Board of Directors Meeting
501 Comfort Place, Conference Room A, Mishawaka
August 21, 2013
11:30 a.m.

BOARD BRIEFING BOOK

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CHAPTER ONE

AGENDA

BOARD OF DIRECTORS MEETING
501 Comfort Place, Mishawaka
Conference Room A
August 21, 2013
11:30 a.m.

A G E N D A

1. Call the Meeting to Order and Introductions –Corey Cressy --11:30AM – 11:40 AM

2. Approval of June 19, 2013 Minutes *(action)* – Corey Cressy -- 11:40AM – 11:42 AM

3. President's Report *(information)* - Mark Murray --11:42AM – 11:55 AM

4. Finance Committee *(action)* – Wendell Walsh – 11:55 AM – 12:05 PM
   (a) June and July Financial Statements

5. Foundation Update *(information)* – Terry Rodino 12:05 – 12:15 PM

6. Lunch from 12:15 - 12:45 PM -- All

7. Board Education *(information)* – Don Schumacher, President/CEO, NHPCO -- 12:45 PM to 1:30 PM including time for Q&A

8. Adjournment *(action)* -- 1:30 PM

Note new time and location for August

Next meeting October 23 at 7:30 a.m.
501 Comfort Place, Mishawaka

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Center for Hospice Care
choices to make the most of life

CHAPTER TWO

MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
June 19, 2013

Members Present:	Becky Asleson, Carmi Murphy, Corey Cressy, Francis Ellert, Julie Englert, Mary Newbold, Melanie Davis, Tim Yoder, Wendell Walsh
Absent:	Amy Kuhar Mauro, Jim Brotherson, Michael Method, Terry Rodino
CHC Staff:	Mark Murray, Amy Tribbett, Dave Haley, Donna Tieman, Karl Holderman, Mike Wargo, Becky Kizer

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 7:30 a.m.	
2. Minutes	• Melanie D. stated her name was misspelled on page 5, #9. That will be corrected. A motion was made to accept the minutes of the 04/17/13 meeting with the above correction. The motion was accepted unanimously.	M. Davis motioned M. Newbold seconded
3. President's Report	• Through May, referrals are up 13%. Referrals from self/family are up 46% and now surpass physicians indicating our media campaign is working. Both Hospice Houses have been very busy. Their ADC combined is 12 and YTD 10. This will help us determine how many beds we will need for the new campus. • In 2010 we had a disastrous installation of the Cerner software and many things didn't work. We purchased version 5.0, but were trained on version 4.3. We began discussions with Cerner in July 2011 for some type of credit and we have finally come to a settlement of $51,065.10. They will also send two experts for three days at their expense to compare the way we are using the software to their benchmarks. • We have signed a clinical affiliation agreement with the I.U. School of Medicine for students to do a four-week rotation in hospice and palliative care. Our medical directors will be given Associate Clinical Instructor status, which will give them access to I.U.'s publications and information. If we get the Mayo Clinic fellowship program, we would then be providing education for medical students, residents and fellows. • Amy Tribbett completed a nonprofit leadership certification program on social media marketing at the Mendoza College of Business. • Dave Haley met with area hospitals to discuss their level of interest in hiring us to provide their palliative care services. There is a lot of interest from SJRMC and EGH.	

Topic	Discussion	Action
	• A copy of the 2012 Year in Review is in the board packet. Our print/web coordinator, Jim Wiskotoni, did an excellent job putting it together. • The 08/21 board meeting will be held at the Mishawaka campus from 11:30-1:30. Don Schumacher, President/CEO of NHPCO, will join us in person to present an overview of the hospice industry, its current challenges and its future. • We have signed contract with iReferDR, an App for doctors to be able to make referrals, sign and order for hospice care over an iPhone or Droid smartphone. The App is HIPAA compliant and encrypted. The app is totally customized to CHC and we will be the only hospice in our service area to offer it for the first six months. • With the proposed 2014 wage index update for fiscal intermediaries, we are looking at a 1.1% rate increase, but with addition to the 2% sequestration cut, we are getting paid less on 10/1/13 than we are now. CMS has decided they will no longer allow hospices to bill for a primary diagnosis of Debility or Adult Failure to Thrive. In 2012, 11-12% of all hospice claims in the country had these as a primary diagnosis to a cost of $1 billion. New quality reporting and data collection will begin in 2014. Hospices that fail to report anything will receive an additional 2% rate cut beginning fiscal year 2016. Public reporting on hospice quality measures will not be initiated prior to 2017. There is no reimbursement for any of this additional data collection. We have to hire an outside vendor for survey administration and quarterly data submission starting in 2015. No reimbursement for this either. • We are now required to put in all related diagnosis and CMS may possibly pay differently for various diagnoses. CMS is talking about rebasing the routine home care rate and how much we get paid could be cut about $10/day. They are looking at a site of service cut of 5% for patients in nursing homes. 33% of hospices don't have an inpatient unit, 22% put no GIP costs on their cost report, and 30% no bereavement costs at all, so CMS is concerned that some hospices are not providing the full spectrum of hospice care. CMS also says Medicare D has paid $33 million for medications that should have been paid for by hospices. • At the 05/29 staff meeting we reviewed these challenges with staff. It all comes down to compliance and following the rules and asking whether this patient is eligible for this level of care today, and does our documentation prove it. We think we do a remarkable job and are possibly too conservative. Per the latest	

Topic	Discussion	Action
	PEPPER Report, we are so far below where we would need to be concerned. We have taken a lot of effort to improve the quality of our documentation. Patient care coordinators are doing random chart audits to ensure the education we have done with the nurses is transitioning to the patient record. This allows them to see which staff they need to work more closely with. • Starting in January we began a Non-Admit QAPI project to look at assessed patients that the IDT decided were not appropriate for hospice services. We are looking to see if there are any trends or whether we are being too conservative. The referring doctor feels the patient is appropriate, so it is an opportunity to further educated them as well. Internal follow up on non-admitted patients will be done weekly instead of monthly. We have had a lot more referrals, but a lot more deaths and the length of stay continues to go down—73 days from 76 last year, and the median is 12-13 days instead of 16 days. The average length of stay has not grown from last year, but the number of patients we are caring for is higher. As census grows, we hire more staff and we will continue to grow with the needs of the community.	
4. Finance Committee	• The financial statements for April and May were presented. April operating revenue $1.4 million, total revenue $1.7 million, total expenses $1.3 million, net gain of $366,000, beneficial interest in the Foundation $204,000, net without beneficial interest $160,000. May operating revenue $1.5 million, total revenue $1.5 million, total expenses $1.4 million, net gain $50,000, beneficial interest in Foundation loss of $72,000, net without beneficial interest $123,000. YTD operating revenue $7.3 million, total revenue $8.1 million, total expenses $6.8 million, net gain $1.3 million, beneficial interest in Foundation $729,000, net without beneficial interest $574,000. YTD Assets $32 million, up from $29.7 million a year ago. • Per accounting rules, we have to show the beneficial interest in the Foundation. When we went to two separate entities, we have to keep two separate sets of statements and reports to show the relationship between the two entities. We are required to recognize the Foundation like we would a subsidiary, so the Foundation's overall net gain/loss is reflected in the income statement and the number backed out, so we have a true idea of what CHC did in and of itself. The assets of the new campus are the assets of the Foundation and will be on its books.	

Topic	Discussion	Action
	• A motion was made to accept the April and May financial statements as presented. The motion was accepted unanimously.	C. Murphy motioned J. Englert seconded
5. Foundation Update	• Fundraising is 7% ahead of last year. Hopefully this trend will continue, even though we see reports about nonprofits not expected to get back to pre-recession or pre-2008 fundraising levels until about 2018. So we feel good about where we are with it. • The Helping Hands Award Dinner on 05/01 was a great success. About 510 people attended and the event grossed $225,000. The net will be about 80% of that. The 5th Annual Bike Michiana for Hospice is 09/15. We already have over 300 riders registered compared to about 150 at this time last year. We expect over 1,000 riders. The Walk for Hospice is 08/11 at Beutter Park. The city won't be done with construction on the river walk and Central Park until the end of year, so the event will be held at Beutter. We will have an open house that afternoon for people who attend the Walk. The annual Friends of Hospice campaign features stories of patients describing how the CHC team helped improve their quality of living. • Three Notre Dame Students are interning in Uganda this summer (see the President's Report, page 6-7). The Kellogg Institute for International Studies is funding the interns, along with other resources, so there is no expense to us. Denis Kidde works with people at Notre Dame to identify students and match them up with appropriate programs in Uganda. He has identified eleven intern opportunities in the country. • Film Marketing Services is distributing our film "Okuyamba" on the Shorts HD channel seen on Direct TV and ATT Cable. They are also working on negotiating TV rights on their Europe/Africa channel. We will get $500 every time it airs. • Construction on the Mishawaka campus continues to move forward. The first group of employees is scheduled to move in on 07/01. • Chris Taelman has been hired as our new Chief Development Officer effective 07/15.	
6. Board Education	• At the April board meeting we distributed elevator speech cards that explain the differences between CHC and other hospices. Please refer to CHC by its full name, Center for Hospice Care—don't just say "Hospice." Attendance at board meetings is important. 100% of the board contributes to CHC. There is no	

Topic	Discussion	Action
	minimum required, but it would be great to keep that trend alive. The Bylaws list the duties of the board and the standing committees. Participation on a committee is voluntary. We also have informal committees like the Helping Hands Award Selection Committee and the Helping Hands Award Dinner Committee. Some non-board members do serve on some of the standing committees. The executive committee would decide which committees needed more members. If you are interested in participating on one of the committees, let Corey C. know before the August meeting. He will send out an email out after today's meeting with more information.	
7. Chairman's Report	• Congratulations on getting the $51,000 settlement from Cerner. This type of thing can be easily pushed to a back burner. • iReferDR App – Only six other hospices have this. It is very new. Anybody, including family members, can also download it. iReferDR will help us develop a marketing plan. If we could get patients in one day earlier, it would be about $300,000 additional revenue. Doctors are not aware of which hospice is for-profit and nonprofit hospice, and sometimes they are surprised to hear that their patient is with another hospice than CHC, because they think we are the only one. Some doctors are hired by a hospice or nursing home to be their medical director, and so the doctor makes referrals to that hospice. The Stark Physician Self-Referral Law only applies to most all provider types except hospice, so it is legal to do that. It was an over site when it became law. The App is a remarkable opportunity. What we do with the marketing plan and how we roll it out is very important. The first step is with doctors. A lot of referrals come from the nurse or nurse practitioner at the doctor's office. The community liaisons will show the App on a tablet. We could survey the end user on what they need and what would be most helpful. We can make quick content changes on the App.	
Adjournment	• The meeting adjourned at 8:38 a.m.	Next meeting 08/21

Prepared by Becky Kizer for approval by the Board of Directors on 08/21/13.

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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
August 21, 2013
(*Report posted to Board Website August 15, 2013)*

This meeting takes place in Conference Room A & B at the new Mishawaka Campus (MC) at 11:30 AM and is scheduled to last two hours. Lunch will be served. This report includes event information from June 20 – August 21, 2013. The Hospice Foundation Board meeting has been rescheduled for Friday, August 23, 2013 at 8AM in Conference Room G at the MC.

