeting
- Elkhart Clinic Neurology Luncheon
- Elkhart Clinic Business After Hours Open House
- Attended Gerontology Consortium Monthly Meeting
- Elkhart Chamber of Commerce Women's Council Networking Luncheon
- Embrace the Journey Elkhart Community Foundation Grant program with Council of Aging for Seniors
- Attended the Kosciusko County Continuity of Care
- Presented at the Kiwanis Lunch with Mike Wargo / Dennis Kidde
- Presentation to the Cambridge Apartments (subsidized senior housing) on Advanced Directives
- Elkhart County Council on Aging Embrace the Pace Program Presenter lunch sponsor
- Winona Lake Senior Center Speaker
- Warsaw Tigers Apartments speaker
- Presentation to ALS Support Group
- Waterford: arranged Lunch and Learn for Social Workers
- MGI membership meeting

Referral Source Quality Meetings and Lunches

- Lunch – Northwest Family Practice
- Lunch – Internal Medicine Associates
- Lunch – Morningside Administrator, SW, Activity Director
- Lunch: University Park Family Practice
- Dr. Rosenblum Cardiologist – La Porte
- Lunch – Portage Road Family Medicine

- Healthwin – Talked about patient mix. They are doing all short term lately. Requested that he think of us for those patients completing rehab and going home who are hospice appropriate.
- Dr. Wheet – Good discussion of Breathe Easy and Heartwize.
- Drs Peters/Kubley Lunch
- Dr Alexander Lunch
- Elkhart Clinic Cardiology In-service Lunch
- North Central Cardiology In-service Lunch
- Michael White at Memorial – Good Gen. Inpatient LOC meeting to discuss process. Met with Dr. Hall about family reluctance.
- Discussed short lengths of stay with Dr. Leininger
- St. Paul's -- At request of Dr. Kolbe was supposed to be Lunch and Learn for all nurses and CNAs but turned out only SW, Admin, DONs, Unit managers which was great opportunity to talk for more than an hour. I did overview on H and Alice did pain assessment. Discussed all aspects.
- Sprenger -- Wonderful meeting with DON Karen and Administrator Jim May, years ago at
- St. Paul's. He remembered Judy Kelly fondly, and Karen was impressed with CHC care of grandmother in Rochester 5 years ago.
- Meeting regarding General IP at EGH. 15 plus staff from EGH and five of us.
- Grace Village – Jackie Snider, DON -- Met with her regarding our first patient at the ECF.
- Tammy Gettinger Kosciusko Community Hospital Case Management Manager
- Dr. Parshod -- Wonderful opportunity to discuss multiple programs. Wishes to meet with Dr. Gifford to discuss Palliative Care Consults (PCC).
- Sanctuary at St. Paul's -- Met with DON, ADON, Administrator, AL Director to discuss specifically role of HeartWize and BreatheEasy in AL setting. Wish to make it part of "Wellness program." Discussed PCC. Very positive meeting – met for more than 90 minutes
- Chris Young Office Manager for MC Internal Medicine -- Excellent conversation regarding CHC services and specialty programs.
- Elkhart County Council on Aging – we co-sponsored Consider the Conversation presentations to Elkhart area churches.
- Miller's Merry Manor would like to host Consider the Conversation in collaboration with CHC
- Oak Wood Manors is hosting a Living with Loss group for us in LaPorte.

WELCOME NEW CHC BOARD MEMBERS

Please join me in welcoming our new board members, Becky Asleson, Francis Ellert, Michael Method, MD, and Tim Yoder. All four completed their new board member orientation on April 9 with a two-hour luncheon seminar presented by members of the CHC Administrative Team. A new 2013 Roster of CHC Board Members along with contact information is included as an attachment to this report.

CHC BOARD MEMBER RESIGNS

Lori Price has resigned her position as a CHC board member. She will become President of Loyola Gottlieb Memorial Hospital in Melrose Park, Illinois on May 7. Lori has served twice on the board for a total of 11 years (1996-2002 and 2008-2013). We thank her for her service, support and loyalty to our hospice program and wish her the best of luck in her new position and best wishes for an exciting and rewarding future.

2012 – 2013 BOARD OF DIRECTORS SELF EVALUATION

The results of the CHC Board of Directors Self Evaluation are included in your Board Briefing Book. As always, the evaluation is not intended to be an evaluation of CHC or its staff but rather to be a peer review evaluation of the perceptions the board has of itself and its performance. This year, following several email reminders from Becky, 60% of the CHC Board participated. In 2013, 9 of 15 participated. In 2012, 8 of 14 participated. In 2011, 9 of 15 participated. In last year's April 2012 President's Report, I mentioned that we were considering making this an every other year exercise. After meeting with Corey Cressy, CHC Board Chair, and the Executive Committee on 4/10, we will make this change and go to an every other year schedule. In the future, we are also eliminating the question regarding the CHC board setting fundraising goals since this question is no longer applicable now that the Hospice Foundation has this responsibility.

CHC TO RECEIVE NATIONAL FHSSA GLOBAL PARTNERSHIP AWARD

CONFIDENTIAL: This is a secret and will not be announced until April 25. The third annual FHSSA Global Partnership Award will be presented to the Center for Hospice Care/Hospice Foundation during the National Hospice and Palliative Care Organization's (NHPCO) Management and Leadership Conference at the Gaylord National Resort and Convention Center in National Harbor, MD on 4/25. Nine hospice partners applied for this year's award. According to the upcoming FHSSA press released, "The Global Partnership Award is an opportunity for FHSSA to recognize the outstanding efforts of a FHSSA partner that went above and beyond the expectations of a partnership. The award winner is selected based on creativity in fundraising, partner collaboration, staff contribution and commitment, and community outreach and involvement." The award comes with a cash donation to the African hospice partner, who in our case is the Palliative Care Association of Uganda. The first award was presented in 2011 to Suncoast Hospice in Florida, the largest not-for-profit hospice in the U.S. with an average daily census of over 1,800 patients. Last year the award was a tie and given to The Denver Hospice in Colorado and The Community Hospice of Albany, NY. CHC/HF's winning application for this award is attached to this report. It was written primarily by Hospice Foundation staff member, Cyndy Searfoss.

SEQUESTER PAYMENT CUTS FOR HOME CARE AND HOSPICE NOW IN EFFECT

April 1 marked the start of the Medicare reimbursement rate reductions under the automatic federal spending cuts – known as the sequester – which went into effect last month. Both home care and hospice services are included in the across the board Medicare rate cuts.

As a reminder, the sequestration that took effect on 4/1 will be implemented as follows:

Home Health Services: A 2% payment reduction will be applied to episodes with end dates of April 1 and later.

Hospice: A 2% reduction will apply to all services with a claim "through date" for services beginning April 1, 2013.

CHC RECEIVES GOLD CAPITAL INVESTMENT AWARD

Due to our significant investment on the banks of the St. Joseph River in Mishawaka, CHC received a GOLD "Capital Investment Award" at the 2013 Salute to Business event presented by the Chamber of Commerce of St. Joseph County. A copy of the certificate and program page showing other winners is attached to this report.

NATIONAL UPDATE

New research published in the March issue of Health Affairs found that hospice enrollment saves money for Medicare and improves care quality for Medicare beneficiaries with a number of different lengths of services. Led by Amy S. Kelley, MD, MSHS, from the Brookdale Department of Geriatrics and Palliative Medicine at the Icahn School of Medicine at Mt. Sinai, researchers looked at the most common hospice enrollment periods: 1 to 7 days, 8 to 14 days, 15 to 30 days, and 53 to 105 days. Within all enrollment periods studied, hospice patients had significantly lower rates of hospital and intensive care use, hospital readmissions, and in-hospital death when compared to the matched non-hospice patients. The study reveals that savings to Medicare are present for both cancer patients and non-cancer patients. Moreover, these savings appear to grow as the period of hospice enrollment lengthens with the observed study period of one to 105 days. Study authors suggest that investment in the Medicare Hospice Benefit translates into savings overall for the Medicare system. Researchers note that if 1,000 additional beneficiaries enrolled in hospice 15 to 30 days prior to death, Medicare could save more than $6.4 million," A copy of the article is attached to this report.

On the other hand, according to Medicare Payment Advisory Commission (MedPAC) commissioners, the government should consider 5% Medicare payment cuts for hospice services provided in skilled nursing facilities (SNF) -- as if hospice hasn't already experienced more than its fair share of cuts since 2009 with more on the way. Speaking at a public meeting on April 4 in Washington, D.C., the commissioners revisited recommendations from a 2011 report from the Department of Health and Human Services Office of Inspector General (OIG). That report gave advice to the Centers for Medicare & Medicaid Services (CMS) in advance of an Affordable Care Act requirement to reform Medicare hospice payments after Oct. 1, 2013. The OIG researchers wrote, arguing for payment reform, "Medicare currently pays hospices the same rate for care provided in nursing facilities as it does for care provided in other settings, such as private homes. The current payment structure provides incentives for hospices to seek out beneficiaries in nursing facilities, who often receive longer but less complex care." The MedPAC commissioners also claimed hospices provide more aide visits on average to SNF residents than at-home patients, even though nursing staff should be on hand to provide assistance with daily living activities. MedPAC proposed that CMS could enact anywhere from a 3% to 5% cut in hospice payments for SNF residents and that they based this reduction is on a formula that assumes "equal provision of aide visits" in home and facility settings, and accounts for the labor costs of these two types of care.

NOTRE DAME ONE CREDIT CLASS REPEAT DRAWS LARGER ATTENDANCE

SC 43350: Introduction to Hospice and Palliative Care was repeated on Saturday, February 23 at the University of Notre Dame from 7:30 AM – 5:15 PM. We were once again pleasantly surprised to see so many students (95 in all) enroll in the all-day Saturday class. The course was first offered on campus in the Fall Semester 2011 and included more than 80 students. The class, which was designed to provide undergraduate students with an introductory understanding of hospice and palliative care, included students from a number of pre-professional studies program with the vast majority of them being those particularly interested in pursuing careers in medicine. The daylong course covered a variety of topics focusing on how hospice and palliative care is given in the current healthcare system. Students were also given an introduction in the compassionate interpersonal communication skills required in caring for those in need of palliative care or who are dying. The class was taught by an interdisciplinary team that included physicians, nurses, social workers and bereavement counselors as well as other hospice and palliative care staff. Eleven CHC staff participated in all. Designed by Dominic Vachon, Director of Ruth M. Hillebrand Center for Compassionate Care in Medicine and Mike Wargo, the course included films, panel discussions, lectures and a mock interdisciplinary team meeting. One of the students attending the class wrote in his evaluation, "While it was admittedly quite a long day, I gained invaluable insight into a field I initially knew almost nothing about, and I feel that whether or not my future directs me toward palliative care, the lessons I learned have great universal applicability among all health professions and I truly feel that I will be better able to serve patients as a doctor due to the knowledge I gained here." Topics included among the day's 12 different presentations were: Understanding the Hospice Model of Care; The Physician's Role in Hospice and Palliative Medicine; The Hospice Nurse as Care Coordinator; Palliative Care: My Journey as an Oncologist and the Grieving Process.

BOARD WEBSITE

Although we do not have a PowerPoint at every board meeting, the ones we have had over the last year have now been posted to the secure CHC board website under "Archived PowerPoints."

OUT AND ABOUT

Several staff attended the Chamber of Commerce of St. Joseph County annual "Salute to Business" on February 26 at Century Center.

Dave Haley, VP/COO and Greg Gifford M.D., CMO, attended the annual assembly of the American Academy of Hospice and Palliative Medicine in New Orleans on March 13 -16.

Several staff attended the annual "Logan Lunch" on March 19 at Century Center.

Amy Tribbett, Director of Marketing and Access, attended the Total Customer Management Summit in San Francisco on April 4 – 5. The conference explored organizational challenges in the areas of relationship marketing, community management, acquisition, retention and loss, through traditional, digital and interactive channels.

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

Copy of Health Affairs article "Hospice Enrollment Saves Money for Medicare and Improves Care Quality Across a Number of Different Lengths-of-Stay"

Copy of CHC's Capital Investment Award

Copy of South Bend Tribune front page article, "Facing the End Sooner" from April 8. NOTE: This article was picked up by the Associated Press and appeared as an AP story in newspapers all across the country the week of 4/8.

Year-three marketing campaign packet.

2013 Roster of Center for Hospice Care Board Members

Dave Haley's Census Reports.

South Bend Tribune business section update on the Mishawaka Campus from April 6.

Thank you letter from Marshall Intermediate Center, South Bend.

Compliance Committee Minutes of 03/20/13

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

March 2013 Financials.

2012 Audited Financials

Latest addition of CHC's physician newsletter, "H&P."

CHC – business card listing the Top Ten Reasons Why CHC is the Right CHoiCe

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, June 19, 2013** at 7:30 AM in Conference Room E in Suite 200 at the AFO. In the meantime, if you have any questions, concerns, suggestions or comments, please contact me directly at 574-243-3117 or email mmurray@centerforhospice.org .

# # #

Center for Hospice Care
BOARD OF DIRECTORS SELF-EVALUATION
2013 Survey Results

5 = Very Good 4 = Good 3 = Average 2 = Fair 1 = Poor

9 out of 15 people responded. Number of Responses for each rating is listed in the box along with Average Score.

#	Question	Very Good	Good	Average	Fair	Avg. Score 2013	Avg. Score 2012	Avg. Score 2011
1	Board has full and common understanding of the roles and responsibilities of a Board.	5	3	1		**4.4**	**4.7**	**4.4**
2	Board members understand the organization's mission and its products / programs.	9				**5.0**	**4.7**	**4.6**
3	Structural pattern is clear (Board, officers, committees, administrative team, staff).	8	1			**4.9**	**4.7**	**4.6**
4	Board has clear goals and actions resulting from relevant and realistic strategic planning.	7	1	1		**4.7**	**4.5**	**4.4**
5	Board attends to policy-related decisions, which effectively guide operational activities of staff.	4	4	1		**4.3**	**4.7**	**4.5**
6	Board receives regular reports on finances, budgets, products, program performance, and other important matters.	9				**5.0**	**4.9**	**4.7**
7	Board helps set fundraising goals and is actively involved in fundraising.	1	6	2		**3.9**	**3.6**	**3.5**
8	Board effectively represents the organization to the community.	4	4	1		**4.3**	**4.6**	**4.3**
9	Board meetings facilitate focus and progress on important organizational matters.	8		1		**4.8**	**4.7**	**4.5**
10	Board regularly monitors and evaluates progress toward strategic goals and products / program performance.	6	2	1		**4.6**	**4.7**	**4.4**

#	Question	Very Good	Good	Average	Fair	Avg. Score 2013	Avg. Score 2012	Avg. Score 2011
11	Each member of the Board feels involved and interested in the Board's work.	2	4	3		**3.9**	**4.2**	**3.7**
12	All necessary skills, stakeholders, and diversity are represented on the Board.	2	3	3		**3.4**	**4.6**	**4.2**

Ratings by percent of responses:

	2013	**2012**	**2011**
Very Good	61%	64%	48%
Good	26%	31%	42%
Average	13%	5%	9%
Fair	0%	0%	1%

Please list three to five points on which you believe the Board should focus its attention in the next year. Be as specific as possible in identifying these points.