CENSUS

Through the end of July, we have received 1,636 referrals, a 10% increase from July of 2012. The number of patients served year to date (YTD) at the end of July is up 6% from same time last year and the number of original admissions is up 12% from July 2012. It has been a challenge to get ahead on an average daily census (ADC) basis due to the number of deaths. For January thru July 2013, we have experienced an average of 132 deaths per month, a 9% increase from the same period last year. We continue to experience very late referrals, often too late. So far in 2013, of the non-admitted referrals, 20% of these patients expired before we could get there, and we nearly always get there the same day the referral comes in if the family allows. Overall, the percentage of patients who die before admission 2013 YTD is running 6.43%, which is a slight improvement from 7.09% at this same time last year.

July 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	412	1,322	1,243	79
Original Admissions	129	1,011	904	107
ADC Hospice	293.26	299.36	327.90	(28.54)
ADC Home Health	19.97	19.25	17.98	1.27
ADC CHC Total	313.23	318.61	345.88	(27.27)

June 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	401	1,193	1,124	69
Original Admissions	108	882	785	97
ADC Hospice	297.43	300.41	329.41	(29.00)
ADC Home Health	16.23	19.13	16.96	2.17
ADC CHC Total	313.66	319.54	346.37	(26.83)

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	194	189	175	174					186
Ply:	58	54	59	60	59	61	60					64
Elk:	59	63	68	62	68	70	70					616
SBH:	6	6	6	5	6	4	5					4
EKH:	1	4	4	4	6	4	4					4
Total:	305	315	330	325	328	314	313					319

HOSPICE HOUSES

July 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
SB House Pts Served	33	213	176	37
SB House ALOS	4.55	5.43	5.56	(0.13)
SB House Occupancy	69.12%	77.96%	66.66%	12.30%
Elk House Pts Served	28	147	147	0
Elk House ALOS	4.32	5.43	5.56	(0.13)
Elk House Occupancy	55.76%	54.45%	55.94%	-1.49%

June 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
SB House Pts Served	29	190	156	34
SB House ALOS	4.59	5.32	5.39	(0.07)
SB House Occupancy	63.33%	79.79%	66.01%	13.78%
Elk House Pts Served	29	127	127	0
Elk House ALOS	3.86	5.41	5.31	0.10
Elk House Occupancy	53.33%	54.22%	52.98%	1.24%

PATIENTS IN FACILITIES

Of the 412 patients served in July, 140 resided in facilities and of the 401 patients served in June, 140 resided in facilities. The average daily census of patients in skilled nursing homes, assisted

living facilities, and group homes during July was 107; June was 107 and YTD through July it was 109.

FINANCES

Karl Holderman, CFO, reports that the July and year-to-date July 2013 Financials will be posted to the Board website on Friday morning, August 16th following Finance Committee approval. They will review both June and July at that time. The draft, non-approved June 2013 financials are below.

June 2013 Financial Information

Center for Hospice Care

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

June Overall Revenue	$	1,705,932	Year to Date Overall Revenue	$	6,647,585
June Total Expense	$	1,340,594	Year to Date Total Expense	$	5,393,556
June Net Gain	$	365,338	Year to Date Net Gain	$	1,254,029

Hospice Foundation

June Development Income	$	130,675	Year to Date Development Income	$	395,247
June Investment Gains (Loss)	$	188,412	Year to Date Investment Income	$	856,927
June Overall revenue	$	324,060	Year to Date Overall Revenue	$	1,258,576
Total June Expenses	$	119,262	Total Year to Date Expenses	$	456,320
June Net Gain	$	204,798	Year to Date Overall Net	$	802,256

Combined

June Overall Revenue	$	1,825,196	Year to Date Overall Revenue	$	7,103,904
June Overall Net Gain	$	365,338	Year to Date Overall Net Gain	$	1,254,029

At the end of June 2013, Center for Hospice Care's Year to Date Net without the beneficial interest in the Hospice Foundation was $609,290.

At the end of June 2013, CHC and HF combined had a net without investments of $378,998.

At the end of June 2013, the Foundation's Intermediate Investments (formerly known as Pool Two) totaled $3,997,638. Long Term Investments (formerly known as Pool Three) totaled $11,202,835.

CHC's assets on June 30, 2013, including its beneficial interest in the Hospice Foundation, totaled $32.4MM. At June 30, 2013 HF's assets totaled just over $23.4MM and debt (low interest line of credit) associated with the Mishawaka Campus project totaled just over $4MM.

CHC VP/COO UPDATE

Dave Haley, VP/COO, reports on July 29 he received an email from Molly Feely, MD, Hospice and Palliative Care Program Director at the Mayo Clinic in Rochester, Minnesota, confirming the Mayo Graduate Education Committee has approved an inpatient hospice rotation with Center for Hospice Care. The Mayo Legal team will be sending us Practice Letter of Agreement (PLA) soon. Dr. Feely also reports that Mayo currently has a Fellow who is interested in doing a rotation with CHC in March/April of 2014. Dates are tentative pending schedules and completion of the PLA, but they are penciled in as March 17th - April 11th. We are not publically publicizing this via press releases, etc., until everything is finalized and both institutions have a clear understanding of each other's hopes and requirements are when it comes to media. We are also waiting to see if there are expectations about such delineated in the PLA before we begin discussions in this area.

We have signed a clinical affiliation agreement with Midwestern University Arizona College of Osteopathic Medicine located in Glendale, Arizona to provide a palliative care medical clinical rotation for a senior osteopathic medical student. This rotation will be from October 21 to November 1, 2013. This is the second teaching affiliation agreement we have developed this year with a medical/osteopathic school designed to provide palliative care teaching experiences to senior level students. CHC Medical Director, Jon Kubley, MD will act as the preceptor for this student rotation.

Dave received a letter on July 8 by Federal Express from Dave Krishna, the Chief Operating Officer of Enclara, our national hospice pharmacy vendor. This is a company which provides national pharmacy services to CHC and over 18,000 hospice patients across the U.S. each day. This letter graphically portrays our pharmacy performance over the past five years. We have been included in Enclara's "Top Ten National Performers" for the cost efficient use of non-formulary drugs. At our current performance level for non- formulary drug costs of 18 cents per patient day, we are operating at 61% below Enclara's national hospice provider client average of 46 cents per patient day. Five years ago we were operating at $1.07 per patient day. This is an 83% performance improvement in five years. With regard to our current performance level for drug shipping costs at 5 cents per patient day, we are operating at 58% below Enclara's national hospice provider client average of 12 cents per patient day. Five years ago we were operating at 24 cents per patient day. This is a 79% performance improvement in five years. CHC is particularly appreciative to the hard and consistent efforts of our Chief Medical Officer, Greg Gifford, MD and Donna Tieman, DON for these outstanding achievements in controlling CHC pharmacy costs. Their focused work, as seen in the improvements over each of the previous five years, has brought us to a new level of pharmacy managerial excellence. A copy of the Enclara letter is attached to this report.

Dave and Greg Gifford, MD met with Saint Joseph Regional Medical Center in Plymouth to discuss their desires for assistance with Palliative Care. We have offered to provide Medical Director Jon Kubley, MD as a representative to attend periodic meetings and to provide palliative care consults as requested by their medical staff.

We have updated our agreement with Memorial Hospital of South Bend to include allowing fragile hospital inpatients to be simultaneously discharged from the hospital and admitted to hospice, while remaining physically in the hospital. These agreements are now in place at all three major hospitals.

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

DIRECTOR OF NURSING UPDATE

Donna Tieman, RN, DON, reports the nursing department is in the process of planning the first CHC on-site Certified Hospice and Palliative Nurse Study Course. The intensive one day class will prepare our nurses to achieve certification as a hospice and palliative nurse specialist. The class will be taught by Robin Hassig, RN, BSN, CHPN with Visiting Nurse Service and Hospice Home in Ft. Wayne, IN. The class will also prepare Rebecca Fear, RN, the CHC Nurse Educator, to teach the class to future CHC nursing participants rather than brining someone in from the outside.

CHC nursing staff has completed two of the ten Pediatric End of Life Nurse Education Consortium modules. Participation in and completion of the Pediatric curriculum will strengthen the CHC pediatric hospice program; as well provide the best possible care to our pediatric patient and family population.

Donna Tieman, DON, and Danielle Stilley, RN, Elkhart Hospice House Coordinator, participated in an on-site meeting with a team of professionals from Memorial Hospital in their efforts to provide a more peaceful night for their patients. The meeting was held on July 26 in the Elkhart Hospice House. The Memorial Team toured Hospice House and sought information regarding special training and techniques utilized by CHC in providing peaceful environments for our patients.

HOSPICE FOUNDATION VP / COO UPDATE

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

Fund Raising Comparative Summary

Through May 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	395,299.97
May	358,108.50	389,785.41	332,141.44	416,792.85	446,125.49
June	739,094.00	477,029.89	427,098.62	513,432.22	534,757.61
July	782,028.00	532,913.52	487,325.01	579,801.36	604,696.88
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	130,694.68
May	92,613.21	33,768.72	51,753.98	90,909.04	50,825.52
June	94,353.52	74,084.48	90,718.18	92,036.89	65,815.51
July	43,103.73	55,278.63	53,536.39	62,069.43	69,939.27
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**	**580,730.49**

Special Events & Projects

As of 8/12/13, Bike Michiana for Hospice has more than 400 registered riders and volunteers for this year's event. The ride will be held on Sunday, September 15th at St. Patrick's County Park. Moser's Austrian Café will be the SAG restaurant for Spicer Lake, replacing LaSalle Grill. All other SAG restaurants, including Yesterday's, Fiddler's Hearth, Indulgence Café, Corndance Tavern and Grand Mere Inn, have once again signed on to prepare and serve food for the 5th annual event. This year's commemorative jersey has been designed and will be used as a fundraising incentive as well as available for purchase. The ride is being heavily promoted via social media and press releases to riders in the Chicago area as well as Indianapolis, Fort Wayne and Kalamazoo.

This year's Walk for Hospice, which coincided with an Open House for the Mishawaka Campus, was held on August 11th on the Mishawaka Riverwalk. Due to construction in Central Park and on the Riverwalk, the Walk began at Beutter Park. The Walk was promoted locally on TV, radio and billboards at minimal cost. Many thanks to Amy Tribbett and Transcend Hospice Marketing for their assistance in securing these opportunities. We also used social media extensively. We seem to be having some success in rebooting this nearly 30 year-old event.

Here are the preliminary results for the 2013 28th Annual Walk for Hospice along with a comparison of the previous two years:

2013 Walk PRELIMINARY
Approximately 402 participants (includes walkers, volunteers and staff)
$13,691.95 - donations received at the Mishawaka Riverwalk
$13,472.00 - advance donations and sponsorships
$6,000 - sponsorship pledge outstanding
TOTAL DONATIONS: $33,163.95

The results from the previous two years were:

2012 Walk
410 participants (includes walkers and volunteers)
$15,860.39 in donations at the park
$12,185 in online donations and sponsorships
TOTAL DONATIONS: $28,045.39

2011 Walk
416 participants
$12,609.96 in donations at the park
$14,128.50 in online donations and sponsorships
TOTAL DONATIONS: $26,738.46

FHSSA/PCAU

Our FHSSA partnership with the Palliative Care Association of Uganda (PCAU) continues to expand and now we are working with our partner's partners.

Three students from the University of Notre Dame, who were placed with PCAU partner organizations for summer internships, have returned. Gaby Austgen is a MS in Global Health from the University of Notre Dame's Eck Institute for Global Health. While in Uganda, she helped in structuring a national palliative care audit (framework for monitoring and evaluation and worked with the palliative care team at Mulago National Referral Hospital in Kampala.

Anna Heffron is an honor's student with majors in biochemistry and philosophy. While in Uganda, Anna undertook a research project that compared the practice of palliative care delivery in Uganda with those in the United States. PCAU identified Hospice Jinja as a suitable member organization to host Anna. Hospice Jinja coordinates its services around Busoga region and its team visits and networks with the five hospitals in the region. It also has outreach clinic programs near remote villages.

Emmie Mediate is a junior minoring in International Development Studies with Africana Studies and Pre-Medicine majors from University of Notre Dame's Kellogg Institute for International Studies. This was Emmie's second trip to Uganda, having spent some time last summer in Hoima and Gulu doing research work. She was placed at Kawempe Home Care, a PCAU community based member organization that provides holistic home care to people living with TB, HIV/AIDS and or cancer.

Two staff members, Karen Smith-Taljaard and Bridget Smith, will be travelling to Uganda on August 26th. They were selected from among a number of CHC staff members who submitted proposals to PCAU's Scientific Committee to be presenters at the 5th Bi-Annual PCAU Palliative Care Conference being held on August 29th and 30th at the Imperial Royale Hotel in Kampala. During the week of September 2nd, Karen and Bridget will have the opportunity to shadow and work alongside their African counterparts in order to share mutually beneficial information, knowledge and techniques. Karen will be working at Hospice Jinja and Bridget will be working at Hospice Africa Uganda. The draft of the Conference Schedule is attached to this President's Report

with the areas of CHC's / HF's USA involvement with our two staff and Mike Wargo highlighted in yellow.

Film Productions

Okuyamba won a Bronze Award in the Social Responsibility category in the 34th Annual Telly Awards competition. The Telly Awards was founded in 1978 to honor excellence in local, regional and cable TV commercials. Non-broadcast video and TV program categories were soon added. Today, the Telly is one of the most sought-after awards by industry leaders, from large international firms to local production companies and ad agencies. With the quality of non-broadcast productions, traditional local & cable television commercials and programming on the rise, along with the world of online video continuing to rapidly evolve, the 34th Annual Telly Awards received over 12,000 entries from all 50 states and five continents.

Two recent graduates of the Notre Dame Film, Television & Theatre Department, Marty Flavin and Collin Erker, have been interning with the Hospice Foundation this summer. Their focus is on helping to create a series of videos that can be used to promote various foundation-sponsored events and initiatives. Among the projects on which they've been working: a promotional video for the annual PCAU/ND summer internship program, which are sponsored by the foundation and PCAU and are funded by the Kellogg Institute for International Studies; a commercial for next year's Walk for Hospice, which will be used in social media publicity and PSA's; and shooting interviews for the upcoming comprehensive fundraising campaign video.

Mike Wargo will be taking a film crew to Africa to shoot a new documentary called *The Road to Hope*. Where *Okuyamba*'s focus was on the delivery of care palliative care to patients dying deep in the villages of Uganda, *The Road to Hope* will focus on the plight of the orphaned children who were often times the sole caregivers for their parents as they were dying. What happens to them? Where do they go? How do they cope? How do they receive an education? Who are some of the people and organizations that devote their work to helping them move on with their lives and to become happy, healthy and productive adults? Since this is not a uniquely Ugandan issue, the film will explore the work that's being done by organizations in other African nations as well. Film and television actress Torrey DeVitto, whose current shows include Pretty Little Liars, The Vampire Diaries and Army Wives, and who serves as a Hospice Ambassador for the National Hospice and Palliative Care Organization and the National Hospice Foundation, will be part of the team.

Mishawaka Campus

Interior Phase I new construction is complete; exterior work will continue through the rest of the summer. The first group of AFO employees moved into the new facilities on June 28th. LTC and AFO West employees followed on July 1 and July 5, respectively. A press conference, ribbon-cutting ceremony, open house, and invitation VIP reception is scheduled for August 20th. The press release for these events is included as an attachment to this President's Report.

Annual Giving

The 2013 Friends of Hospice was launched the last week of May. This year's appeal features the stories of patients describing how their CHC team helped to improve their quality of living during

their final days. This appeal, which will run through Thanksgiving, is being promoted via Crossroads, direct mail, social media, and the Foundation's e-newsletter and web site.

Communications

The Hospice Foundation e-newsletter continues feature mini-articles on events, PCAU, various giving opportunities as well as new campus updates. The e-newsletter email list currently includes more than 1,000 subscribers.

The Summer 2013 issue of Crossroads will be mailed to 35,000 households in August. The cover story features an article about the meaning behind the revised Hospice Foundation logo and our work to more closely align the images of CHC and HF. Other articles will include the 29th Annual Helping Hands Award Dinner, the annual Elkhart Campus memorials dedication, annual report, employee giving, Camp Evergreen's 20th Anniversary, CHC/HF and PCAU's receipt of the third annual Global Partnership Award from FHSSA, my visit to where hospice began in 1967 -- St. Christopher's Hospice in London, summer internships and a donor profile about one of our most consistent and longest term donors, Kelley Kelsey.

The Foundation, Walk and Bike web sites continue to be updated on an on-going basis. An item of particular note on the Foundation site are the blogs done by each of the ND interns, who shared their experiences in Uganda this summer.

To solicit input regarding our strategic direction with respect to fundraising activities, Mike and I hosted a series of luncheons and cocktail receptions at the Guest House. Board members, key community leaders, prospective donors, and other centers of influence were invited to take part in the events, which were followed by optional campus tours.

Staff Updates

Chris Taelman's first day as Chief Development Officer for the Hospice Foundation was July 15th. He is responsible for Major Gifts, Capital Campaigns and Planned Giving. Chris came to us directly from Saint Mary's College where he was Director of Major Gifts. Prior to Saint Mary's College, he worked as Director of Marketing and Strategy at I.U. Health LaPorte Hospital. He was also VP of Community Relations and Development at Madison Center / Madison Foundation for nearly eight years, and for eight years prior to that he was the Manager of Community Relations for NIPSCO. Chris brings to the Hospice Foundation more than 20 years' experience in marketing, fundraising, fund development, public affairs, communications management, staff management and budgeting primarily with not-for-profit healthcare providers.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

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

Outreach in June & July

During this time, CHC's three fulltime Community Liaisons visited more than 160 Physician Practices and made 135 visits to assisted living, nursing homes, and other extended care facilities.

Nearly 60 visits were made to our service area hospitals. The liaisons completed 14 patient / family pre-assessments during this time as well.

Lunches, Senior Networking and Speaking Engagements:

- Lunch with Community Physicians of Bremen – 3 physicians 15 staff attended
- Walkerton Nutrition site – 6 people
- Optimist Club – 13 people
- Oakwood Manor – 50 People – open house
- Marshall Co Older Adult Services – 9 people – Consider the Conversation
- Starke Co Chamber – Featured Speaker – 20 people
  Presentation to IUSB Elkhart Death and Dying Class (23 attendees)
- Presentation to Goshen Morning Kiwanis (16)
- Dr. Hershberger – LaGrange inservice luncheon
- Dr. Egli – Topeka inservice luncheon
- Presentation at Hearth at Juday Creek for caregivers
- Fulton Co Medical Clinic (2 doctors attended, 20 staff)
- Lunch for physicians at staff of Midwest Cardiology
- Lunch for SB Neurology
- Breakfast meeting for Elm Road Family Practice
- Lunch for Michiana FP (Drs. Troyer, Scheel, Jacobs, Jacobs)
- Lunch with North Central Internists in Lagrange – one on one with Dr. Kameni
- North Central Indiana Hispanic Health Fair – Goshen
- Meeting with Elkhart Clinic Oncology Dr. Haque nurse Kristan
- Met with Annette RN/Manager for Dr. Marker.
- Met with Dr. Aldridge, now based in Rochester.
- Spoke with Chris Mueller who was the administrator at Catherine Kasper Home and is now at Hickory Creek.
- Met with Audrey SW at Bremen Health Care several times to discuss services and referrals.
- Met with Janet, Community Liaison for Trinity Home Care Rochester.
- Met with Trinity Home Care – Michigan City
- Scheduled lunch meeting with Midwest Cardiology
- Scheduled meeting with Angel, DON at Sprenger
- Hispanic Health Coalition
- CHC was a sponsor for Picnic in the Park for Kosciusko County Council on Aging Senior Center. (75 attendees)
- Promoting our upcoming Grief Forum in Nappanee at area physician offices, libraries, and funeral homes and Nappanee Missionary Church, Nappanee – Over 4000 active members. We are setting up a special grief program in August in Nappanee.

<u>New in the Marketing & Access Department</u>

- CHC Hospice Referral App Update. CHC has worked with a third party to develop a free to referral sources and the public, downloadable app for mobile devices. Rather than having to fax a written order, CHC's Hospice Referral app allows doctors to refer patients for care online wherever they are — whether visiting hospitalized patients or talking with families in the office. Use of the app will mean more efficient admissions, a smoother transition to hospice that maintains continuity of care, and more effective communication between physicians and Hospice by the Bay. When it is ready for launch, versions will be available

at Google's Play Store for Android-based phones and tablets, and at the App Store for use on iPhones and iPads.

- The newest edition of Choices was mailed at the end of July.

TIME CHANGE FOR AUGUST 21 BOARD MEETING

Just a reminder that the August 21 Board Meeting will be the first inside our new Mishawaka Campus Phase I facility. It is a two-hour luncheon meeting from 11:30 AM – 1:30 PM. In recognition of this special occasion I have arranged for J. Donald Schumacher, PsyD to join us in-person to present an overview of the hospice industry, its current challenges, and its future as he sees it. Don is the President and CEO of the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA. He is also President/CEO of NHPCO's affiliate organizations, the National Hospice Foundation, FHSSA (formerly known as the Foundation for Hospices of Sub Saharan Africa), and its 501(c)4 Capitol Hill advocacy organization, the Hospice Action Network.

Don has agreed to meet with the CHC Administrative Team Tuesday night, present at a special All Staff meeting Wednesday morning at 8 AM (staff need to have this meeting early so they can spend the rest of the day seeing patients), and then join us for the special CHC luncheon Board Meeting and present to the board and allow time for Q&A from the CHC Board members.

With over 53,000 members including 3,880 hospice and palliative care provider members, NHPCO is the oldest and largest membership organization representing hospice and palliative care programs and professionals in the world. NHPCO members care for over 90% of the nation's more than 1.6 million hospice patients. Don has more than 30 years' experience in hospice and palliative care administration and has been Pres/CEO of NHPCO since 2002. From 1989 through 2002 he was Pres/CEO of a very successful hospice program in Buffalo, NY. He led the development of an integrated campus launching a variety of hospice-related organizations including nursing homes, mental health and pediatric care facilities, and a stellar bereavement education program.