1. Future goals
2. Achieving current goals
3. Health care in general, including universal coverage.
4. Encourage all board members to participate in at least one fund raising event either as a volunteer or participant.
5. If possible and if beneficial, attend a Hospice conference at the national or state level to support staff and executive officers.
6. Each board member should be on one of the committees.
7. I think if those not attending would attend, they would show interest. By not attending, I sometimes think they do not feel involved.
8. I am not big on diversity and meeting the "norm." I do feel we are diverse by what we bring to the table with our talents.
9. Getting people to attend. If it does not fit their schedule, then move onto another board that does.
10. Maybe having a staff person give a five minute presentation on what they do at Hospice and what it means to them. I would ask from one of your janitors and all the way up the food chain.
11. Keep everyone updated on the new construction project and reassure how it is being paid for.
12. Make it a point to support <u>at least</u> two of the numerous fund raising events held throughout the year.
13. Reducing the number of patients that never get from the hospital to Hospice care. I know with the new agreements with three area hospitals that should improve.

14. Continued community education of services and that they are available at no cost.
15. More board participation in organization events.
16. Continue building the “Center for Hospice” name through continued advertising. Continue to develop relationships with physicians and their office personnel to obtain referrals.
17. There was talk about creating a Caregiver Training Center. Even to give “seminars” (a series) for caregivers would be helpful to the community and any additional patients as the time comes.
18. Obviously the completion of Phase I and II of the Mishawaka campus.
19. Continue to work toward the goal of having Mayo Clinic personnel working with the Center. Will also be a very good “promotional” tool.

How would you improve the Board’s effectiveness?

1. More emphasis on attendance and the elevator speech to help spread the word.
2. The board is very effective. No improvement needed. Board members are engaged.
3. Not much you need to do.
4. Provide more time for board education around its roles and responsibilities. Then, discuss these as we approve items on the agenda.
5. Go over roles of board committees at least once a year. Encourage board members to be more active at committee level.
6. More specific information on ways to improve the use of talents and experiences of our board members both within Hospice and out in our community.
7. Involving more board members on subcommittees.
8. Attendance at meetings by members needs to be a priority. Encourage involvement in various aspects of the organization.

Please identify any Board-level performance gaps and recommended solutions.

1. None that I am aware of.
2. Maybe get Dave more involved in the meetings.
3. 100% attendance by every board member is impossible. However, some are absent often. Their input is missed.
4. As board vacancies are filled, Hispanic-Americans and African-Americans who are interested in the mission of the organization should be considered.
5. Board participation needs to continue to be encouraged. The pace of the meetings has slowed a little bit to where people feel comfortable in asking and taking part in discussions. This participation needs to be encouraged.

FHSSA
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FHSSA Global Partnership Award 2013

Objectives: Partnerships are only as strong as the commitment of the two organizations involved. The FHSSA partnership program strives to create and support long lasting, sustainable relationships between US and African Hospice/Palliative care programs. The FHSSA Global Partner Award recognizes the exemplary work of one partnership that has demonstrated leadership, innovation and has significantly contributed to the sustainable development of hospice and palliative care through their FHSSA Partnership.

Eligibility: Each US FHSSA partner program is invited to nominate themselves and their African partner for the work that they accomplished in the preceding year. All applications received by the submission deadline will be considered for this award. All applications must be approved and signed by your program's Director/CEO. In order to maintain equitable consideration of applications, any additional information not requested, i.e. photos, etc., will removed from the application before being shared with the review committee.

Nomination Deadline: All self-nomination applications are due to FHSSA's office by February 22nd, 2013.

Selection Criteria: The following criteria will be used to determine the award recipient:

- Successful completion of the basic partnership goals
  - Communication with your partner at least quarterly
  - Visiting your partner or bringing your partner to your program at least once every two years
  - Raising at least $5000 annually for your partner
  - Having an established partnership committee
  - Wiring though FHSSA
  - Completion of FHSSA's yearly partnership report
- Creativity in Fundraising
- Staff engagement in your partnership
- Collaboration with your African partner
- Local (U.S.) community engagement

Review Process: Each application will be reviewed by a committee consisting of FHSSA staff, members of the FHSSA committee and foundation board, and representation from the leadership of the African Palliative Care Association (APCA). Only the information provided in the award application will be used to determine the award recipient. Applications should be completed assuming the review committee has no prior knowledge of your partnership.

Recognition: Both the winning US and African partner organizations will receive the FHSSA Global Partnership Award at the 2013 NHPCO Management and Leadership Conference during a special presentation at The FHSSA Breakfast on April 25th, 2013. The partnership receiving the award will also be announced during the conference's Opening Plenary. A monetary prize of $500 will be awarded to the recipient African partner and commemorative plaques will be given to both partners. Additionally, the winning partnership will be depicted on a sign at the FHSSA booth during MLC. Each year the recipient partnership's organization names will be added to a public wall display at the National Center for Care at the End of Life.

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FHSSA Global Partner Award Application

US Partner Name:	Center for Hospice Care/Hospice Foundation
African Partner Name:	Palliative Care Association of Uganda
Year Partnership was Established:	2008
Contact Person's Name:	Mike Wargo
Contact Person's Email:	wargom@centerforhospice.org
Contact Person's Phone Number:	574-243-2059

1. Completion of FHSSA's basic partnership goals

How often does your organization communicate with your African partner?
At least 2-3 times per week

Do you have a partnership committee?

X Yes ☐No

Did your organization meet/exceed the fundraising goal of $5000 in 2012?

X Yes ☐No

What amount of funds did your organization raise in 2012 for your partnership?
$25,005

Does your organization wire funds to your African partner through FHSSA?

X Yes ☐No

Has your organization completed the 2012 yearly partnership survey?

X Yes ☐No

2. Fundraising

Please describe in the space below, how your organization raised funds to support your African partner in 2012, highlighting fundraising activities that you feel particularly show your organization's creativity and innovation:
World Hospice Day: For World Hospice Day 2012, Center for Hospice Care/Hospice Foundation held its inaugural "Okuyamba Fest" event, featuring a screening of the short documentary film *Okuyamba*. In addition to being used as a fundraising tool for the CHC/HF partnership with PCAU, this documentary has been screened throughout the United States, as well as internationally, in an effort to raise awareness about the dire need for palliative care in Subsaharan Africa. In addition, we held a silent auction of Ugandan artwork and craft items as well as artwork of South Bend area artists, and an international sampling of foods, beers and wines. Proceeds from these activities benefited both FHSSA and PCAU. Employee Giving: Using payroll deduction, CHC/HF has an employee giving program in place to which staff may contribute a portion of their salary to support PCAU's work. Called the *Uganda Impact Fund*, these donations have been used to assist PCAU with office rent. During 2012, 47 CHC/HF staff members made contributions to the Uganda Impact Fund, totaling $7,506. Since its inception in 2010, the fund has raised more than $15,000 all of which has benefited both FHSSA and PCAU as all funds are sent directly to FHSSA for distribution. In addition, a number of staff members also attended Okuyamba Fest and other PCAU-related events held during Rose's visit. PCAU Building Fund: Started in 2012, this fund was established to provide financial support for sustainable office space. Since this is one of PCAU's top strategic priorities, all the proceeds of Okuyamba Fest, CHC/HF's World Hospice & Palliative Care Day event, were directed into a fund designated for acquisition of a permanent PCAU Home. That event raised nearly $10,000 and this amount is currently being held in HF's account for future distribution. In addition, all of the funds that CHC staff defer through payroll deduction in the Uganda Impact Fund, and which CHC remits to FHSSA for disbursement, are directed toward PCAU's facilities. In 2012, CHC/HF contributed approximately 75% of PCAU's annual rent. Web Site: The HF web site, www.foundationforhospice.org/partners, includes a section on "Partners" that details the organizations' partnership with PCAU and encourages visitors to make a donation to support PCAU's work.

3. Staff Engagement

Please describe how staff at both your hospice program and your African partner's program were engaged in your partnership in 2012:
Rose Kiwanuka, PCAU Country Director, traveled to the US in March 2012 to participate in a number of CHC/HF events as well as to attend the NHPCO Management & Leadership Conference. Payment for all meals, lodging and international air travel was funded by the Hospice Foundation. While in South Bend, Rose met with University of Notre Dame faculty and staff to discuss current and possible research projects and student internship programs in Uganda; participated in Q & A sessions following screenings of *Okuyamba* at Indiana University South Bend, Notre Dame and Goshen College; held a series of meetings with staff of Center for Hospice Care and Hospice Foundation on partnership initiatives such as the Clinical Palliative Care Course scholarships, the PCAU building fund, strategic planning and fundraising. While at the MLC, Rose and Mike fielded questions from the audience following a screening of Okuyamba. Roberta Spencer, volunteer and member of our FHSSA Community Partnership Committee, spent nearly two months in Uganda in early 2012 to work on a number of partnership initiatives. Among them: visited potential sites for a permanent PCAU home; reviewed and analyzed surveys received from attendees of the 4th bi-annual PCAU conference and began planning for the 5th bi-annual conference scheduled to take place in August 2013; developed an educational program for Ugandan clergy, and others assigned by clergy, teaching them how to deliver spiritual care to the sick; identified future student internship sites for spiritual care, physician residents, and social workers; obtained additional information needed for an on-going palliative care mapping project being conducted through a collaboration between PCAU, HF and the University of Notre Dame's Geospatial Analysis Laboratory; followed up on 2011 meetings between Mike Wargo and Hospice Africa Uganda's Institute leadership team regarding the ability to increase the school's capacity to educate nurses as Nurse Prescribers as well as the ability to train Clinical Officers through a specially designed rapid training program; reviewed, revised and helped to finalize PCAU's new 5-year strategic plan; made field visits to Nurse Prescribers trained through funding from HF/CHC and reported back regarding their progress and successes; developed an outline for a handbook for Spiritual Leaders; attended several District Meetings to promote the partnership and respond to questions; met with PCAU staff and attended numerous meetings within the community (e.g. APCA, Ministry of Health, etc.) and throughout the country. Mike Wargo, Hospice Foundation VP/COO, traveled to Uganda in summer of 2012 to work on a number of partnership initiatives. Among them: met with Members of Parliament to advocate for palliative care issues; participated in meetings with PCAU staff and various consultants; made rounds with the Mulago Hospital Palliative Care team to see first-hand the daily challenges they experience in getting to patients dying in various wards throughout the hospital; visited Kawempe Home Care and met with Dr. Sam Guma, Executive Director, regarding future Notre Dame student intern placements (note: following an interview process, ND pre-med student Emmie Mediate has been selected to intern at Kawempe for 10 weeks this coming summer); met with the PCAU Board of Directors to discuss strategic plan initiatives; visited APCA and met with Faith Mwangi-Powell and senior staff to discuss current challenges and identify potential areas for collaboration; toured five potential sites for a permanent PCAU home; met with six current CHC/HF-sponsored CPCC scholarship students, chancellor and faculty at HAU Institute; visited remote clinics desiring to begin accessing morphine; visited recently graduated CHC/HF-sponsored CPCC student, currently serving as a hospital administrator at Mubende Regional Referral Hospital, to identify any obstacles to his ability to begin delivery of PC services within the hospital; visited a child caregiver being sponsored by the CHC/HF-sponsored "Road to Hope" funding initiative to determine his welfare and make arrangements for him to attend boarding school; presented at the Kibaale District Palliative Care Update Meeting; toured potential sites for 2013 Bi-Annual Conference; met with Denis Kidde regarding his upcoming move to the US and his impending duties and

responsibilities as the International Program Representative at the Hospice Foundation; met with Dr. Carla Simmons (Kitovu Home Care in Masaka) regarding child caregiver issues; visited and toured Mobile Hospice Mbarara; met with USAID and Open Society Institute representatives to provide updates regarding current initiatives and discuss potential collaborations; met with Hospice Africa Uganda founder, Dr. Anne Merriman, to discuss long-term issues and opportunities.

In the space below, please describe the impact that your partnership has had on your organization during 2012:

Staff members were very engaged in activities involving Rose during her 2012 visit. Foundation staff learned first-hand how their fundraising and communication efforts directly impact the operational efficiencies and staff morale at PCAU. As a result, several additional staff members have become motivated to engage in giving to the Uganda Impact Fund.

Following Rose's last visit, members of the CHC support services and nursing teams became advocates for the development of a staff exchange program through which they would travel to Uganda to learn about the delivery of palliative care in a third world country and to assist in furthering PCAU's mission through delivery of educational programs and hands-on training in palliative care techniques.

Through our Hospice Foundation's sponsorship of students to participate in the one year CPCC diploma program, our staff feels an even bigger connection to PCAU's mission in that they have come to truly appreciate the manner in which our organization cares about --- and for --- those dying in pain on the other side of the world. By way of example, our staff takes great pride in knowing that we have been able to help increase the number of health care professionals in Uganda who are authorized to prescribe morphine. For the academic year 2012-13, CHC/HF sponsored six students, which brings the total number of CHC/HF-sponsored students to 11 during a period of three years. We anticipate having as many as ten health care workers sponsored for the next session, which is scheduled to begin in August 2013.

4. African Partner Collaboration

Please describe any projects, goals, events, or other activities (not including fundraising activities) that you and your African partner collaborated on in 2012 and their impact:
Each year that the partnership progresses, the two organizations find more ways to strengthen their ties and increase their collaborative efforts. 2012 saw some very wonderful collaborations: *Okuyamba* Documentary: This award-winning documentary depicts the seemingly monumental issues PCAU encounters in its daily work. To do so, a Hospice Foundation-sponsored film crew went deep into the forests of Uganda to offer viewers a glimpse at the astounding challenges facing its terminally ill people while sharing stories of the 90 percent who receive no assistance with pain or comfort in their final days. The result: It has helped increase awareness world wide of the suffering of patients with life-limiting illnesses in Uganda as well as Subsaharan Africa as a whole. The film was released to the film festival circuit in early 2012 and has now screened in nearly 100 theatres and assorted venues. An Official Selection at 17 film festivals, the film has earned numerous awards, including the Inaugural Morfogen Art of Caring, Indie Fest, Accolade Competition, Best Shorts and a was a Silver Winner at the Prestige Awards. www.okuyamba.com The Road to Hope Program: CHC/HF supports this bereavement program through proactive volunteer-driven fundraising efforts. During 2012, its first year in existence, which provides financial support for child care givers to attend school following the death of their parent(s), the fund provided support to five children enrolled in the program. These are children who have spent much of their lives looking after a loved one. Once their loved one dies, they are often left with no formal skills to tackle the realities of life and no way to obtain these skills. PCAU Update Meetings: Through funding, mentorship and support supervision, CHC/HF facilitates update meetings that bring together PCAU member organizations to promote sharing palliative care and advocacy experiences. PCAU members also meet with the national association and Ugandan Ministry of Health to learn what's happening at the national level. During 2012, CHC/HF staff and volunteers were involved in many of these meetings and a portion of the funding provided to PCAU from the Hospice Foundation is used to pay toward the cost of these meetings. International Program Representative: As the Hospice Foundation further solidifies its partnership with PCAU, an international program representative was been added to the staff in 2012. Denis Kidde, who worked for the African Palliative Care Association for the past seven years, was hired into this role in summer 2012. He and his wife, Grace, immigrated to the US in September 2012 to assume this role. His tasks include facilitating various FHSSA initiatives, establishing parameters for mutually beneficial internship opportunities for US students in Uganda and providing ongoing technical and relationship support. Beyond providing a salary and benefits, CHC also provides housing accommodations for Denis and Grace at its Guest House located at its new hospice campus in Mishawaka, IN. New Strategic Plan: As the result of funding provided by HF, PCAU was able to engage the services of a professional facilitator and writer to complete a new five-year strategic plan for PCAU, which was completed and published in summer 2012.

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5. 5. Community Engagement

How have you utilized existing, or established new community relationships, to promote your partnership and the activities of the partner organizations in your respective local communities?
In each of the Foundation's quarterly publication, Crossroads, we have included a spread of articles about the partnership and initiatives undertaken. This publication reaches approximately 36,000 households per issue. In addition, our Foundation web site features a partnership section that provides information about collaborative work and provides links to learn more: www.foundationforhospice.org/partners We have also used existing relationships with donors, board members and others to raise awareness and "friends" for the partnership through *Okuyamba* Fest as well as private screenings of *Okuyamba*, meet and greets with Rose, guest lectures and teaching opportunities in courses at a number of area institutions of higher learning, including the University of Notre Dame, Indiana University South Bend, Goshen College and St. Mary's College. One of our local colleges is the University of Notre Dame, with which we have had a good working relationship for many, many years. Since partnering with PCAU, however, that relationship has gone to a whole new level. Notre Dame has been involved in various initiatives in Uganda since the late 1950's. As a result of our FHSSA/PCAU partnership, we are now closely involved with many of the university's colleges, departments and programs that either were (or are now) working in Uganda. The Kellogg Institute for International Studies has funded a range of student interns to work with PCAU and its member organizations. Among them: M.Div. students from the Department of Theology, pre-med majors from the College of Science and students from The Ford Family Program in Human Development Studies and Solidarity and the Department of Anthropology. In addition, we've engaged in a palliative care mapping project with the ND Geospatial Analysis Laboratory, which resulted in publication of a new Uganda Palliative Care map, and produced a documentary film with students, alumni and faculty of the Department of Film, Television & Theatre. In 2012, we began exploring the development of a periodic palliative care audit program that would involve students in the Master of Science in Global Health program at the Eck Institute for Global Health.

Thank you for completing your application. Please have the Senior Officer of your organization sign the application below. After signing, please scan and submit the application by email to info@fhssa.org

[signature] 2/21/13

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THE CARE SPAN

Hospice Enrollment Saves Money For Medicare And Improves Care Quality Across A Number Of Different Lengths-Of-Stay

Amy S. Kelley (amy.kelley@mssm.edu) is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, in New York City.

Partha Deb is a professor and director of graduate studies in the Department of Economics at Hunter College and a professor at the Graduate Center, City University of New York.

Qingling Du is a statistician in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

Melissa D. Aldridge Carlson is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, and the director of research methods training for the Mount Sinai Medical Student Training in Aging Research Program.

R. Sean Morrison is a tenured professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai; the director of the school's Hertzberg Palliative Care Institute; and the Herman Merkin Professor of Palliative Care.

ABSTRACT Despite its demonstrated potential to both improve quality of care and lower costs, the Medicare hospice benefit has been seen as producing savings only for patients enrolled 53–105 days before death. Using data from the Health and Retirement Study, 2002–08, and individual Medicare claims, and overcoming limitations of previous work, we found $2,561 in savings to Medicare for each patient enrolled in hospice 53–105 days before death, compared to a matched, nonhospice control. Even higher savings were seen, however, with more common, shorter enrollment periods: $2,650, $5,040, and $6,430 per patient enrolled 1–7, 8–14, and 15–30 days prior to death, respectively. Within all periods examined, hospice patients also had significantly lower rates of hospital service use and in-hospital death than matched controls. Instead of attempting to limit Medicare hospice participation, the Centers for Medicare and Medicaid Services should focus on ensuring the timely enrollment of qualified patients who desire the benefit.

As of 2012, 5 percent of the most seriously ill Americans accounted for more than 50 percent of health care spending, with most costs incurred in the last year of life as a result of hospital-based treatment.[1-3] Despite those high and escalating health care costs, numerous studies demonstrate that seriously ill patients and their families receive suboptimal care, characterized by untreated pain and physical symptoms, spiritual and emotional distress, high family caregiving burdens, and unnecessary or unwanted treatments inconsistent with their previously stated wishes and goals for care.[4-11]

Hospice has been shown to greatly improve the quality of care for patients and their families near the end of life. Under Medicare Part A, the hospice benefit covers palliative care services delivered by a team of professionals, including physicians, nurses, social workers, chaplains, home health aides, and volunteers, to dying patients—that is, patients with a life expectancy of six months or less—who are willing to forgo curative treatments.[12]

Studies have consistently demonstrated that hospice is associated with reductions in symptom distress, improved outcomes for caregivers, and high patient and family satisfaction.[8,13-15] Recent evidence also indicates that continuous hospice use reduces the use of hospital-based services—including emergency department visits and intensive care unit stays—and the likelihood of death in the hospital.[16]

The number of hospices has increased rapidly over the past twenty years, making hospice programs available to almost all eligible Americans.[17] Medicare hospice spending has risen considerably with the growth and development of new hospice programs, particularly in the for-profit sector, and the resulting rise in the number of patients accessing the hospice benefit.[18,19]

This increase in spending has led the Centers for Medicare and Medicaid Services to explore methods of containing Medicare hospice spending, such as through payment reform or investigation of hospices with long lengths-of-stay.[20] What is not known, however, is how the length of hospice enrollment relates to overall Medicare spending at the end of life—including what periods of enrollment might decrease net Medicare costs as compared to usual care and, if they do, by how much.

The length of hospice enrollment that might achieve the greatest cost savings to Medicare is the subject of considerable debate. Some scholars have argued that beneficiaries must be enrolled in hospice longer than current practice to achieve financial savings under Medicare.[21–23] Others have found that longer hospice length-of-stay is associated with higher Medicare spending—particularly for those with noncancer diagnoses.[24]

In the largest and most rigorous study to date, Donald Taylor and colleagues observed that hospice enrollment 53–105 days before death maximized Medicare savings compared to usual nonhospice care.[23] However, this study has been criticized for its inability to control for factors not present in Medicare claims that are known to be associated with higher costs, such as patients' functional status.[25]

Another criticism cited notable differences between the hospice and control groups: Hospice users had greater costs in the period preceding hospice enrollment compared with their matched controls.[25] Such limitations cast doubt on the validity of the reported findings regarding both the timing of hospice enrollment to maximize savings and the magnitude of those savings.

Health care reform in the past decade has sharpened the focus on increasing the value of health care and on forging effective policy to guide that process. A clearer understanding of the value of existing Medicare programs thus is required. In this study we aimed to better understand the value of Medicare hospice by examining the relationship between length of hospice enrollment and overall Medicare costs.

Specifically, we compared Medicare costs for patients receiving hospice care to those of patients not receiving hospice care across four different periods of hospice enrollment: 1–7, 8–14, and 15–30 days before death, the most common enrollment periods, and 53–105 days before death. In addition, we investigated both the source of hospice-related savings, if any, such as decreased hospital admissions and fewer hospital and intensive care unit days, and the impact of hospice on selected measures of quality of care at the end of life, including thirty-day readmission rates and in-hospital death rates.

We used the rich survey data from the Health and Retirement Study, in combination with individual Medicare claims, and adjusted for previously unmeasured factors known to influence costs, such as functional status and social characteristics. These analyses revealed that net savings to Medicare are not limited to hospice enrollment 53–105 days prior to death but are also observed across the most common enrollment periods: 1–7, 8–14, and 15–30 days before death.

Study Data And Methods

We examined data from the Health and Retirement Study, a longitudinal survey administered to a nationally representative cohort of adults over age fifty. Serial interviews are conducted every two years and include information on participants' demographic, economic, social, and functional characteristics. Each interview cycle, participants who died since the last interview are identified, and dates of death are drawn from the National Death Index. More than 80 percent of participants provided authorization to merge their survey data with Medicare claims,[26,27] a necessary step in the present analysis.

SAMPLE We sampled all survey participants who died during 2002–08. We included those age sixty-five or older who had continuous Medicare Parts A and B coverage for twelve months prior to death, while excluding those enrolled with Medicare managed care (for whom claims data were therefore incomplete). This methodology yielded a final sample of 3,069 people, both enrolled and not enrolled in Medicare hospice prior to death.

For the analyses of each enrollment period, we also excluded those who enrolled in hospice prior to the study outcome period (7, 14, 30, and 105 days, respectively) and those whose final predeath interview took place within the study period.

MEASURES We categorized periods of enrollment in Medicare hospice before death based on the number of days prior to death that enrollment occurred, as follows: 53–105 days (the period expected to maximize reduction in Medicare spending),[23] 15–30 days, 8–14 days, and 1–7 days. For each period, the primary outcome was total Medicare spending measured from the beginning of the enrollment period to death.

We adjusted expenditures for inflation (2008 dollars) and for geographic differences in Medicare prices. We also examined six other measures of care utilization: hospital admissions, hospital and intensive care unit days, intensive care unit admission (any or none), thirty-day hospital readmission (any or none), and in-hospital death.

We selected independent variables based on our conceptual framework, "Determinants of Treatment Intensity for Patients with Serious Illness," which postulates that treatment intensity is influenced by both regional and patient or family determinants.[28] We selected variables that could serve as empirical measures of each construct in the conceptual model: age; sex; race or ethnicity; education; net worth; marital status; insurance coverage; functional status; residential status; medical conditions; and regional supply of hospital beds, specialist physicians, and local hospital care intensity.

Variables were drawn from Health and Retirement Study data, individual Medicare claims, and the *Dartmouth Atlas of Health Care*.[29] Additional details are provided in the online Appendix.[30]

STATISTICAL ANALYSES We employed doubly robust methods combining propensity score matching and regression adjustment.[31] We first determined hospice enrollment in relation to date of death from individual Medicare hospice claims. For each enrollment period, we then developed propensity scores for hospice and nonhospice patients to estimate each subject's likelihood of hospice enrollment during the specified period.

We used logistic regression to estimate the likelihood of hospice enrollment using all of the independent variables, described above, that may be associated with treatment intensity. Additionally, we included as a covariate the number of hospital days prior to the target hospice enrollment period up to six months before death, to account for prior utilization as a predictor of subsequent utilization.

We then matched hospice enrollees to one or many nonhospice controls within ± 0.02 of the standard deviation of the propensity scores. Unmatched subjects were excluded. This procedure was completed for each enrollment period, resulting in the following sample sizes: 1,801 (1–7 days), 1,506 (8–14 days), 1,749 (15–30 days), and 1,492 (53–105 days).

We examined bivariate comparisons of unadjusted measures of spending and use, as well as patient characteristics, using the matched, weighted samples. We then conducted multivariable regressions for each of the outcome measures, once again adjusting for all independent variables.

Following the estimation of each fully adjusted regression, we examined the adjusted means, including 95 percent confidence intervals, and incremental effects in outcomes between groups of hospice enrollees and matched nonhospice controls. Additional details are provided in the online Appendix.[30] Analyses were conducted using the statistical analysis software Stata, version 11.

LIMITATIONS Three study limitations are worth noting. First, the data are retrospective, following back from date of death—that is, we employed a mortality follow-back design. This retrospective approach artificially removed the prognostic uncertainty faced by patients and physicians when making treatment decisions. The mortality follow-back design and our inability to randomly assign patients to treatment groups may therefore have biased the results.

However, by using detailed survey data, propensity score matching procedures, and multivariable regression to adjust the results, we minimized the effect of this bias more than could have been achieved through the use of administrative claims data alone.

Second, we were unable to factor into the analysis direct measures of individual preferences and goals of care. We did, however, adjust for all available characteristics known to be potentially associated with treatment preferences, such as education, race, and debility.

Third, we were not able to fully assess quality of care, which, in combination with cost, determines value. We included among our secondary outcomes two markers of potentially low-quality care: thirty-day hospital readmission and in-hospital death. In addition, many prior studies have demonstrated high quality of and satisfaction with hospice and palliative care.[8,13–15,32–36]

Study Results

SUBJECT CHARACTERISTICS Among the 3,069 subjects, 1,064 (35 percent) were enrolled in hospice prior to death. The mean hospice length-of-stay was 49 days (median 16 days, range 1–362 days). Patient and regional characteristics of subjects are reported in Appendix Exhibit 1.[30] Subjects' mean age at death was eighty-three years. Subjects were predominantly non-Hispanic white (80 percent), female (56 percent), covered by supplemental private insurance (50 percent), and educated through high school or beyond (58 percent). Fifty-eight percent reported needing no assistance with basic activities of daily living leading up to the study period, while 21 percent resided in a nursing home. Twenty-three percent were eligible for both Medicare and Medicaid.