MORE COMPETITORS IN CHC SERVICE AREA

There are now 28 different hospice programs in our eight county service area. Inexplicably, the 23,363 residents of Starke County -- ranked 82 out of 92 Indiana counties for population -- now have 14 different hospice programs to choose from.

Recent entries into our eight county service area include:

<u>Fulton County</u>
Premier Hospice and Palliative Care – Indiana LLC
Carmel, IN

<u>Kosciusko County</u>
Family Hospice & Palliative Care (DBA as "Family LifeCare")
Berne, IN

LaPorte County
VITAS Healthcare Corporation Midwest (DBA as Vitas Innovative Hospice Care)
Merrillville, IN
and
Peace Hospice and Palliative Care Indiana Corporation
Munster, IN

Starke County
The Hospice Group
Indianapolis, IN

As you might expect, four of the five programs listed above are for-profit entities.

CMS PUBLISHES HOSPICE MEDICARE RATES FOR FEDERAL FY2014

The Centers for Medicare and Medicaid Services (CMS) have published the FY2014 rates for all hospice programs, effective October 1, 2013, the first day of the 2014 federal fiscal year. Nationally, the overall average rates show an increase of 1.7% over FY2012, although this is somewhat overstated due to "hidden cut" calculations related to the phase-out of the Budget Neutrality Adjustment Factor (BNAF) that began in 2009. The FY2014 BNAF rate adjustment is a multiplier to the wage index and is already included in the wage index and is invisible to providers. The BNAF phase-out will continue with successive 15 percent reductions from FY 2014 through FY 2016. The final hospice payment update percentage for FY 2014 is 1.7 percent and is based on the final inpatient hospital market basket update for FY 2014 of 2.5 percent reduced by a 0.5 percentage point productivity adjustment and by 0.3 percentage point as mandated by the Affordable Care Act and which specifically targets hospice providers.

The FY 2014 published calculation includes the following:

Final hospital market basket update for FY2014:	2.5%
Less productivity adjustment:	-0.5%
Less additional hospice-specific productivity adjustment:	-0.3%
FY2014 national rate increase:	1.7%

However, these calculations do not include the additional 2% cut due to the Congressional Sequestration. Hospices began receiving an automatic 2% cut in whatever they billed Medicare beginning April 1, 2013.

When calculating hospice rates, the wage index multiplier is the same for all Core Based Statistical Areas (CBSA) and rural areas, but the wage index values for a given area change from year to year and this always impacts, either positively or negatively, the wage index and the applicable rates depending upon where the patient lives. We never know what the CBSA multiplier for our service areas will be for the October 1 start of the next fiscal year until it is published in August / September, just weeks prior to its effective date. This makes for challenging planning and

budgeting. The wage index value is based upon the Home Health Prospective Payment System current year 2013 wage index values with the BNAF reduction already applied.

Even while the national average payment rate for hospices beginning October 1, 2013 will be below September 30, 2013 (a 1.7% increase and a 2% sequester cut yields a -.3% cut), due to the CBSA multiplier, CHC new rates for 10/1/13 lead us into slightly positive territory from where we are now for three of our four CBSA rate structures, including our key St. Joseph County area where the highest concentration of our patients is located. Last year, we were hit hard in our St. Joseph County CBSA and now appear to have recovered half of last year's cut.

We have four different CBSAs throughout our eight county service area. Three of our eight counties (St. Joe, Elkhart, and LaPorte) have their own specific CBSA wage index multipliers which are used to calculate our rates. The other five counties use the basic Indiana "rural rate" and corresponding index multiplier. Based upon where the patient physically resides – which county – determines what Medicare pays us. After the sequester is computed into our rates, we see that in St. Joseph County, Routine Level of Care will increase $2.76 per patient day and the rates for the South Bend Hospice House inpatient level of care will increase $12.26 per patient day from where they are now. Elkhart Routine LOC will be cut by $1.66 per patient day and the Elkhart Hospice House will receive a cut of $6.12 per patient day. Elkhart is the only CBSA to see effective post sequestration cuts from where we are today. I never thought I would be pleased over a cut, but the reality is that all of this could have been much worse.

NEW RATES EFFECTIVE OCTOBER 1, 2013 PER PATIENT DAY

	St Joseph	**Elkhart**	**LaPorte**	**IN - Rural**
Routine (651)	149.86	145.22	151.60	138.52
Continuous Care (652)	874.60	847.49	884.78	808.42
Respite (655)	155.68	155.90	157.10	146.44
Inpatient (656)	667.55	648.30	674.78	620.66

CURRENT RATES PER PATIENT DAY THRU SEPTEMBER 30, 2013

	St Joseph	**Elkhart**	**LaPorte**	**IN - Rural**
Routine (651)	147.10	146.88	146.38	137.82
Continuous Care (652)	858.47	857.21	854.31	804.32
Respite (655)	152.87	152.69	152.29	145.31
Inpatient (656)	655.32	654.42	652.37	616.87

So what does this all really mean? We are in the fortunate basket by not having reimbursement cut across the board. We are actually going to experience a fractional bump up in the next FY2014 beginning 10/1 in three of our four rate structures. Based on our average daily payor source case mix at 07/31/13 on an annualized basis the FY2014 sequestered rates will generate $166,095 additional gross revenue (not accounting for commercial and self-pay adjustments) across all of our per diem programs (Medicare, Medicaid, Commercial Insurance, Self Pay) compared to our current sequestered rates.

HOSPICE "PEPPER" REPORT CONTINUES TO INDICATE CHC NOT AT RISK FOR FRAUD AND ABUSE

We have received our second PEPPER Report in April, but due to data errors by the federal contractor creating the report for the hospice industry, corrected reports were distributed in June. It is included as an attachment to this President's Report. The report is from TMF Health Quality Institute who is under contract with the Center for Medicare and Medicaid Services (CMS) to provide comparative data reports to various Medicare provider sectors and to Medicare Administrative Contractors/Fiscal Intermediaries (for us Palmetto GBA) in support of efforts to reduce Medicare fee-for-service improper payments. PEPPER stands for Program for Evaluating Payment Patterns Electronic Report and is designed to show individual hospices how their live discharge rates and lengths of stay stack up when compared with other hospices in Indiana, within the Palmetto jurisdiction, and nationwide. The report summarizes a hospice's Medicare claims data in areas that may be at risk for abuse or improper payment. Hospices with high billing patterns (at or above the national 80th percentile) are identified as "at risk" for improper Medicare payments and are encouraged to ensure that they are complying with Medicare payment policy, that services provided to beneficiaries are medically necessary, and that medical record documentation supports the services that are billed. This information is intended to generally tell us if we have a problem and where we might want to look to correct it. The theory is that a hospice who has a large percent of their patients alive over 180 days may have admitted patients who were not eligible for hospice care to begin with. A hospice program who has a large percent of the patients discharged alive may have enrolled patients who were not eligible to begin with and then discharged them alive after banking Medicare reimbursement they were not entitled to collect. CHC appears to be well below any thresholds for concern. While, the report covers the last three federal fiscal years, below are the PEPPER stats from the most recent federal fiscal year, October 1, 2011 – September 30, 2011. Again, the suggestion is that a problem may exist is a hospice program is above the 80th percentile for their peer groups. This report continues to point out to me that CHC may be entirely too conservative with whom it admits.

	National 80th Percentile	Palmetto 80th Percentile	Indiana 80th Percentile	CHC Actual Percent
Percent of Patients Alive over 180 Days	22.1%	24.2%	17.8%	9.7%
Percent of Patients Who are LIVE discharges	11.1%	13.3%	12.5%	1.7%

Since the report looked at data over three consecutive fiscal years, CHC's three-year average long LOS was 11% and the live discharge was 2.5%. The most recent federal fiscal year data reported shows CHC has been trending down in both categories.

MEDICARE COMPLIANCE COMMITTEE MINUTES

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

CHC PREPARED FOR NEW HIPAA COMPLIANCE DEADLINE OF SEPTEMBER 23

Significant changes have been made to the privacy and security obligations of providers with respect to patients' protected health information with the release of the Omnibus Final Rule on January 17, 2013. With the Omnibus Rule, the Department of Health and Human Services made important changes to the privacy and security requirements under HIPAA and the HITECH Act, including creating a new breach standard, clarifying the definition of a business associate, and implementing the increased liability and penalty structure mandated by the HITECH Act. Except with respect to certain grandfathered business associate agreements, covered entities and business associates are required to come into full compliance with the Omnibus Rule by September 23, 2013. CHC has engaged HIPAA / HITECH legal authority Susan Ziel, a nurse attorney and partner with the law firm of Krieg DeVault LLP, (Indianapolis, Chicago, and Minneapolis offices) to update all of our policies. Ziel skillfully assisted CHC through its HIPAA breach circumstances in August of 2011. A conference call with Susan will be scheduled to go over the changes with the Administrative Team and our internal Security and Privacy officers followed by training of staff as needed.

OUT AND ABOUT

I attended the NHPCO Combined Boards of Directors (NHPCO and all three affiliate organizations) meetings in London, England June 25-28. Joint international board meetings with NHPCO and Help the Hospices (the U.K. version of NHPCO) were held along with a reception at the House of Lords, tours of the first original hospice in the world, St. Christopher's Hospice, along with other many other special activities.

Two CHC staff members, a social worker and an Admissions Representative attended the Hospice Action Network's (HAN) Advocacy Intensive and visited with elected officials in Washington, DC on 07/29-07/30. The Advocacy Intensive was a free two-day event, consisting of policy and advocacy training and meetings with Members of Congress and/or their staff assigned to healthcare. For the last two years HAN has been requesting hospice staff working in the field to visit Congressional offices rather than CEO-types and have found this to be a much more effective means to relay the true "hospice story" to federal lawmakers. Instead of a message of "stop cutting our rates" – the same message from every bloc of Medicare providers, relating true stories of the difference hospice is making to their constituents has proven more meaningful and memorable.

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

Dave Haley's Census Reports.

Remarkable letter from a woman who grew up in the Guest House.

Internal Medicare Compliance Committee Meeting Minutes

Copy of the South Bend Tribune article from 7/27/13 regarding the event celebrating the 20th anniversary of Camp Evergreen.

Copy of the front page South Bend Tribune article form 8/12/13 regarding the 28th annual Walk for Hospice.

Copy of 8/14/13 press release, "Young Palliative Care Patients Receive Support from Local Organizations" regarding a grant to CHC from Goshen Hospital and Health Foundation.

Copy of 8/15/13 press release, "Center for Hospice Care and The Hospice Foundation Announce the Grand Opening of their New Mishawaka Campus"

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

July 2013 and Year to Date Financials.

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, October 23, 2013 (NOTE: This is the fourth Wednesday of the month) at 7:30 AM** in the large Conference Room A&B, first floor at the Mishawaka Campus, 501 Comfort Place, Mishawaka, IN 46545. 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 .