HOSPICE ENROLLMENT FOR 53–105 DAYS Eighty-eight (70 percent) subjects enrolled in hospice for 53–105 days prior to death were matched to 1,404 decedents not enrolled in hospice for 53 days or more prior to death. There were no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 2).[30]

In fully adjusted analyses of outcomes spanning the last 105 days of life, subjects enrolled in hospice for 53–105 days prior to death had significantly lower mean total Medicare expenditures than matched controls ($22,083 versus $24,644, $p < 0.01$) (Exhibit 1). Hospice enrollees during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, thirty-day hospital readmissions, and in-hospital deaths (all $p < 0.01$) compared to nonhospice enrollees. Differences between the groups' total intensive care unit days were not significant in the fully adjusted model ($p = 0.11$). Additional details are provided in Appendix Exhibit 3.[30]

HOSPICE ENROLLMENT FOR 15–30 DAYS One hundred thirty-three (80 percent) subjects enrolled in hospice for 15–30 days prior to death were matched to 1,616 decedents not enrolled in hospice for 15 days or more prior to death. There were no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 4).[30]

In fully adjusted analysis of outcomes spanning the last thirty days of life, subjects enrolled in hospice for fifteen to thirty days prior to death had significantly lower average total Medicare expenditures than matched controls ($10,383 versus $16,814, $p < 0.01$) (Exhibit 1). Those enrolled in hospice during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, intensive care unit days, thirty-day hospital readmissions, and in-hospital deaths (all $p < 0.05$). Additional details are provided in Appendix Exhibit 5.[30]

HOSPICE ENROLLMENT FOR 8–14 DAYS Ninety (70 percent) subjects enrolled in hospice for 8–14 days prior to death were matched to 1,416 decedents not enrolled in hospice for 8 days or more days prior to death. Again, we found no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 6).[30]

In fully adjusted analysis of outcomes spanning the last fourteen days of life, subjects enrolled in hospice for eight to fourteen days prior to death had significantly lower average total Medicare expenditures than matched controls ($5,698 versus $10,738, $p < 0.01$) (Exhibit 1). Once again, we found that those enrolled in hospice during this period also had fewer hospital admissions, intensive care unit admission, hospital days, and in-hospital deaths (all $p < 0.01$).

The hospice group had fewer intensive care unit days than the nonhospice group, but this difference did not reach statistical significance ($p = 0.11$). Additional details are provided in Appendix Exhibit 7.[30]

HOSPICE ENROLLMENT FOR 1–7 DAYS Three hundred eight (80 percent) subjects enrolled in hospice for 1–7 days prior to death were matched to 1,493 decedents not enrolled in hospice for 7 days or more prior to death. There were no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 8).[30]

In fully adjusted analysis of outcomes spanning the last seven days of life, subjects enrolled in hospice for one to seven days prior to death had significantly lower average total Medicare expenditures than matched controls ($4,806 versus $7,457, $p < 0.01$) (Exhibit 1). Consistent with those patterns observed in other enrollment periods, those enrolled in hospice during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, intensive care unit days, and in-hospital deaths (all $p < 0.01$).

COMPARING OUTCOMES ACROSS HOSPICE ENROLLMENT PERIODS Exhibits 2–4 compare the incremental effects in outcomes between subjects enrolled in hospice and nonhospice matched controls across the study periods. The adjusted savings in total Medicare spending ranged from $2,561 for those enrolled 53–105 days prior to death to $6,430 for those enrolled 15–30 days (Exhibit 2).

The adjusted decrease in total hospital days ranged from 9.0 for those enrolled 53–105 days prior to death to 0.9 for those enrolled 1–7 days, and the decrease in intensive care unit days ranged from 4.9 for those enrolled 53–105 days to 0.5 days for those enrolled 1–7 days (Exhibit 3). The adjusted reduction in in-hospital deaths was similar across groups, and the adjusted reductions in intensive care unit admissions and thirty-day hospital readmissions were largest for those enrolled for 53–105 days (Exhibit 4).

Discussion

Medicare costs for patients enrolled in hospice were significantly lower than those of nonhospice enrollees across all periods studied: 1–7 days, 8–14 days, and 15–30 days, the most common enrollment periods prior to death, as well as 53–105 days, the period previously shown to maximize Medicare savings.[23]

In addition, reductions in the use of hospital

EXHIBIT 1

Health Care Use At The End Of Life For Subjects Enrolled In Hospice And Matched Nonhospice Controls

Measure of use	Hospice group, adjusted means	Propensity score matched controls, adjusted means
TOTAL MEDICARE EXPENDITURES, 2008 US DOLLARS		
Last 105 days[a]	22,083	24,644[b]
Last 30 days[c]	10,383	16,814[b]
Last 14 days[d]	5,698	10,738[b]
Last 7 days[e]	4,806	7,457[b]
TOTAL HOSPITAL DAYS		
Last 105 days[a]	3.50	12.50[b]
Last 30 days[c]	1.60	5.70[b]
Last 14 days[d]	0.19	4.36[b]
Last 7 days[e]	0.29	1.20[b]
TOTAL HOSPITAL ADMISSIONS		
Last 105 days[a]	0.58	1.22[b]
Last 30 days[c]	0.34	0.74[b]
Last 14 days[d]	0.08	0.48[b]
Last 7 days[e]	0.12	0.35[b]
TOTAL ICU DAYS		
Last 105 days[a]	0.71	5.65
Last 30 days[c]	0.31	2.91[f]
Last 14 days[d]	0.03	1.61
Last 7 days[e]	0.08	0.57[b]
PROPORTION WITH ICU ADMISSION		
Last 105 days[a]	0.15	0.37[b]
Last 30 days[c]	0.10	0.31[b]
Last 14 days[d]	0.02	0.23[b]
Last 7 days[e]	0.05	0.15[b]
PROPORTION WITH 30-DAY HOSPITAL READMISSION		
Last 105 days[a]	0.11	0.26[b]
Last 30 days[c]	0.02	0.12[b]
PROPORTION DYING IN THE HOSPITAL		
Last 105 days[a]	0.02	0.42[b]
Last 30 days[c]	0.06	0.44[b]
Last 14 days[d]	0.09	0.48[b]
Last 7 days[e]	0.15	0.53[b]

SOURCE Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTES** Sample sizes vary across periods of enrollment. For enrollment 53–105 days before death: hospice patients, $n = 88$; matched controls, $n = 1,404$. For enrollment 15–30 days before death: hospice patients, $n = 133$; matched controls, $n = 1,616$. For enrollment 8–14 days before death: hospice patients, $n = 90$, matched controls, $n = 1,416$. For enrollment 1–7 days before death: hospice patients, $n = 308$; matched controls, $n = 1,493$. Multivariable regression models adjusted for age; sex; race/ethnicity; education; net worth; marital status; insurance coverage; functional status; residential status; medical conditions; and regional supply of hospital beds, specialist physicians, and local hospital care intensity. 95 percent confidence intervals for all estimates are available in the online Appendix (see Note 30 in text). ICU is intensive care unit. [a]Hospice enrollment 53–105 days before death. [b]Difference between hospice and control groups statistically significant at $p < 0.01$. [c]Hospice enrollment 15–30 days before death. [d]Hospice enrollment 8–14 days before death. [e]Hospice enrollment 1–7 days before death. [f]Difference between hospice and control groups statistically significant at $p < 0.05$.

services at the end of life both contribute to these savings and potentially improve quality of care and patients' quality of life. Specifically, hospice enrollment was associated with significant reductions in hospital and intensive care unit admissions, hospital days, and rates of thirty-day hospital readmission and in-hospital death.

EVIDENCE OF MEDICARE SAVINGS Our results not only are consistent with prior studies for Medicare spending, but they also strengthen this evidence by replicating the results within a sample more thoroughly matched for individual health, functional, and social characteristics, as well as regional factors. Finding no difference between the hospice and control groups' pre-enrollment health care use is evidence of this improved match, as compared to prior work.[23]

Specifically, Taylor and colleagues reported a maximum reduction in Medicare spending among patients enrolled in hospice for 53–105 days prior to death.[23] We found Medicare savings among this group, too, but we also found a similar level of savings among those enrolled for 1–7 days and increased savings among those enrolled for 8–30 days prior to death. Furthermore, we demonstrated parallel reductions in hospital and intensive care unit use, hospital readmissions, and in-hospital death.

INCREASING VALUE THROUGH MEDICARE HOSPICE These findings, albeit limited to enrollment up to 105 days, are of particular importance because they suggest that investment in the Medicare hospice benefit translates into savings overall for the Medicare system. For example, if 1,000 additional beneficiaries enrolled in hospice for 15–30 days prior to death, Medicare could save more than $6.4 million, while those beneficiaries would be spared 4,100 hospital days. Alternatively, if 1,000 additional beneficiaries enrolled in hospice for 53–105 days before death, the overall savings to Medicare would exceed $2.5 million.

Although our findings suggest that hospice enrollment results in savings to the Medicare program across a number of different lengths-of-stay, this work also highlights several areas for future research.

First, because of the limitations of our data set, we were unable to precisely determine the point at which hospice approaches usual care in terms of costs. Future studies will be needed to address this question.

Second, our data were also not able to identify the differential effects of hospice on specific diagnoses. This is of particular importance given the recent growth of for-profit hospices, which typically enroll more patients with noncancer diagnoses (and longer average lengths-of-stay) compared to not-for-profit programs.

We found that net Medicare savings for patients with longer lengths-of-stay are lower because of the per diem cost of hospice services. However, we note that if 1,000 additional beneficiaries enrolled in hospice for 53–105 days before death, these beneficiaries could avoid 9,000 hospital days at the end of life. Indeed, our findings suggest that substantial reduction in hospital days—a primary goal of health care reform—is achieved regardless of the length of hospice enrollment.

Finally, our findings cannot be extrapolated to novel models of health care delivery or reimbursement, such as the integration of hospice programs into accountable care organizations or graded per diem payment systems, higher reimbursement for earlier and later days of enrollment, and lower reimbursement for the middle days.[20,37] The ability of these models to achieve savings while maintaining or improving quality is unclear and must be evaluated.

BARRIERS TO TIMELY HOSPICE ENROLLMENT Our results, when taken together with those of prior studies, suggest that hospice increases value by improving quality and reducing costs for Medicare beneficiaries at the end of life. Yet aggressive efforts to curtail Medicare hospice spending, including the Office of Inspector General's investigation of hospices that enroll patients with late-stage diseases but unpredictable prognoses, are ongoing.

Our findings suggest that these efforts may be misguided. Indeed, this study reveals that savings are present for both cancer patients and noncancer patients and that reductions in the use of hospital services and numbers of hospital days, hospital admissions, and hospital deaths appear to grow as the period of hospice enrollment lengthens within the observed study period (up to 105 days). These outcomes not only are less costly but also have all been associated with higher quality of care and increased concordance with patients' preferences.

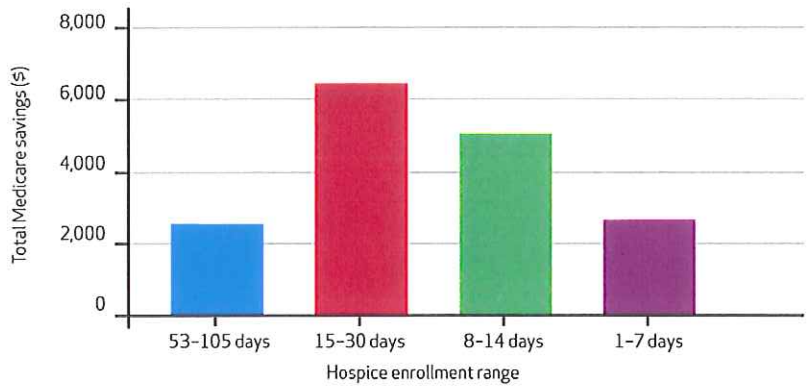
Although sample-size limitations prevented us from examining enrollment beyond 105 days, the trend in our data and the projections by Taylor and colleagues support the idea that efforts to curtail hospice enrollment may actually increase use and spending overall. Instead of working to reduce Medicare hospice spending and creating a regulatory environment that discourages continued growth in hospice enrollment, the Centers for Medicare and Medicaid Services should focus on ensuring that patients' preferences are elicited earlier in the course of their diseases and that those who want hospice care receive timely referral.

An additional barrier to timely hospice referral may be limited knowledge or misconceptions regarding hospice and palliative care.[38] In particular, the hospice requirement to forgo curative treatments—even if they might not be beneficial—may be difficult for patients and families to accept or prompt fears of health care rationing. Because some treatments may be used for both curative and palliative purposes, this regulation and the variability with which hospice providers interpret it may also cause clinicians to be uncertain about hospice eligibility.[39]

Several recent state and federal policy initiatives are designed to promote patient-centered care, specifically by increasing palliative care education among all health professionals and requiring that clinicians apprise patients of palliative treatment options early in the course of a serious illness.[40–42] Such efforts to elucidate patients' preferences and values early may increase timely referral to hospice.

EXHIBIT 2

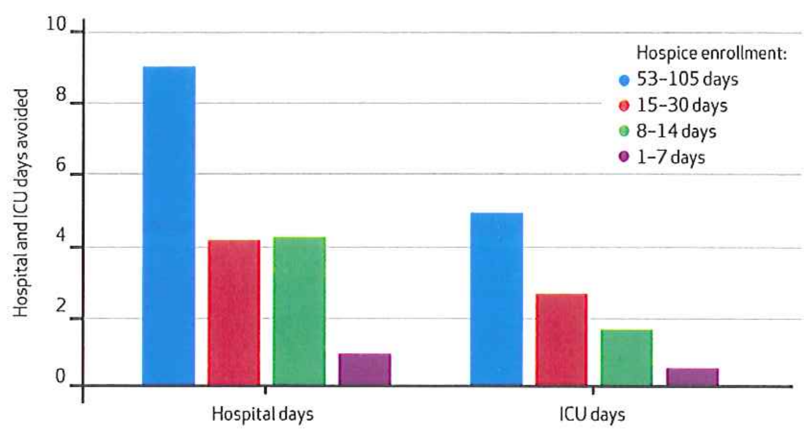
Incremental Savings In Medicare Expenditures, By Various Lengths Of Hospice Enrollment Before Death With Matched Nonhospice Controls



SOURCE Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTE** Total savings to Medicare denote the incremental difference in Medicare spending between hospice and nonhospice groups.

EXHIBIT 3

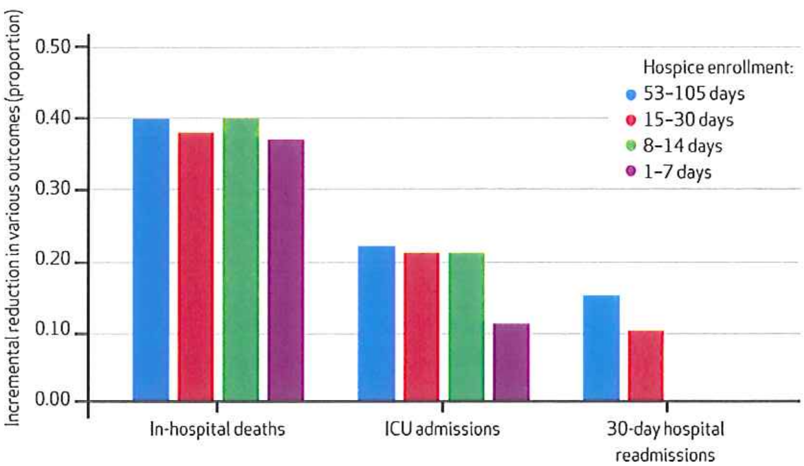
Incremental Reductions In Hospital Days And Intensive Care Unit Days, By Various Lengths Of Hospice Enrollment Before Death With Matched Nonhospice Controls



SOURCE Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTE** Hospital and intensive care unit (ICU) days avoided is expressed as the incremental effect in days between hospice and nonhospice groups.

EXHIBIT 4

Incremental Reductions In Hospital Deaths, Intensive Care Unit Admissions, And Thirty-Day Readmissions, By Various Lengths Of Hospice Enrollment Before Death With Matched Nonhospice Controls



SOURCE Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTES** Incremental reduction in various outcomes (in-hospital deaths, ICU admissions, and thirty-day hospital readmissions) is expressed as the incremental effect in proportion between hospice and nonhospice groups. ICU is intensive care unit.

Finally, highly specialized and fragmented care may also present a barrier to hospice access, particularly for patients with the most complex and highest-cost illnesses: those 5 percent of patients, many in their last year of life, who account for nearly half of the nation's health care spending.[1-3] Not only is care for this group characterized by costly hospital-based treatment, but it is also often highly fragmented and of poor quality, particularly among those who are dually eligible for Medicare and Medicaid.[43] Although many demonstration projects seek to address this concern,[43] few target this population's need for assistance in identifying individualized goals of care and developing comprehensive treatment plans to achieve those goals.

One such comprehensive treatment approach might be the enhancement of formal partnerships between hospital palliative care teams and hospice. Evidence from existing models that incorporate hospital palliative care services demonstrates improvement in quality indicators, heightened patient and family satisfaction, reduced hospital use, and increased rates of hospice referral.[44] These benefits may be even more substantial if formal relationships between established palliative care teams and community hospice programs were developed in order to offer a bridge to timely hospice enrollment.

Conclusion

Hospice enrollment during the longer period of 53–105 days prior to death and the most common period within 30 days prior to death lowers Medicare expenditures, rates of hospital and intensive care unit use, 30-day hospital readmissions, and in-hospital death. Building upon prior studies of hospice and palliative care that have demonstrated higher quality and improved patient and family satisfaction,[8,13-15,32-36] this finding suggests that hospice and palliative care are critical components in achieving greater value through health care reform: namely, improved quality and reduced costs.

Medicare should thus seek to expand access to hospice services so that hospice can contribute to its full potential to the overall value of care. To do so, substantial barriers to timely hospice enrollment must be overcome. The Centers for Medicare and Medicaid Services should abandon efforts to reduce Medicare hospice spending and delay hospice enrollment and should instead focus on ensuring that people who want hospice care receive timely referral.

Within the current Medicare hospice benefit, several approaches may expand access and increase appropriate and timely referral to hospice. These approaches include formalized partnerships between hospital palliative care programs and community hospice programs and the promotion of patient-centered care by educating patients, families, and physicians about the availability and benefits of hospice and palliative care services.

Finally, ongoing demonstration projects and novel models of health care delivery and reimbursement should place a high priority on the rigorous evaluation of hospice service use and its impact on the value of care. ■

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NOTES

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ABOUT THE AUTHORS: AMY S. KELLEY, PARTHA DEB, QINGLING DU, MELISSA D. ALDRIDGE CARLSON & R. SEAN MORRISON

Amy S. Kelley is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

In this month's *Health Affairs*, Amy Kelley and coauthors report on their study examining Medicare costs for hospice patients enrolled for different lengths-of-stay, ranging from 1 day to 105 days. Using data from the Health and Retirement Study and individual Medicare claims, they found savings for Medicare across all lengths-of-stay examined. Hospice patients also had less hospital use than matched controls, and thus a higher quality of life. The authors argue that instead of attempting to limit Medicare hospice participation for fear of not seeing savings, the Centers for Medicare and Medicaid Services should focus on ensuring the timely enrollment of qualified patients who desire the benefit.

Kelley is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, and is a board-certified physician in internal medicine, geriatric medicine, and palliative medicine. Her research focuses on improving the quality of care for older adults with serious medical illness. She is particularly interested in regional practice variations and the relationship between patient characteristics and treatment intensity.

In 2012 Kelley was selected for the Paul B. Beeson Career Development Award in Aging Research from the National Institute on Aging and won the American Geriatrics Society's best paper award in geriatrics research. Kelley earned a master's degree in health services from the University of California, Los Angeles, and a medical degree from Cornell University.

Partha Deb is a professor and director of graduate studies in the Department of Economics at Hunter College.

Partha Deb is a professor and director of graduate studies in the Department of Economics at Hunter College and a professor at the Graduate Center, City University of New York. He is also an adjunct professor at the School of Public Health, Hunter College; a senior adviser at the Center for Medicare and Medicaid Innovation, Department of Health and Human Services; a research associate at the National Bureau of Economic Research; and a faculty fellow at the Brookdale Center for Healthy Aging and Longevity, Hunter College. Deb also serves on the editorial board of *Health Services Research*. He earned a master's degree and a doctorate in economics from Rutgers University.

Qingling Du is a statistician in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

Qingling Du is a statistician in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai. Her work focuses on developing statistical models to study health care delivery systems. Du earned a master's degree in statistics from the University of Chicago.

Melissa D. Aldridge Carlson is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

Melissa Aldridge Carlson is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, and the director of research methods training for the Mount Sinai Medical Student Training in Aging Research Program. She is a member of the National Palliative Care Research Center's Scientific Review Committee and serves on the editorial board of the *Journal of Palliative Medicine*. She earned an MBA from New York University, a master's degree in public health from Columbia University, and a doctorate in health policy and administration from Yale University.

R. Sean Morrison is a tenured professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

Sean Morrison is a tenured professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai; director of the school's Hertzberg Palliative Care Institute; and the Herman Merkin Professor of Palliative Care. He is the director of the National Palliative Care Research Center and was the president of the American Academy of Hospice and Palliative Medicine. Morrison serves on the editorial board of *Palliative Medicine* and is the senior associate editor of the *Journal of Palliative Medicine*. He earned a medical degree from the University of Chicago.

2013 SALUTE *to* BUSINESS

CAPITAL INVESTMENT AWARD

THE CHAMBER IS PLEASED TO RECOGNIZE

Center for Hospice Care

FOR THEIR CONTINUED INVESTMENT IN THE COMMUNITY

Jeff Rea
President and CEO

sjc
ST. JOSEPH COUNTY
CHAMBER OF COMMERCE

Jacqueline Barton
Chamber Board Chair

CAPITAL INVESTMENT AWARDS

The Chamber recognizes these member businesses and organizations for their continued investment in the community through capital investments.

GOLD

- Center for Hospice Care
- Daman Products Company, Inc.
- Data Realty LLC
- FDC Graphic Films, Inc.
- Gates Automotive
- Golden Corral
- Holladay Corporation
- Lock Joint Tube LLC
- Memorial Hospital of South Bend
- Saint Joseph Regional Medical Center
- South Bend Silver Hawks
- Sprenger Health Care of Mishawaka
- Steel Warehouse Company, Inc.
- Tire Rack
- University of Notre Dame

SILVER

- Bethel College
- DoubleTree by Hilton South Bend
- Dunkin' Donuts
- Eddy Street Executive Suites
- Southfield Village
- Tanglewood Trace

BRONZE

- 1st Source Bank
- Bayer HealthCare
- Center for the Homeless
- Charles S. Hayes, Inc.
- Doctors Express Granger
- F & F Machine Specialties
- Fairfield Inn Mishawaka
- German Concepts
- Habitat for Humanity of St. Joseph County
- Indiana Michigan Power
- Indiana Trust & Investment Management Co.
- Inovateus Solar LLC
- Koontz-Wagner Holdings, LLC
- Logan Community Resources, Inc.
- Trinity School at Greenlawn
- Zolman Tire Inc.

Facing the end sooner

South Bend Tribune/GREG SWIERCZ

Isabel Stickley of South Bend speaks about her husband, Ralph, and the 14 months he spent in hospice before he died in 2011. She and Ralph, high school sweethearts, were married for 64 years. "There would never be anyone else for me," she says now. "I had the best."

South Bend Tribune 4-8-13

Studies say most wait too long to enter hospice care

By VIRGINIA BLACK
South Bend Tribune

SOUTH BEND — When Isabel Stickley first heard the suggestion that she consider hospice care for her husband, Ralph, she remembers thinking, "How dare you?"

Her strong, quiet husband — who had run every day, never smoked or drank alcohol — had declined in health since his first heart attack at the age of 77. But ready to die? No way.

"I didn't understand," Mrs. Stickley says now, acknowledging a natural reluctance for patients or their families to agree to hospice. "They want to say, 'Oh, no, it's not the end.'"

Because they believe hospice care means giving up at the very end of life, recent studies say, the average length of time patients enroll in a hospice program is only three days — not nearly long enough to fully benefit from what such care has to offer.

Two University of Notre Dame MBA students released results from a study late last year that asked 300 residents among St. Joseph, Marshall, Elkhart and LaPorte counties about their perceptions of hospice care.

About 12 percent of those surveyed said they would call hospice within only a few months of expected death; 11 percent cited a few days to less than a month; and 22 percent said they didn't know.

A majority consistently said they'd seek hospice information from a doctor, or rely on their doctors to suggest the need for hospice, the survey reported. Yet doctors seem reluctant to suggest hospice care to their patients.

Research published in February in the Journal of the American Medical Association noted that more than 28 percent of dying patients received hospice care for three days or less.

Although the numbers of those enrolled in hospice has risen slightly since 2009, a news release from the National Hospice and Palliative Care Organization says "concerns about the increasing number of people receiving hospice for three days or less is a call for action."

And yet another set of results, from a study published in March by the Brookdale Department of Geriatrics and Palliative Medicine at Mount Sinai, suggests that, in addition to better support and quality of life, the overall medical costs to Medicare are lower for longer-term hospice patients than for those not enrolled in hospice.

See SOONER/A2

FROM PAGE A1

Sooner: Most wait too long, studies say

Ten facts about hospice care

The National Hospice and Palliative Care Organization released this list last week of things you might not know about hospice care:

- Hospice is not a place; it's high-quality care that focuses on comfort and quality of life.
- Hospice is paid for by Medicare, Medicaid and most insurance plans. Fear of costs should never prevent a person from accessing hospice care.
- Hospice serves anyone with a life-limiting illness, regardless of age or type of illness.
- Hospice provides expert medical care as well as spiritual and emotional support to patients and families.
- Research has shown the majority of Americans would prefer to be at home at the end of life; hospice makes this possible for most people.
- Hospice serves people living in nursing homes and assisted living facilities.
- Hospice patients and families can receive care for six months or longer.
- A person may keep his or her referring physician involved while receiving hospice care.
- Hospice offers grief services to family members to help them adjust to the loss in their lives.
- Research has shown people receiving hospice care can live longer than similar patients who do not opt for hospice.

Patients must meet certain criteria for hospice care, including a health condition for which aggressive treatment seems unlikely to prolong life.

But misunderstandings about hospice care persist, says Amy Tribbett, director of marketing and access for the Center for Hospice Care headquartered in Mishawaka.

Hospice organizations, including hers, have increased their outreach to doctors and other health care professionals and are appealing directly to communities of senior citizens, she says.

"If you think about it, (doctors) were trained to cure," Tribbett says of their reluctance. But rather than abandoning a patient, a doctor can still be involved while the patient is in hospice care.

Sometime patients do improve and are removed from hospice.

"Life expectancy actually increases while in hospice because of the quality of care in hospice," she says. And if a patient is enrolled in a hospice program, improves and "graduates" from it and at some period later declines again, he or she may be re-certified for it.

As they like to say, Tribbett adds, "The most common phrase we hear from families is: 'I wish we had contacted hospice sooner.'"

'Not a death sentence'

As Ralph Stickley's health declined, he moved into Southfield Village on the city's south side, as Mrs. Stickley moved into independent living nearby.

She tried to take him home, she remembers, but her 5-foot-9 husband sometimes fell and was too much for her to care for.

By the time he died on Oct. 17, 2011, at the age of 85, he had a host of issues, including dementia, Alzheimer's, Parkinson's and his heart trouble. "It was to the point he couldn't blow his own nose, he couldn't roll over in bed, he couldn't talk," Mrs. Stickley says.

He had also been enrolled in hospice for 14 months, although the family would not have predicted he would have lived so long.

But during that time, Mrs. Stickley says, the family was well supported by Southfield Village employees and hospice workers.

"They were able to guide us through it," she says, including the couple's two grown children. And hospice workers responded quickly to needs as they arose.

In fact, the family's primary hospice nurse, who would generally visit two or three times each week, contacted Mrs. Stickley on the year anniversary of his death.

That nurse, Karen Hudson, says hospice workers are able to bond with families when they have enough time — which in her view is too infrequent.

"It's unfortunate, but it's unusual," Hudson says of Mr. Stickley's 14-month enrollment in hospice. "People tend to wait till the last minute."

With shorter stays, she says, "you're just putting out fires." To truly advocate for a patient and help a family through the best experience possible, more time is a great advantage.

"Hospice is not a death sentence," the nurse says. "It's about living life the best you can for as long as you can, and people unfortunately don't see it that way."

Her own husband, Bruce, died last September, a few days short of his 60th birthday. Hudson says his rare form of cancer prompted them to spend his last several months in ways other than undergoing treatment.

"We traveled, we enjoyed life, we made memories," Hudson says. "We could not have made a better choice."

The longtime nurse says she recognizes medicine as a business and that doctors often see their roles as offering treatment rather than counseling patients to prepare for end of life.

"The generation we serve comes from the generation of, 'Doctors are gods,'" Hudson says. "We always do what the doctors say to do."

Mrs. Stickley says she does not regret the lengthy amount of time her husband spent in hospice.

She remembers him as a thinker and an amateur astronomer who built his own telescope. At his funeral service, the family displayed things he had created, including a hobby horse he'd made for his 3-year-old great-granddaughter.

"Oh, those blue eyes," the 86-year-old sighs about her husband, whose wedding rings she still wears. "Oh, that smile."

Still, "it was sad when he died," Mrs. Stickley says, but because of how his life ended, "it wasn't tragic. ... They were there to guide us through it."