# # #

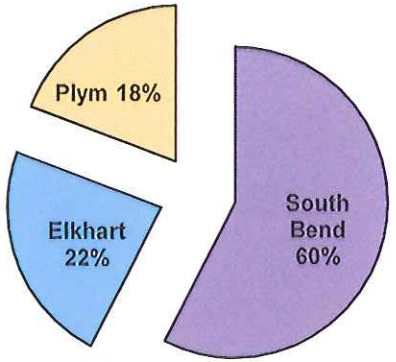
Center for Hospice Care

2013 YTD Average Daily Census (ADC)

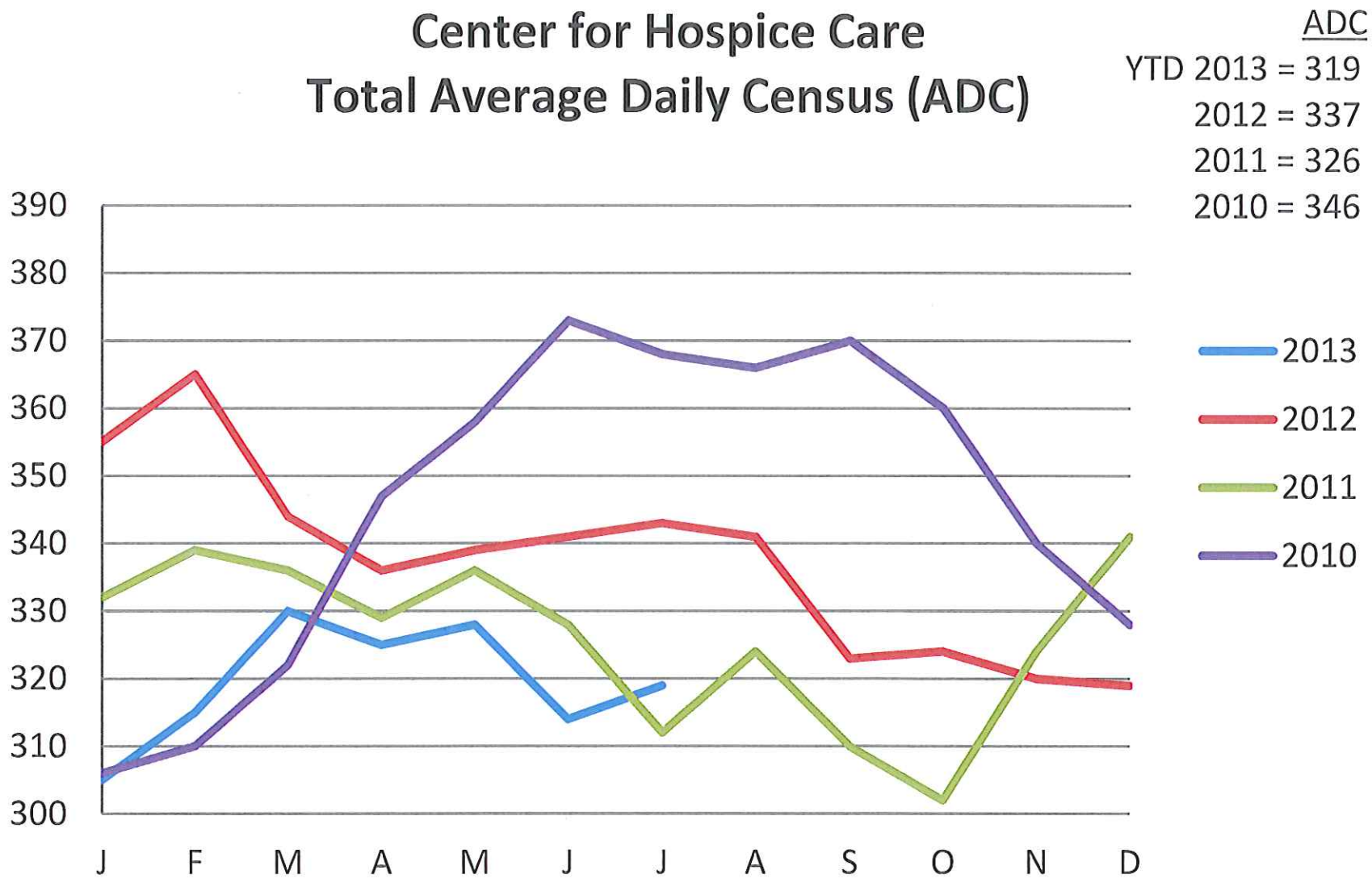
(includes Hospice House and Home Health)

	All	South Bend	Elkhart	Plymouth
J	305	187	60	58
F	315	193	68	54
M	330	199	72	59
A	325	199	66	60
M	328	195	74	59
J	314	179	74	61
J	319	190	69	59
A				
S				
O				
N				
D				
2013 YTD Totals	2236	1342	483	410
2013 YTD ADC	**319**	**192**	**69**	**59**
2012 YTD ADC	346	204	76	65
YTD Change 2012 to 2013	-27	-12	-7	-6
YTD % Change 2012 to 2013	**-7.7%**	**-6.0%**	**-9.2%**	**-9.9%**

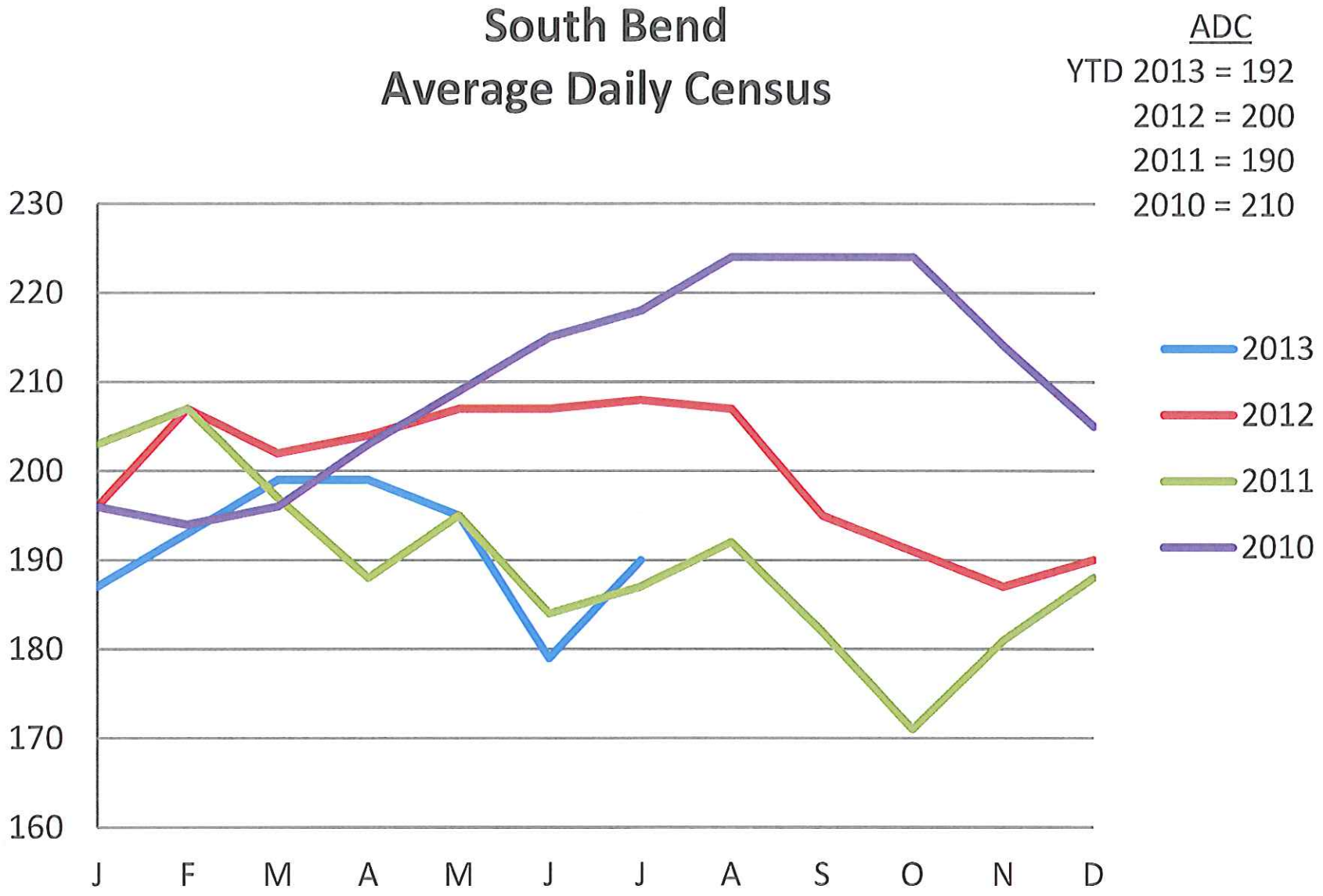
2013 YTD ADC by Branch	
South Bend	60.0%
Elkhart	21.6%
Plymouth	18.3%
All	100%



Center for Hospice Care
Total Average Daily Census (ADC)