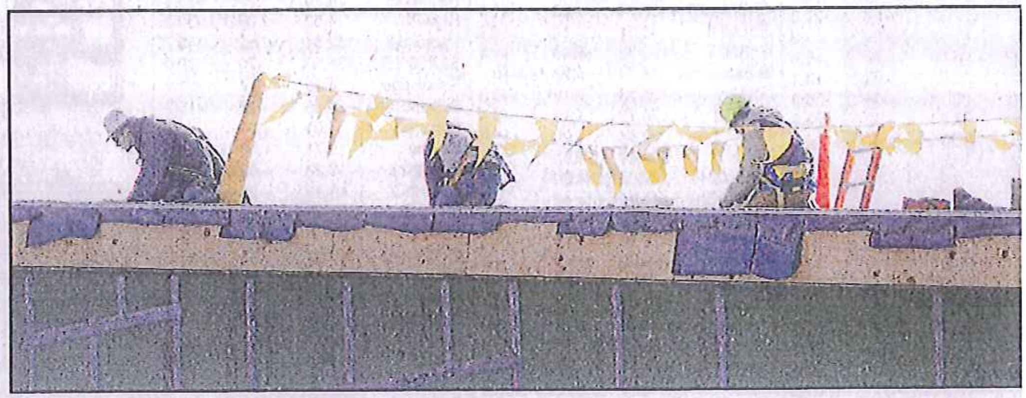
Contact Virginia Black:
574-235-6321
vblack@sbtinfo.com
facebook.com/tribune.virginia black

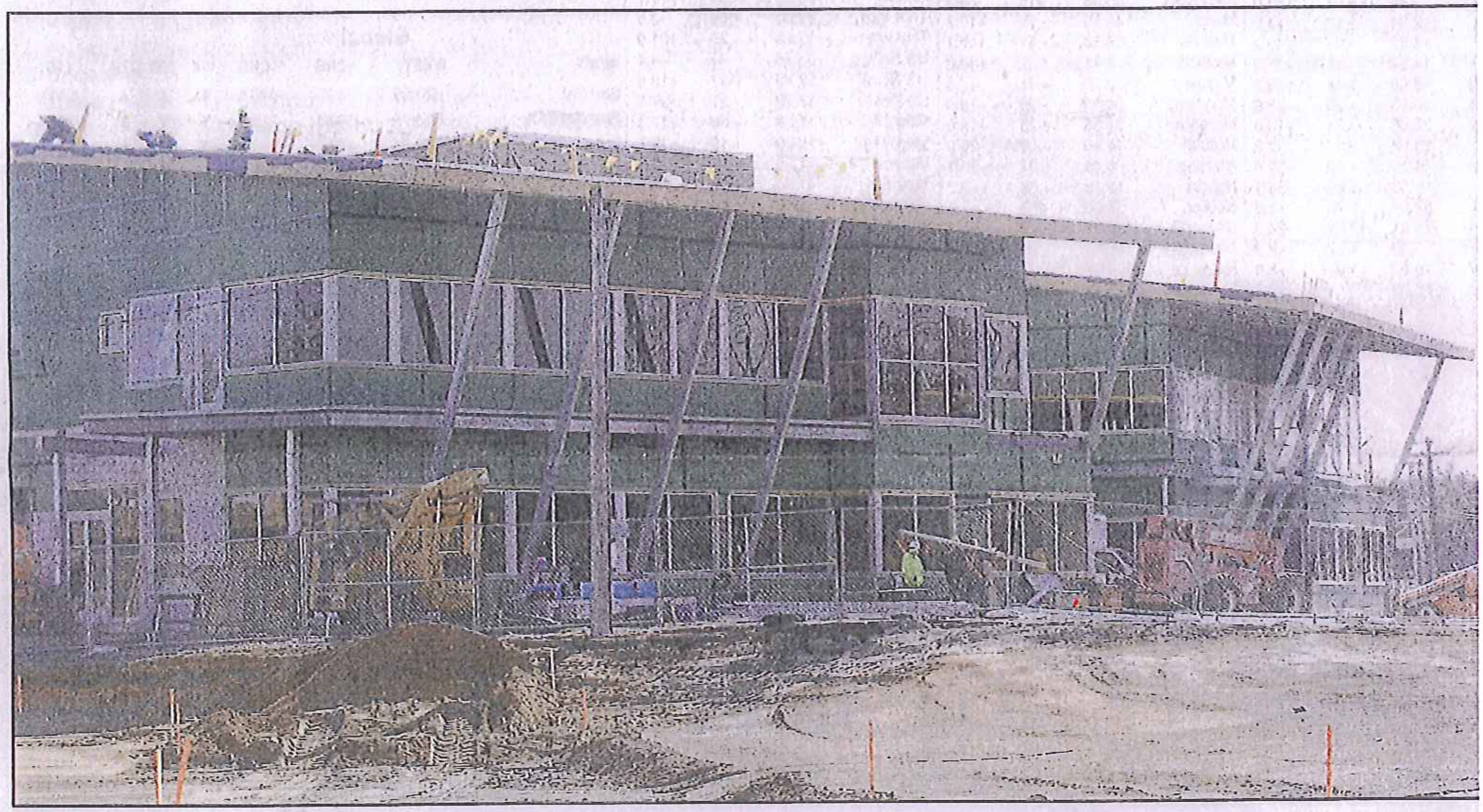
South Bend Tribune
4-6-13

New hospice campus

The first phase of the nearly five-acre campus for the Center for Hospice and Palliative Care is well on its way to being finished by June. The campus is on the north bank of the St. Joseph River between Central Park and Cedar Street in Mishawaka. DJ Construction is doing the work, which began in September. Aside from this office building, renovations also are under way on two existing buildings that will become part of the new campus, including the former Edgewater Florist building, which will become a Palliative Care Center.

South Bend Tribune Photos
GREG SWIERCZ





MARSHALL INTERMEDIATE CENTER
1433 BYRON DRIVE
SOUTH BEND, IN 46614
TEL. 574-231-5801
MR.JAME BOWEN, PRINCIPAL

March 27, 2013

Mr. Mark Murray
The Center for Hospice and Palliative Care, Inc.
111 Sunnybrook Court
South Bend, IN 46637-3437

Dear Mr. Murray,

Just recently, Annette DeGuch and Sheri Nisely Frazier completed an eight week group counseling experience to address grief issues with Marshall Intermediate Center students. The complexity of the group resulted in this group being divided into two groups that were conducted simultaneously thus allowing more time for students to talk and participate. This was very effective as the younger students were quite comfortable in their own group.

These students who had lost a significant family member greatly benefited from these groups. We are most grateful that the Center for Hospice and Palliative Care, Inc. was able to provide this service to our students. Many of our students do not have the consistent transportation resources to travel for this type of counseling. Our students who participated felt that someone was finally listening to them and they learned that they were not alone within their peer group. We are hopeful that the coping skills presented in the sessions will aid the students as they continue their grieving. Three of the students have come to me to express their appreciation for the group experience.

Please accept our sincere appreciation for the services provided to our students. We hope to continue this relationship in the future and look forward to working again with the Hospice staff.

Sincerely,

Mrs. Linda Cress,
School Social Worker

Mr. James Bowen,
Principal

Lights, Camera, Action

NOW PLAYING:

Choices Campaign 2013

Center for Hospice Care

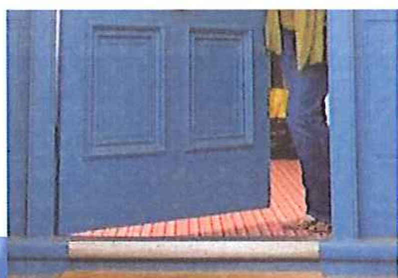
choices to make the most of life

The right choice

Highlight featured speakers with a soft-focus diffused background. Elicit expressions and tones that communicate confidence and compassion. Convey the emotional benefits of "Choices to make the most of life"

Color palette – hopeful, uplifting and confident

helping families
make wise choices



B-roll will demonstrate home visits with CHC staff person and patient; showcase "joy of life" interactions rather than clinical interactions

TV SPOT ONE – THE BEST CHOICE FOR END OF LIFE

BRAND IDENTITY GRAPHICS ON A WHITE BACKGROUND

In a reprise of our campaign kickoff, create an animated spot featuring the **Center for Hospice Care brand name and logo** along with words such as Choice, Hope and others that resonate emotionally. Voiceover will explain why CHC is the **best choice for making the most of life** during the final months, including the **30+ years experience** of the team.

SUPPORTS RESEARCH FINDINGS

Community still isn't retaining names of hospice providers unaided so we want to boldly reinforce the CHC brand. They're starting to understand there is a choice and CHC will be positioned as the best choice. "CHC has been serving your community for 30+ years" has risen in importance as a positive statement.

TESTIMONIAL TWO – THE CHOICE THAT'S COVERED

MARK MURRAY

Mark explains the great care CHC provides to patients and families. And it's covered! – by **Medicare, Medicaid, private insurance and donations** – so hospice care is available to all. Explain care and **support, prescriptions and medical equipment at the patient's home** are all included. Invite families to **call CHC directly** and to **call sooner** to make the most of life.

SUPPORTS RESEARCH FINDINGS

Confusion still exists on how hospice is paid for (over 30% "don't know"; over 50% don't know if their insurance includes hospice coverage), and the community needs to know cost isn't an obstacle to access. "CFC provides care to all, regardless of ability to pay" has risen in importance.

TESTIMONIAL THREE – TAKE CONTROL OF YOUR CHOICES

SENIOR SPOUSE 60+, NON-CANCER DIAGNOSIS

The wife or husband of a former patient talks about **contacting CHC directly** when needing help to care for their spouse at home, despite their doctor not bringing up hospice. Spouse also will describe the care and support received by both the patient and family and how CHC was their **best choice to make the most of life**. Spouse will advise viewers to **call CHC without delay**.

SUPPORTS RESEARCH FINDINGS

Only 35% "already knew" families can self-refer to hospice. Nearly 70% "don't know" which hospice organization serves their community; 51% "don't know" which hospice they would call if they needed care or information.

Television Commercials

To view our new commercials and longer web vignettes, go to

Once you're on the You Tube page, search for **Center4Hospice** and you will be directed to our You Tube channel http://www.youtube.com/user/Center4Hospice

You can see our commercials on some of your favorite channels!

Print Ads

The following ads rotate throughout our eight-county service area in the following papers:

Marshall County, Indiana's community news source since 1851
Pilot News

Warsaw, Indiana
Times-Union
Continuously serving Kosciusko County since 1854

eTruth

rochsent.com

THE ROCHESTER SENTINEL.

heraldargus.com
LA PORTE, INDIANA

GOSHEN NEWS

South Bend Tribune
Serving north central Indiana and southwestern Michigan since 1872

Choose to make the most of life

For more than 33 years, Center for Hospice Care has helped over 25,000 patients live their final months on their terms, providing the depth of services they need to have the highest quality of life possible.

To learn more or self-refer, call anytime.

1-800-HOSPICE or CenterForHospice.org

Center for Hospice Care

choices to make the most of life

Services from Center for Hospice Care are typically covered by Medicare, Medicaid or private insurance. No one is turned away due to inability to pay.

Without a doubt I made the right choice.

– Betty, Ron's wife

"My husband, Ron, had Alzheimer's. Toward the end, he lost his ability to speak. I knew Ron just wanted to be at home. Center for Hospice Care was so good at making sure we had everything we needed to live his last months as he wanted. Our family had a team behind us who knew what they were doing."

To learn more or self-refer, call anytime.

1-800-HOSPICE or CenterForHospice.org

Center for Hospice Care

choices to make the most of life

Services from Center for Hospice Care are typically covered by Medicare, Medicaid or private insurance. No one is turned away due to inability to pay.

And the best part is, it's all covered.

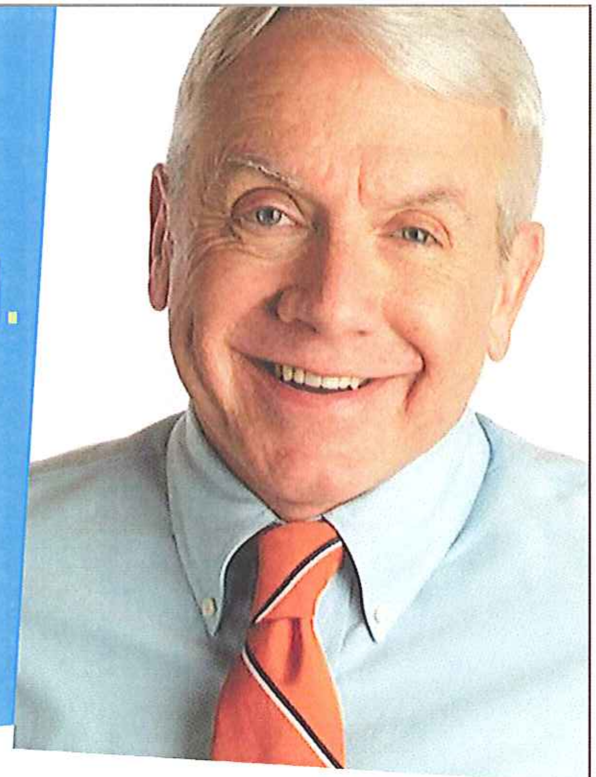
– Mark, President/CEO

"I think people are most surprised at the depth of Center for Hospice Care services. It's much more than they thought it was, including home visits by nurses, social workers, spiritual care, medication delivery and other choices.

"And the best part is, it's all covered under Medicare, Medicaid and most commercial insurance. And nobody is ever turned away due to a lack of insurance or inability to pay."

To learn more or self-refer, call anytime.

1-800-HOSPICE or CenterForHospice.org



Center for Hospice Care

choices to make the most of life

Services from Center for Hospice Care are typically covered by Medicare, Medicaid or private insurance. No one is turned away due to inability to pay.

Billboards

Burkhart

The following three billboards will rotate locations throughout St. Joseph, Elkhart, Marshall and LaPorte counties.

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Center for Hospice Care
2013 BOARD OF DIRECTORS

Asleson, Becky *(03/16)*
51970 Sand Pointe Ct
Granger IN 46530
(563) 209-2816
beckyasleson@gmail.com

Brotherson, Jim *(03/14)*
Baker and Daniels
202 S Michigan St, Suite 1400
South Bend IN 46601
(574) 239-1922
James.brotherson@bakerd.com

Chairman
Cressy, Corey *(03/15)*
Grubb & Ellis/Cressy & Everett
4100 Edison Lakes Pkwy, Ste 350
Mishawaka IN 46545
(574) 485-1513
coreycressy@cressyandeverett.com

Davis, Melanie *(03/15)*
University of Notre Dame
1251 N Eddy St., Suite 300
Notre Dame IN 46556
(574) 631-1837
Mdavis21@nd.edu

Ellert, Francis *(03/16)*
Coca-Cola Bottling Co.
1701 Pidco Drive
Plymouth IN 46563
(574) 936-3220
fellert@cckokomo.com

Secretary
Englert, Julie *(03/15)*
1130 E Jefferson Blvd
South Bend IN 46617
(574) 288-1107
Cell # 574-261-6436
jenglertrn@aol.com

Chairman-Elect
Mauro, Amy Kuhar *(03/15)*
66071 Smilax Rd
North Liberty IN 46554
Cell # 574-276-3364
amauro@ndfcu.org

Method, MD, Mike *(03/16)*
Michiana Hematology Oncology
5340 Holy Cross Pkwy
Mishawaka IN 46545
(574) 237-1328
mmethod@mhopc.com

Murphy, Carmi *(03/15)*
1237 W Jefferson Blvd
South Bend IN 46601
(574) 234-2703
carmimurphy@me.com

Newbold, Mary *(03/15)*
1139 Aline Court
South Bend IN 46614
(574) 291-5300
Newbold125@yahoo.com

Immediate Past Chairman
Rodino, Terry *(03/15)*
Recycled New Pallets
24478 County Rd 45
Elkhart IN 46516
(800) 360-9533
tjrodino@aol.com

Treasurer
Walsh, Wendell *(03/14)*
May Oberfell Lorber
4100 Edison Lakes Pkwy, Ste 100
Mishawaka IN 46545
(574) 243-4100
wwalsh@maylorber.com

Yoder, Tim *(03/16)*
1909 S Main St
Goshen IN 46526
(574) 533-6609
ydtm@maplenet.net

Center for Hospice Care

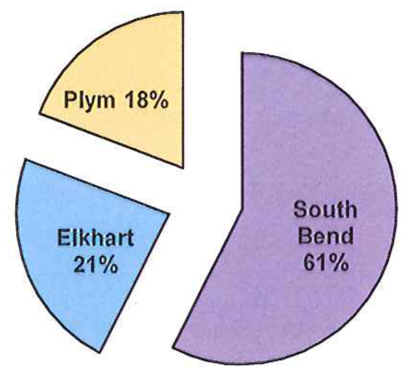
2013 YTD Average Daily Census (ADC)

(includes Hospice House and Home Health)

	All	South Bend	Elkhart	Plymouth
J	305	187	60	58
F	315	193	68	54
M	330	199	72	59
A				
M				
J				
J				
A				
S				
O				
N				
D				
2013 YTD Totals	950	579	200	171
2013 YTD ADC	**317**	**193**	**67**	**57**
2012 YTD ADC	355	202	81	71
YTD Change 2012 to 2013	-38	-9	-14	-14
YTD % Change 2012 to 2013	-10.8%	-4.5%	-17.7%	-19.7%

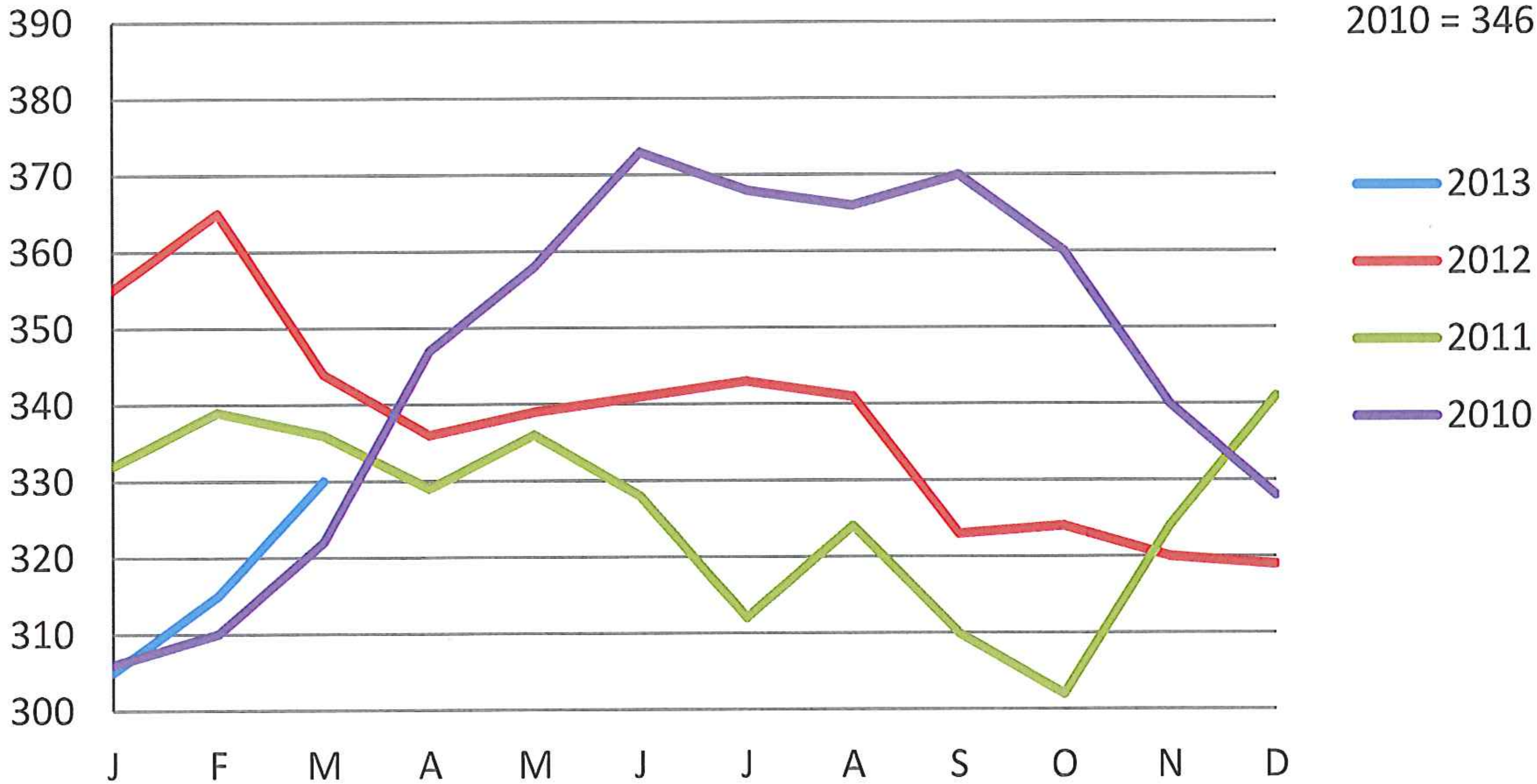
2012 YTD ADC by Branch

South Bend	60.9%
Elkhart	21.1%
Plymouth	18.0%
All	100%



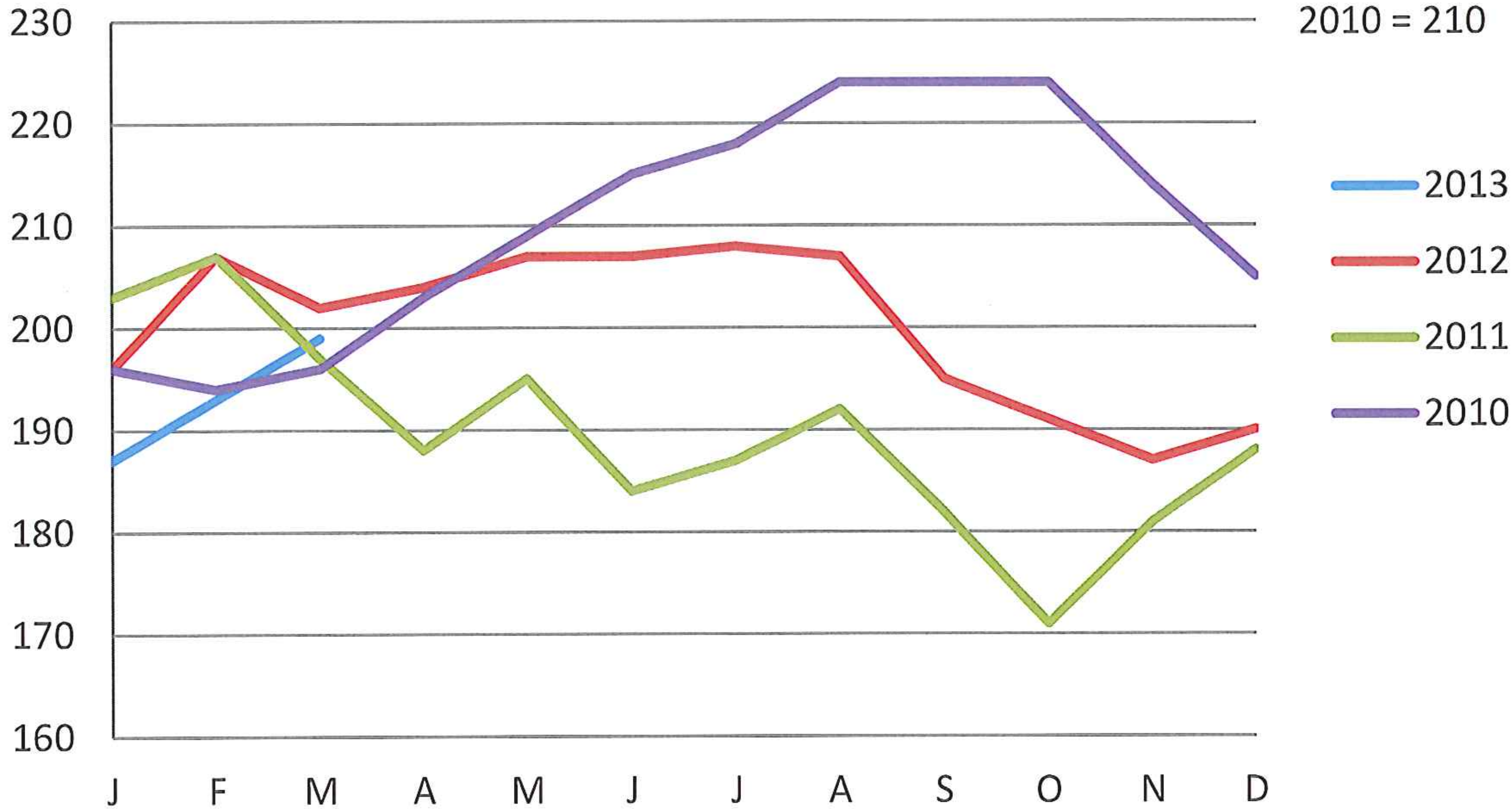
Center for Hospice Care
Total Average Daily Census (ADC)