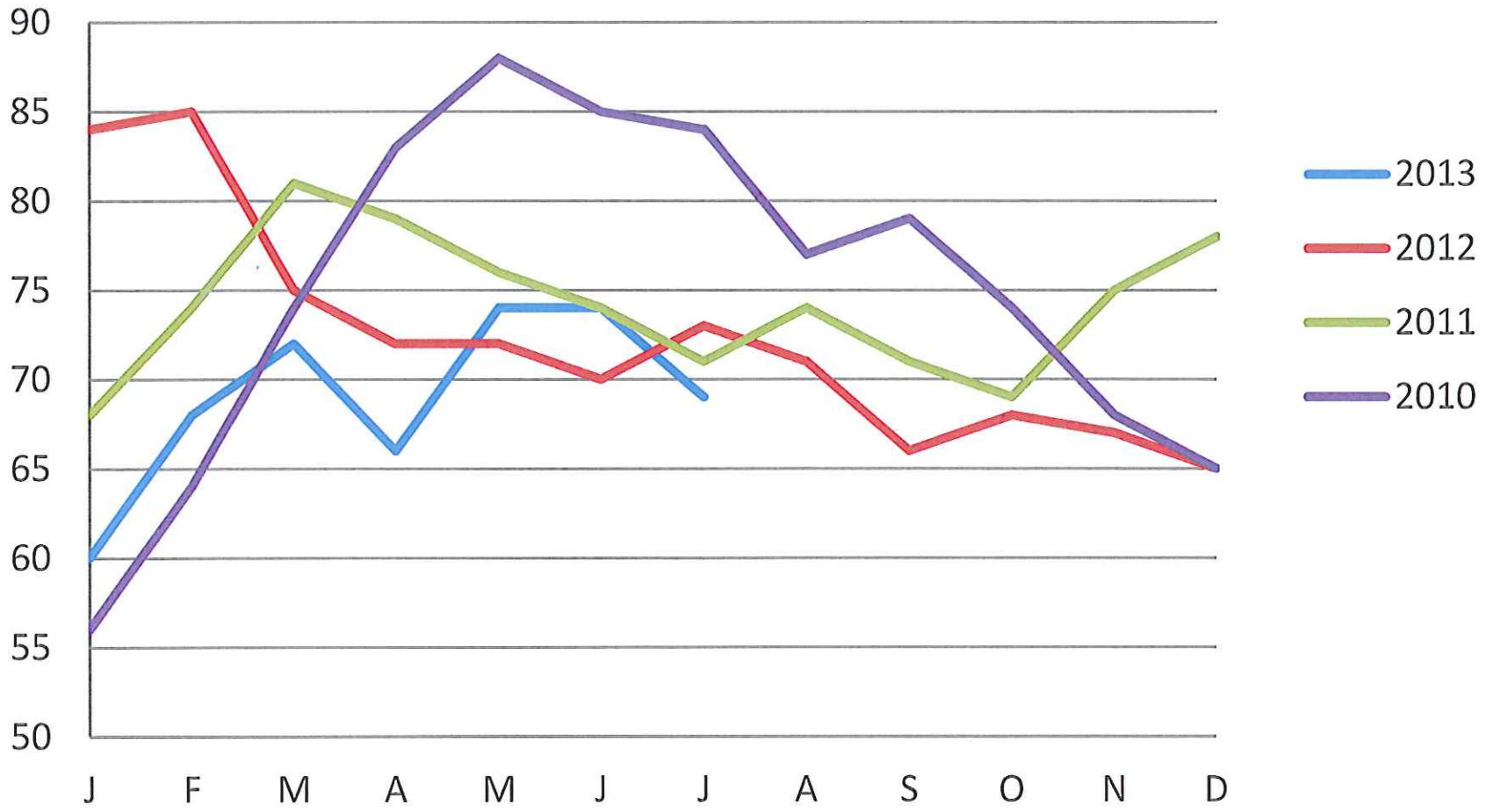


South Bend
Average Daily Census

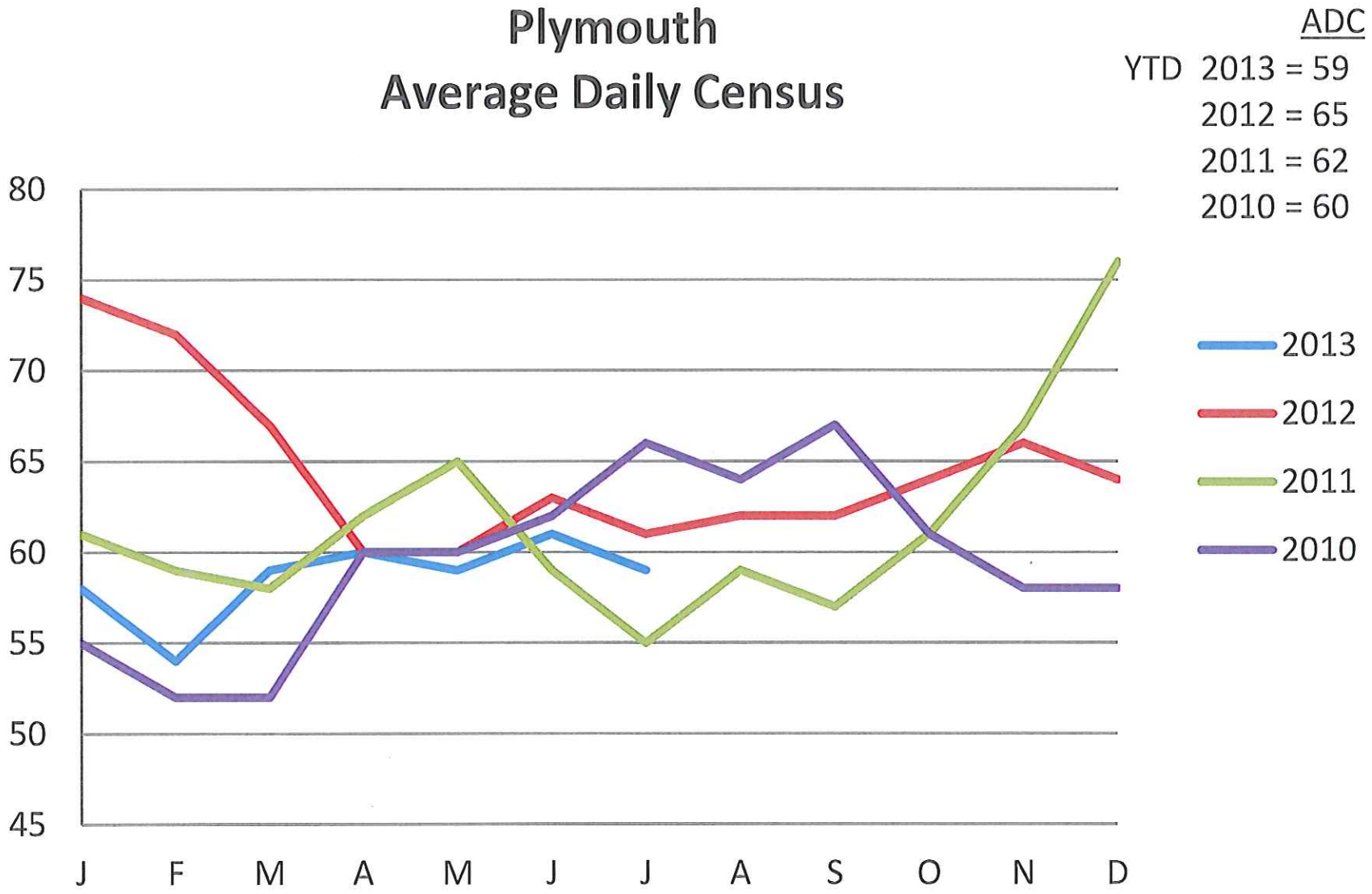


Elkhart
Average Daily Census

ADC
YTD 2013 = 69
2012 = 72
2011 = 74
2010 = 75



Plymouth
Average Daily Census



Center for Hospice Care
Compliance Committee Meeting Minutes
July 24, 2013

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

Topic	Discussion	Action
1. Call to Order: 3:00 p.m.		
2. LCDs	• Dr. Kubley will report at each compliance meeting any changes to the Palmetto LCDs. Palmetto has scaled down the LCDs. We will keep some parts of the old ones, because they have good information for admissions. The LCDs for lung and heart have been combined into cardiopulmonary.	
3. Documentation for GIP	• At the MLC in April, GIP and documentation was very much in the forefront. The OIG is focusing on appropriate GIP and that hospices need to make sure their documentation supports that level of care. Marcia and Donna are looking at documentation by all disciplines and think we have a lot of education we need to do on how to document the need for GIP. Documentation must include our efforts to manage the patient's symptoms prior to initiating GIP. We are seeing in some notes that triage is sending the emergency visit nurse for a new symptom and during that visit, the nurse says we will transfer the patient to Hospice House; however, this is prior to holding the IDT. The nurse must include the IDT in those decisions before talking to the family about transferring the patient to Hospice House. Document the family's goal. The nurse or social worker should document what led up the patient coming to Hospice House. The Hospice House nurse documents what she is seeing now when the patient is admitted. Ann and Danielle are working with Rebecca on documentation for Hospice House staff. Ann gave her staff a handout as a refresher on words and phrases to use and not use. At the monthly nursing leadership meetings, the PCCs are doing random chart audits.	
4. IHPCO Regulatory & Reimbursement Day Update	• The conference echoed above about documentation. Paint the picture. One thing they emphasized was documentation and technical compliance with regulations. An emphasis was placed on clinical documentation, which affects billing and	

Topic	Discussion	Action
	reimbursement. The OIG is focusing on GIP, Part D crossover, and live discharges. Were they really eligible in the first place if it is a live discharge? Some chain hospices that also own nursing homes are being accused of placing nursing home patients in Med A beds, waiting exactly 100 days, moving them to the hospice program they own, collect both R&B and hospice reimbursement, and then discharging from hospice at exactly 180 days. Were they eligible to begin with? • One session at MLC Jennifer Kennedy reminded everyone that the LCDs are guidelines and have never appeared in regulation. We have to paint the picture. Functionality always came up. Talked about the 14 day review and how we need to talk about what the patient was able to do and is now not able to do. Our nurses use a worksheet to help track things in the IDTs. The PPS is being used a lot more too.	
5. 2013 In-service Topic	• The annual in-service will be held at the 09/25 staff meeting. Last year we did compliance 101. After discussion, it was decided we would review the cost of noncompliance and why we are focusing so much on documentation, the hoops we have to jump through for ADRs, etc. Review the Information we have to provide in a timely manner, what happens if they say it is not good enough, consequences, etc. Sometimes it is random charts, sometimes specific beneficiaries. Remind staff what to do when an auditor shows up at the door, a yellow envelope comes in the mail, etc. Karl and Donna will do the presentation. We should also talk about how much documentation has improved and give samples. (1) Hoops jump through and cost when get ADRs and requests for records, (2) what to do when auditor walks in door, (3) This is why we're doing it. Help them understand why they get blue slips.	
6. Hospice Compliance Plan	• Reviewed the hospice compliance plan. The following changes were recommended: • Page 20, ECF: Services Provided to a Hospice Patient – Under Policy, second paragraph, delete, "Contracted staff may be used to provide core services only when necessary during periods of peak patient loads or under extraordinary circumstances." We don't use contracted staff any longer. Under Procedures, delete sixth paragraph. Should be covered in the nursing home contract and doesn't belong in our policy. • Page 26, Plan of Care Coordination – under Policy, delete "on a regular basis." WE are not obligated how often. • Page 27, Elder Justice Act Reporting – ISDH updated the law in February. Will change the Procedures so they say "reasonable suspicion of a crime." We may need	

Topic	Discussion	Action
	to reword the form signed by staff and volunteers. Vicki will check that. We need to review the Act with staff annually. Maybe at the February staff meeting each year. • Page 30, Dating of Medical Records – Donna revised the policy. What about Mobile Care and aides' documentation? If the electronic system down, everyone would be documenting on paper. We may want to add that sometimes the need may arise to document manually. All documentation will be signed and dated with a manual signature. Will add that.	
7. Next meeting	• Next meeting in October will review home health compliance plan.	
Adjournment	• The meeting adjourned at 4:00 p.m.	Next meeting TBA

enclara
Hospice Pharmacy Services

Dave Krishna, COO
Enclara Health
1480 Imperial Way
West Deptford, NJ 08066

July 2, 2013

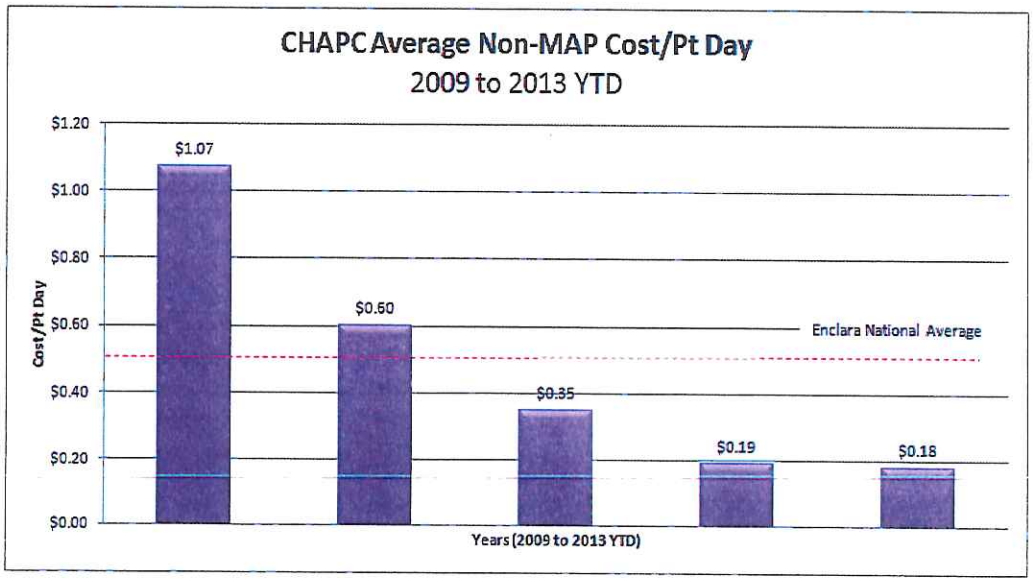
Dave Haley, VP/COO
The Center for Hospice and Palliative Care
111 Sunnybrook Court
South Bend, IN 46637

Dear Dave,

Enclara routinely reviews and trends all of our hospice partner pharmacy related data. We review key elements that reflect financial and quality performance and share with our partners during business reviews. We will sometimes see one of our hospice partners stand out as having made significant achievement in their pharmacy management.

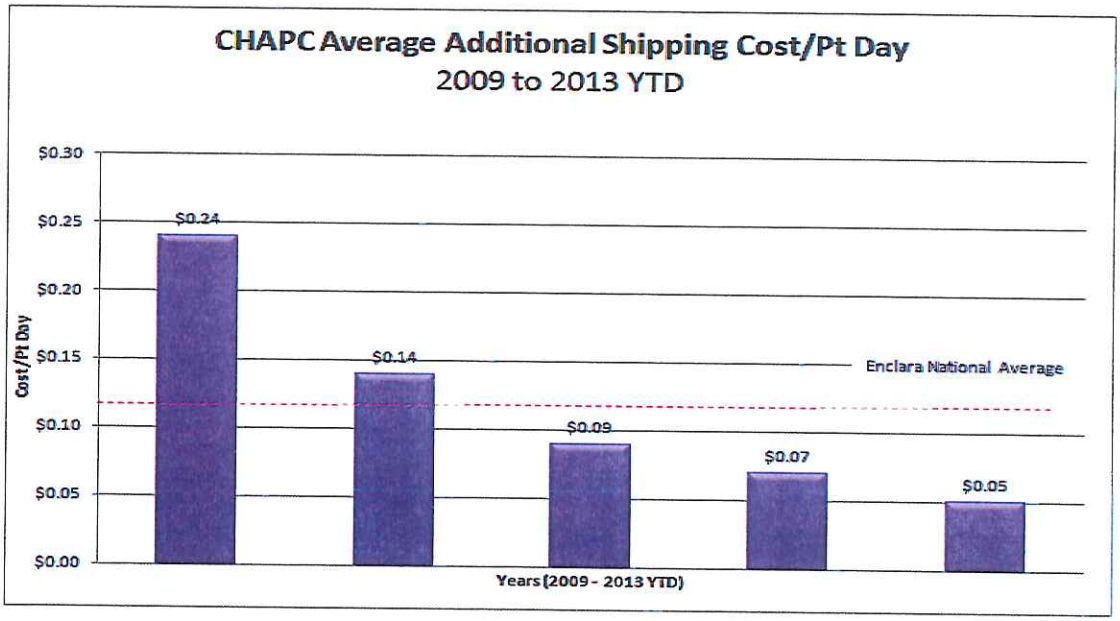
On behalf of Enclara, it gives me great pleasure to inform you that under your leadership, CHAPC has achieved this success. The graphs below detail not only the significant financial improvement you have achieved, but also the positive trend since 2009 specifically with non-formulary and additional shipping costs.

- Non-Formulary Costs: CHAPC ranked in the Top 10 as Compared to Enclara's National Data Base



enclara
Hospice Pharmacy Services

- Additional Shipping Costs:



Dave, we congratulate you and recognize all of your team's hard work and exemplary results. Enclara remains a committed partner to CHAPC as you strive to continue to improve your financial and quality outcomes. Please continue to let us know if Enclara can assist you or your team with anything.

Congratulations!

Dave Krishna
COO
Enclara Health

5th DRAFT OF THE CONFERENCE SCHEDULE

The 5th Biennial

Palliative Care: Caring and Sharing

Venue: Imperial Royale Hotel - Kampala, Uganda

August 29 - 30, 2013

DAY 1: THURSDAY 29th AUGUST 2013				
8.00 – 9.00am		Registration		
9.00-10.30am		Plenary Sessions: Palliative Care in the Current Era of the double burden of disease Chairperson – Dr. Samuel Guma *(Kawempe Home Care)* and Fatia Kiyange *(African Palliative Care Association)*		
	9.00	Welcome and Introduction to PCAU 2013 National Conference Rose Kiwanuka *(Palliative Care Association of Uganda)*		
	9.10	Entertainments from Kawempe Home Care Drama Group Recognition Awards.		
	9.20	The Role of WHO in Palliative Care: Country Representative		
	9.30	Official Opening by the Guest of Honour: Hon. Dr Ruhakana Rugunda (*Minister of health)*		
	10.00	Key note address: Caring and Sharing in Palliative Care: The Spiritual perspective Rev. Fr. Peter Mubiru (Peaces & Justice Uganda)		
	10.20	Global burden of disease, A Regional perspective: Dr Emmanuel Luyirika *(African Palliative Care Association)*		
	10.40	Responding to the disease burden challenges, The Ugandan perspective: Dr Mhoira Leng *(Mulago Palliative Care Unit Uganda)*		
	11.00	Palliative Care in HIV/AIDS: The Value of an Integrated Model: Dr Yvonne Karamagi *(Mildmay Uganda)*		
11.00-11.30		Tea break		
11.30 – 1.00pm		Break Away Session Chair persons **Dr. Jacinto Amandua** *(Ministry of Health)* **Dr. Micheal Etukoit** *(The AIDS Support Organisation)*	Break Away session Chair persons **Dr. Eddie Mwebesa** *(Hospice Africa Uganda)* & **Dr Stella Alamo** *(Reach Out Mbuya)*	**Workshop Session Dr. Jane Nakaweesi** *(Mildmay Uganda)*
	11.30	Advancing the Integration of Palliative Care into the National Health System: A POLICY BRIEF FOR UGANDA *Dr. Harriet Nabudere (Makerere*	Communication with the seriously ill cancer patients *Phanice Jepkemoi (Moi Teaching Refferal Hosptial - Kenya)*	**Pediatric PC** *Dr. Judith Namuyonga (Mulago Hospital)* *Rose Nasaba (SUSTAIN UGANDA)*

		University - Uganda)		
	11.45	Factors affecting the provision of PC in Uganda *Harriet Kebirungi (Palliative Care Association of Uganda)*	Addressing universal psychosocial issues in PC *Karen Smith-Taljaard (Centre for Hospice Care - USA)*	**(90minutes)**
	12.00	Is there value for using PC standards to improve quality? *Bernadette Basemera (African Palliative Care Association)*	Psychosocial issues in PC *Doreck Ekyampire (Hospice Africa Uganda)*	
	12.15	Hotline is a cost effective means to strengthen early case identification, referral and follow up of PC clients: TASO Uganda experience *Seruma E (The AIDS Support Organisation)*	Assessing and Healing Spiritual Pain *Bridget Smith (Centre for Hospice Care - USA)*	
	12.30	Integrating volunteers in a hospital based setting: experience of MPCU *Grace Kivumbi (Mulago Palliative Care Uganda)*	The effect of death and dying on clinical PC health professionals a case of HAU *Berna Mandera (Hospice Africa Uganda)*	
	12.45	**Questions and Discussions**	**Questions and Discussions**	
1.00 – 2.00pm		**Lunch Break and Poster Presentations**		
2.00 – 3.30pm		**Break Away Session** **Chair persons- Dr. Henry Luzze** (*Ministry of Health*) **& Dr Ekiria Kikule** (*Uganda Christian University Mukono)*	**Break Away Session–** **Chair persons Janet Obuni (*UNMU)* & Robert Senteza** (*Kibaale District*)	**Workshop Session** **Chair persons** **Ms Marleene Masclee** (*Africa Palliative Care Association)*
	2.00	Integration of PC in public health facilities: the journey of PC in Tororo district *Stella Agembi (Tororo Hospital)*	Sharing the experience of suffering children with cancer in south western Uganda and how the children's palliative care has helped. *Honest Twinomujuni (Mobile Hospice Mbarara)*	**Organization development** *Zena Bernacca (Hospice Africa Uganda)* *Tom Duku (Pincer International Group of companies Ltd)* **(90minutes)**
	2.15	Palliative Care in Iganga District *David Basoga (Iganga District)*	PC needs of children admitted to the inpatient unit at Mildmay Uganda *Dr. Jane Nakawesi (Mildmay Uganda)*	
	2.30	Scaling up PC through integrated care pathways Gombe Hospital – Butambala *Dr. Joseph Mbuga (Gombe Hospital)*	Peer-led psychosocial clubs: A strategy to improve adherence and school attendance in a comprehensive community based OVC programme *Sharon Nakanwagi (Reach Out Mbuya)*	
	2.45	The impact of good pain control in prolonging quality of	Mortality audits as a way of improving treatment outcomes	

		life of the patient: case study of Ibanda Central Clinic *Dr. Margaret Kasende (Ibanda District)*	on the inpatient paediatric unit Mildmay Uganda *Doreen Sekibombo (Mildmay Uganda)*	
	3.00	End-of-Life care in Hospice Jinja *Diana Basirika (Hospice Jinja)*	Cardiac dysfunction among HIV infected children on combination ART attending JCRC, Kampala, Uganda *Dr. Judith Namuyonga (Mulago Hospital)*	
	3.15	**Questions and Discussions**	**Questions and Discussions**	
3.30 – 4.00		**Tea Break**		
4.00 – 5.00		**2nd Plenary Session - Supporting each other and service Providers' Award** **Chairperson: Rose Kiwanuka** (Palliative Care Association of Uganda) **& Micheal Wargo** (Centre for Hospice Care - USA)		
4.00		**Working with diversity :** **Zena Bernacca** *(Hospice Africa Uganda)*		
4.20		**Perspective of Net Working and Collaboration in Palliative Care:** **Rinty Plukkel** *(Tororo Hospice)*		
4.35		**Patient's Voice: Kawempe Home Care** **Care's Voice: Mulago Palliative care Unit**		
4.45		**Questions and Discussion**		
5.00		**Close**		