ADC
YTD 2013 = 317
2012 = 337
2011 = 326
2010 = 346



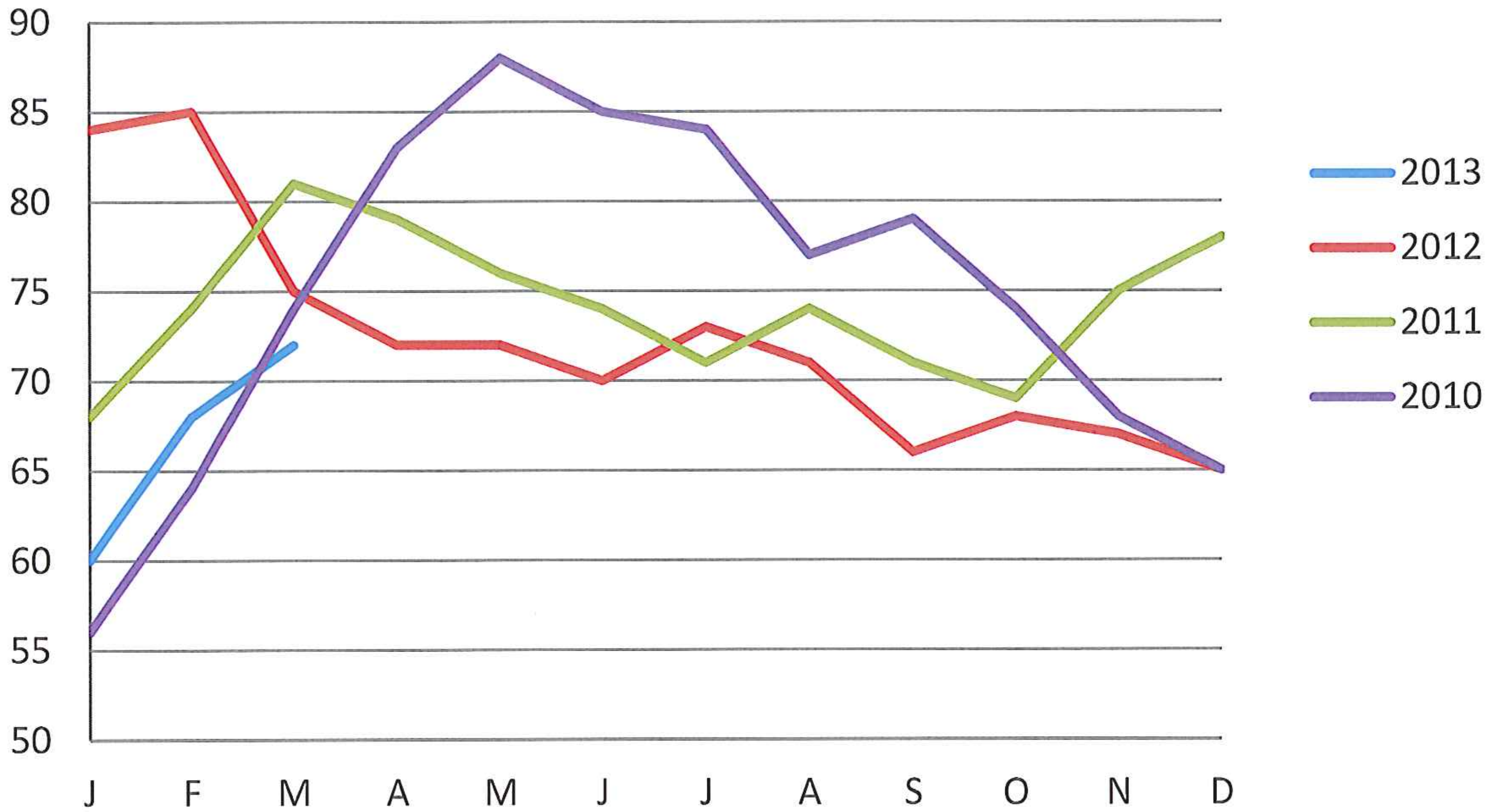
South Bend
Average Daily Census

ADC
YTD 2013 = 193
2012 = 200
2011 = 190
2010 = 210



Elkhart
Average Daily Census

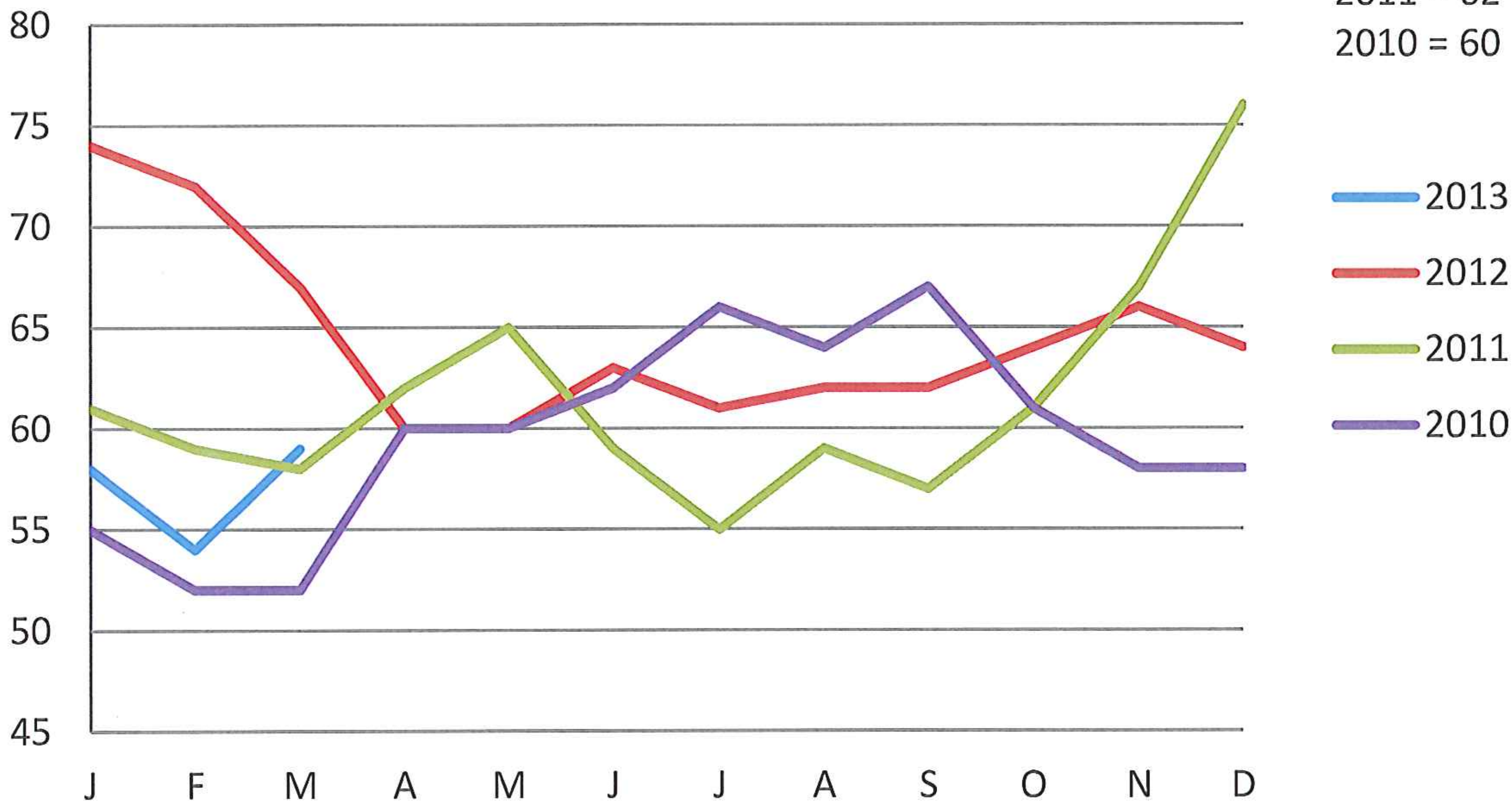
ADC
YTD 2013 = 67
2012 = 72
2011 = 74
2010 = 75



Plymouth
Average Daily Census

<u>ADC</u>

YTD 2013 = 57
2012 = 65
2011 = 62
2010 = 60



Center for Hospice Care
Compliance Committee Meeting Minutes
March 20, 2013

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

Topic	Discussion	Action
1. Call to Order: 3:00 p.m.		
2. Follow-Up to 11/13/12 Meeting	• The "Hospice Manages This Patient's Care" form has been changed to an electronic version. We are ready to start trialing it with a patient. We will work with the facility billing office to make sure they recognize the new form. Once we are confident it is ready, we will go live with it. The form will be more readable and convenient for staff to keep updated, and we hope facilities find it more professional looking versus the handwritten one. It will be part of our electronic medical record. • The next PEPPER report is coming in April. We now have a Live Discharges QAPI.	
3. LCDs	• Distributed copies of an article about the San Diego Hospice's noncompliance problems. One focus was how important the LCDs are. We work closely with our nurses on how to document and the language to use so a patient can qualify. They should say, "Responding to the hospice plan of care," instead of "stable." Over the last two to three years, we have done a lot of education and coaching of staff on how to document better. We give them words and phrases to use, and to add measureable data like arm circumference, weight, how far the patient can walk, etc. We feel comfortable that staff is charting to the LCDs. We tell nurses why it is important to document objectionable data. There is still work that needs to be done in nursing and social work, because both write IDT notes, in painting a better picture on why we agree to add or not add something to the plan of care. We would like to see everyone do away with the phrase "need to revoke." Staff should explain the patient's options under HMB and what will or will not be included in the hospice plan of care. Leave "revoke" out of the conversation. • In February we rolled out a worksheet to the primary nurses about documenting measurable conditions prior to admission, at admission, and at recert, so we can see the	

Topic	Discussion	Action
	facts we are capturing and any decline that exists. • The QA auditors will make sure the LCD is on the chart. The palliative performance scale is being used more too. We do get ADRs from Palmetto, and were paid on all put two the last time. We want to make sure staff knows if we let a patient go because we didn't document to the LCD, it is just as bad as not admitting a patient. The patient is not getting denied anything or cannot get something. It is just that it won't be included in the hospice plan of care under HMB. They have choices they need to make. • Overall we feel good about what we do. From start to finish everyone works hard to do the right thing. The more aware we are of the COPs, the better we are as an agency. Donna and Gail have worked hard at educating nurses on why we do things and how it pertains to regulatory requirements. We always show them the applicable COP. We are moving in the right direction.	
4. Laptops	• Idaho Hospice was fined for a stolen laptop with patient information. This was first time a fine was assessed on less than 500 PHI. Cerner is encrypted on the laptops and Blackberries. They are also password protected. That is why we don't use I-Phones or Androids, because they are not encrypted. Josh can also wipe them clean remotely. We do have a policy regarding staff keeping their laptop in a safe place. We have done everything we possibly can.	
5. 2013 Compliance Goals	• This is the year to review the compliance plans, which is done biannually. Please review your areas of responsibility and bring changes to the next meeting. The plans are posted on the staff website. One new goal should be establishing a formalized process to ensure we are always following Palmetto's current LCDs. There is no pattern on when Palmetto updates them. This is an identified risk area for us. We need to identify someone to take ownership to review them. It should be a medical director that reviews them. Jon agreed to do it and will report on it at each compliance meeting. Mark will send him the link to that page on the Palmetto website. We don't want to not admit someone because we are screening them under the old LCD and they would be eligible under the new version.	
6. Staff In-Services	• The annual staff in-service is held in September. At the next committee meeting we will discuss what topic it will be this year. Last year we did Compliance 101.	
7. Next Meeting	• Start reviewing the compliance plans. Let Vicki know of anything you would like to see on the agenda. Look at the OIG and risk areas.	

Topic	Discussion	Action
Adjournment	• The meeting adjourned at 3:50 p.m.	Next meeting TBA

CHAPTER FOUR

POLICIES

Center for Hospice Care

PLAN OF CARE

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

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

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

PROCEDURE:

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

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

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

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

5. The plan of care is reviewed and updated by the IDT every 15 days or more frequently if needed. Documentation of the review is found in the IDT summary note.

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

7. ~~Reviews of and c~~Changes to the plan of care are documented in the plan and communicated to members of the IDT.

Effective Date: 12/95	Revised Date: 02/13~~07/12~~	Board Approved: 08/15/12
Reviewed Date: 05/11		Signature Date: 08/15/12

Signature:

New

REGULATION: 42 CFR 418.54 – Initial and comprehensive assessment of the patient
42 CFR 418.106 – Drugs and biologicals, medical supplies, and durable medical equipment

PURPOSE: To ensure the safe management of all medications and biologicals related to the care of the hospice patient.

POLICY: All medications and biologicals will be ordered by a physician or nurse practitioner in accordance with the patient's plan of care. These medications and biologicals will be reviewed by a licensed pharmacist through contracted pharmacy for drug to drug interactions, drug-disease state contraindications, drug-allergy interactions, therapeutic duplication, drug therapy associated with laboratory testing, clinical abuse/misuse and appropriateness of drug, dose and duration of treatment.

PROCEDURE:

1. The registered nurse will obtain a verbal or written order for all medications and biologicals, both related and unrelated to the terminal diagnosis. A verbal order will be entered into Cerner by the registered nurse receiving the verbal order, and sent to the physician for his/her signature.
2. All medications and biological orders will be profiled with the contracted pharmacist.
3. The contracted pharmacist will review both dispensed and profiled medications upon admission of the patient and each time a medication is added to the profile.
4. This medication review occurs for all dispensing models, both mail order from the contracted pharmacy, and those dispensed from a local pharmacy.
5. Each time a medication is changed or added, the entire profile is reviewed for drug to drug interactions, drug-disease state contraindications, drug-allergy interactions, therapeutic duplication, drug therapy associated with laboratory testing, clinical abuse/misuse and appropriateness of drug, dose and duration of treatment.
6. The most recent medication profile review for each patient will be documented on the Active Medication Record in the contracted pharmacy database and corresponds to the start date of the most recent medication change.

Effective Date: 03/13	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

Signature:

REGULATION: 42 CFR 418.54 – Initial and comprehensive assessment of the patient
42 CFR 418.106 – Drugs and biologicals, medical supplies, and durable medical equipment

PURPOSE: To ensure the safe management of all medications and biologicals related to the care of the hospice patient residing in Hospice House.

POLICY: All medications and biologicals will be ordered by a physician or nurse practitioner in accordance with the patient's plan of care. These medications and biologicals will be reviewed by a licensed pharmacist through contracted~~Omnicare~~ Pharmacy for drug to drug interactions, drug-disease state contraindications, drug-allergy interactions, therapeutic duplication, drug therapy associated with laboratory testing, clinical abuse/misuse and appropriateness of drug, dose and duration of treatment.

PROCEDURE:

1. The registered nurse will obtain a verbal or written order for all medications and biologicals, both related and unrelated to the terminal diagnosis. A verbal order will be entered into Cerner by the ~~written, signed by the receiving~~ registered nurse receiving the verbal order, and sent to the physician for his/her signature.

2. All medications and biological orders are to be faxed to contracted pharmacy~~Omnicare~~. Orders (either covered or non-covered) will be identified. The contracted pharmacy will profile all orders, but only send the medications requested.

3. The contracted~~Omnicare~~ pharmacist will review both dispensed and profiled medications upon admission of the patient and each time a medication is added to the profile.

4. This medication review occurs for all dispensing models, both mail order from contracted pharmacy~~Omnicare~~ and those dispensed from a local pharmacy.

5. Each time a medication is changed or added, the entire profile is reviewed for drug to drug interactions, drug-disease state contraindications, drug-allergy interactions, therapeutic duplication, drug therapy associated with laboratory testing, clinical abuse/misuse and appropriateness of drug, dose and duration of treatment.

6. The most recent medication profile review for each patient will be documented on the Active Medication Record in the contracted pharmacy~~Omnicare~~ database and corresponds to the start date of the most recent medication change.

New

REGULATION: 42 CFR 418.106(d) – Administration of drugs and biologicals.

PURPOSE: To ensure quality, safe patient care is delivered when medications are administered.

POLICY: All drugs are administered in accordance with accepted standards of hospice and palliative care practice and the patient's plan of care.

PROCEDURE:

1. Drugs may only be administered by a licensed nurse or physician, the patient if able, and others only in accordance with state laws and regulations and as specified in the patient's plan of care.

2. All hospice nurses may administer medications by prescribed route when following physician orders.

3. When a hospice nurse administers any medication to a patient, the name of the medication, strength, dose, amount, route, date, and time of administration is documented in the nurse's visit note.

4. The CHC registered nurse assesses the patient/caregiver's ability to safely administer medications during the initial and comprehensive assessments.

5. The CHC primary nurse or designee provides instruction to the patient/caregiver on the proper administration of medications. Instruction includes, but is not limited to:
   (a) The potential side effects of medications included in the patient's plan of care
   (b) Emergency responses to adverse reactions
   (c) How to safely store medications
   (d) The proper disposal of used syringes or patches
   (e) When to administer medications included in the plan of care
   (f) Documenting self-administration of medication (if appropriate)
   (g) When to call CHC if any difficulties or questions arise regarding self-administration of medication

6. The CHC primary nurse or designee documents all instructions given regarding the safe administration of medication and includes the response of the patient/caregiver to the instructions as appropriate.

Effective Date: 03/13	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

Signature:

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

PURPOSE: To ensure quality, safe prescribing, dispensing, and ordering of patient medications.

POLICY: Medications may only be administered that have been ordered by the patient's physician or designee.

PROCEDURES:

1. Both telephone and written orders for medications are documented in the patient's clinical record and include:
   - Date of the order
   - Name of medication
   - Dose
   - Route
   - Frequency
   - Purpose (if PRN and/or antibiotic)

2. Telephone orders for medications may only be accepted by a registered nurse. The registered nurse will read back and verify every telephone/verbal order given by the physician by repeating the patient's name, and the name, dosage, route, and time of the medication to the ordering physician.

3. A copy of telephone orders is sent to the ordering physician for return with signature and included in the patient's clinical record.

4. Orders for medications are documented in the patient's current medication profile.

5. The registered nurse contacts the pharmacy to fulfill the order.

6. No change may be made t the medication dosage or route without a physician's order.

7. A physician's order is needed to discontinue medications.

Effective Date: 03/13	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

Signature:

REGULARY
REFERENCE: 42 CFR 418.100 c (2)

PURPOSE: To ensure quality care of CHC patients 24 hours, 7 days per week.

POLICY: Patients have access to hospice services twenty-four (24) hours per day, seven (7) days a week by calling the Agency telephone number.

PROCEDURE:

1. Patients/caregivers receive written information at the time of admission regarding how and when to access care during, and after, normal business hours.

2. A Triage Nurse determines emergency needs requiring a patient/caregiver visit. Psychosocial and/or spiritual needs may be referred to the Social Worker, Chaplain or Bereavement Coordinator.

3. The Triage Nurse provides follow-up appropriate to each call. Activities may include:
   a. Calling the patient/family/caregiver;
   b. Arranging a visit to the patient if necessary;
   c. Obtaining physician orders as needed;
   d. Arranging for other services as needed;
   e. Arranging for changes in the level of care as needed;
   f. Obtaining medications, equipment, and/or supplies as needed;
   g. Taking referrals for service; and/or
   h. Taking messages for Agency personnel.

4. All interactions that occur outside of normal business hours are recorded in an email report and, when appropriate, in individual patient clinical records.

5. The Triage and Emergency Visit nurse communicates information (e.g., changes in the plan of care, status updates, deaths, referrals, admissions, etc.) to the IDT via secure messaging in the patient medical record.

6. Interdisciplinary team members notify the Triage Nurse each day to provide patient status updates and plan of care revisions in order to ensure continuity of care.

7. Non-emergent patient visits when indicated normally occur within three hours from the time the need is identified, or as agreed upon by the Agency and patient/caregiver.

8. When clinically indicated, emergency visits are made within one hour from the time the need is identified.