DAY 2: FRIDAY 30th AUGUST 2013				
8.00 – 9.00am		**Registration**		
09.00 – 10.30am		**Plenary Sessions: Sharing knowledge through audit and research** **Chairpersons Dr. Fred Sebisubi** ***(Ministry of Health)*** **and Prof. Harriet Mayanja** *(Makerere University)*		
	09.00	**Building capacity in Audit and Research - Dr Elizabeth Namukwaya** ***(Mulago Palliative Care Unit)***		
	09.25	**Costing for Palliative Care - Eve Namisango** ***(African Palliative Care Association)***		
	09.50	**Research in Children's Palliative Care – Prof. Julia Downing** ***(International Children's Palliative Care Network)***		
	10.15	**Questions and Discussions**		
10.30 – 11.00		**Tea Break**		
11.00 – 13.00		**Break Away Session** **Chair persons Dr Jackson Amone** ***(Ministry of Health)*** **& Dr. LT. Col Patrick Ocen** ***(Uganda Peoples Defence Forces)***	**Workshop Session –** **Dr William Musoke** ***(Mildmay Uganda)***	**Workshop Session–** **Dr. Barbara Mukasa** ***(Mildmay Uganda)***
	11.00	Improving provision of PC in HIV/AIDS organizations through building capacity of	**Clinical issues – Holistic Care** *Harriet Nakiganda (Hospice Africa Uganda)*	**Progress on the Research Agenda** *Julia Downing (Mulago*

		health workers: the Hospice Africa Uganda Institute of Hospice and PC in Africa Experience *Dr. Dorothy Adong Olet (Hospice Africa Uganda)*	*Dr Mbuga J (Gombe Hospital)* *Dr Sangadi G (Soroti Hospital)*	*Palliative Care Unit)* *Eve Namisango (African Palliative Care Association)* **(90minutes)**
	11.15	PC education: Assessing medical students' knowledge of and attitude towards PC after placement at HAU *Dr. Ludovic Zirimenya (Hospice Africa Uganda)*		
	11.30	Outcome evaluation of the Mildmay Uganda Human Resource Capacity Development for PC in Africa *Edith Akankwasa (Mildmay Uganda)*		
	11.45	Development and implementation of clinical protocols within a national hospital setting *Mwazi Batuli (Mulago Palliative Care Unit)*		
	12.00	The PC profiles of breast cancer patients in Mulago Hospital, Kampala, Uganda *Dr. Eddie Mwebesa (Hospice Africa Uganda)*		
	12.15	The role of partnerships in strengthening PC in resource limited settings – TASO experience *E Seruma (The AIDS Support Organisation)*		
	12.30	Prevalence of NCDs among HIV clients accessing care at Mildmay Uganda *Esther Kawuma (Mildmay Uganda)*		
	12.45	**Questions and Discussions**	**Questions and Discussions**	
1.00 – 2.00pm		**Lunch Break and Poster Presentations**		
2.00-3.00		**Plenary Session – Sharing good practices** **Chair Persons Dr. Henry Ddungu *(Uganda Cancer Institute)* and Dr. Alamo Stella** *(Reach Out Mbuya)*		
	2.00	**Ethos and palliative care:** **Dr Anne Merriman** *(Hospice Africa Uganda)*		
	2.30	**Monitoring and Evaluating: Palliative Care Interventions** *Ministry of Health*		

	3.00	**Advocating for Palliative Care: Nationally and internationally:** **Hon. Dr. Christine Ondoa** (*Presidential Advisor*)
	3.30	**Sustaining Palliative Care: The Role of Parliamentarians and Donors in Palliative Care** **Hon. Dr. Twa-twa Mutwalante Jeremiah** (Chair person parliament Palliative Care Advocacy Group)
4.00pm		**Highlights: Summary of the Conference and Closing Ceremony: Rose Kiwanuka** (*Palliative Care Association of Uganda*)
4.15pm		**Close**

TMF
Health Quality Institute

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

May 24, 2013

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

RE: **Correction of Hospice PEPPER (Live Discharges Target Area)**

Dear Chief Executive Officer/Administrator,

Recently TMF Health Quality Institute distributed your hospice's Program for Evaluating Payment Patterns Electronic Report (PEPPER). Subsequently, we discovered an issue affecting the "Live Discharges" report in your hospice's PEPPER. Only hospices whose "Live Discharges" report had any data in the "Your Hospice" section for any of the three time periods (fiscal year 2010, 2011 or 2012) are affected by this issue.

The target area (numerator) definition for the "Live Discharges" report was revised for hospice beneficiary episodes of service that ended July 1, 2012 and later (see the Definitions worksheet, attached) in order to be compliant with CMS Change Request 7677, which required hospices to use additional codes to indicate the reason a beneficiary was discharged alive. The programming code for calculating these statistics was correct.

For episodes ending prior to July 1, 2012 there was an error in the programming code. Instead of identifying hospice beneficiary episodes of service with a length of stay of less than 25 days for beneficiaries who were discharged alive **and** with occurrence code 42 (date of termination of hospice benefit), the programming code identified beneficiary episodes of service with a length of stay of less than 25 days for beneficiaries who were discharged alive **or** with occurrence code 42. This resulted in an inflated "Live Discharges" count for many hospices, and also resulted in incorrect state, jurisdiction and national 80th percentiles. This issue affected statistics for fiscal years 2010, 2011 and 2012.The other reports in the Hospice PEPPER are correct.

We are providing you with a corrected Hospice PEPPER. The PEPPER team at TMF is dedicated to working to ensure statistics reported in the PEPPER are accurate, and we sincerely regret this error. If you have any questions about your PEPPER or this corrected report, please submit them through the "Help Desk" at PEPPERresources.org.

Sincerely,

Kimberly Hrehor

Kimberly Hrehor, MHA, RHIA, CHC

Project Director

PEPPER

Hospice Target Area	Hospice Target Area Definition
Live Discharges	**For discharges prior to July 1, 2012:** Numerator (N): count of beneficiary episodes with a length of stay (LOS) < 25 days discharged alive by the hospice (patient discharge status code not equal to "40" (expired at home), "41" (expired in a medical facility) or "42" (expired place unknown)) with occurrence code "42" (date of termination of hospice benefit) Denominator (D): count of all beneficiary episodes discharged (by death or alive) by the hospice with a LOS < 25 days during the report period (obtained by considering all claims billed for a beneficiary by that hospice) **For discharges beginning July 1, 2012:** N: count of beneficiary episodes with a length of stay (LOS) < 25 days who were discharged alive by the hospice (patient discharge status code not equal to "40" (expired at home), "41" (expired in a medical facility) or "42" (expired place unknown)), excluding: a. beneficiary transfers (patient discharge status code "50" or "51") b. beneficiary revocations (occurrence code "42") c. beneficiaries discharged for cause (condition code "H2") d. beneficiaries who moved out of the service area (condition code "52") D: count of all beneficiary episodes discharged (by death or alive) by the hospice with a LOS < 25 days during the report period (obtained by considering all claims billed for a beneficiary by that hospice)
Long Length of Stay	N: count of beneficiary episodes discharged (by death or alive) by the hospice during the report period whose combined days of service at the hospice is greater than 180 days (obtained by considering all claims billed for a beneficiary by that hospice) D: count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period

Hospice PEPPER (*Corrected*)

Visit PEPPERresources.org

Compare Targets Report, Four Quarters Ending Q4 FY 2012

151501, CENTER FOR HOSPICE & PALLIATIVE CARE INC, THE

The Compare Targets Report displays statistics for target areas that have reportable data (11+ target discharges) in the most recent time period. Percentiles indicate how a hospice's target area percent compares to the target area percents for all hospices in the respective comparison group. For example, if a hospice's national percentile (see below) is 80.0, 80% of the hospices in the nation have a lower percent value than that hospice. The hospice's state percentile (if displayed) and the Medicare Administrative Contractor (MAC) jurisdiction percentile values should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target area indicate that the hospice may be at a higher risk for improper Medicare payments. The greater the percentile value, in particular the national and/or jurisdiction percentile, the greater consideration should be given to that target area.

Target	Description	Target Count	Percent	Hospice National %ile	Hospice State %ile	Hospice Jursidict. %ile	Sum of Payments
Live Discharges	Discharges prior to 7/1/12: Proportion of beneficiary episodes with a LOS < 25 days with occurrence code "42" (date of termination of hospice benefit), to all discharges with a LOS < 25 days. Discharges beginning 7/1/12: Proportion of beneficiary episodes with a LOS < 25 days discharged alive (patient discharge status code not equal to "40" (expired at home), "41" (expired in a medical facility) or "42" (expired place unknown)), excluding patient discharge status code "50" or "51" (discharged/transferred to a hospice), excluding occurrence code "42" (beneficiary revokes), excluding condition code "H2" (beneficiary discharged for cause) or "52" (beneficiary moves out of service area), to all discharges with a LOS < 25 days	13	1.7%	2.6	5.3	1.1	$52,886
Long LOS	Proportion of beneficiary episodes discharged (by death or alive) by the hospice during the report period whose combined days of service at the hospice is greater than 180 days (obtained by considering all claims billed for a beneficiary by that hospice), to total number of beneficiary episodes discharged (by death or alive) by the hospice during the report period	123	9.7%	24.7	30.4	18.6	$7,912,265

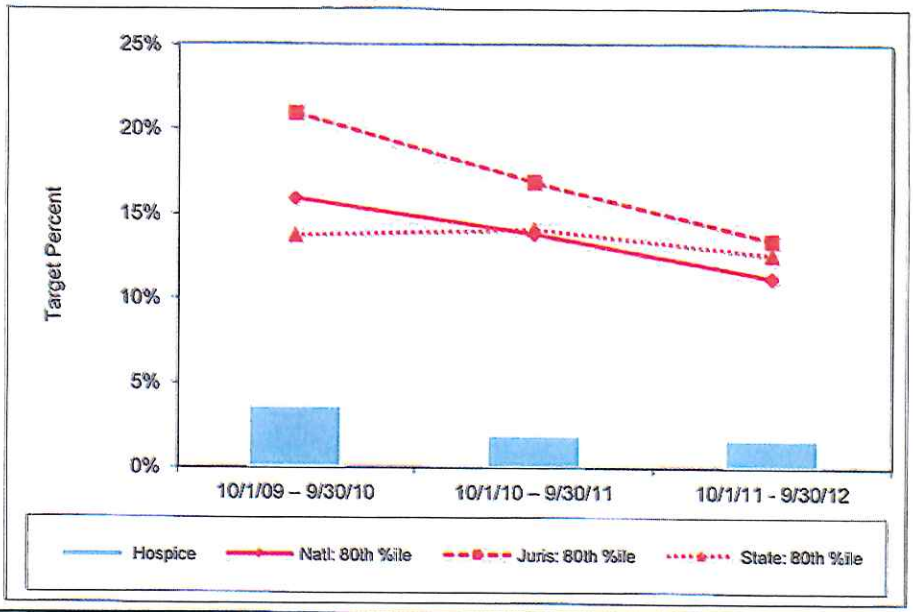
Note: State and Jurisdiction %tiles are not reported when there are fewer than 11 hospices or when there are no hospices with at least 11 target claims.

151501, CENTER FOR HOSPICE & PALLIATIVE CARE INC, THE

Live Discharges (*Corrected*)

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

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



YOUR HOSPICE	10/1/09 – 9/30/10	10/1/10 – 9/30/11	10/1/11 - 9/30/12
Target Area Percent	3.7%	2.0%	1.7%
Target Count For discharges prior to July 1, 2012: (Numerator:count of beneficiary episodes with a LOS < 25 days discharged alive by the hospice (patient discharge status code not equal to "40", "41" or "42") with occurrence code "42" For discharges beginning July 1, 2012: (Numerator:count of beneficiary episodes with a LOS < 25 days who were discharged alive by the hospice (patient discharge status code not equal to "40", "41" or "42"); see Definitions worksheet for exclusions	26	15	13
Denominator Count (see Definitions worksheet for complete definition)	706	758	744
Target (Numerator) Average Length of Stay	10.2	13.5	10.4
Denominator Average Length of Stay	7.7	7.6	7.9
Target (Numerator) Average Payment	$3,284	$2,295	$4,068
Target (Numerator) Sum of Payments	$85,391	$34,428	$52,886

*Data not available when numerator count less than 11

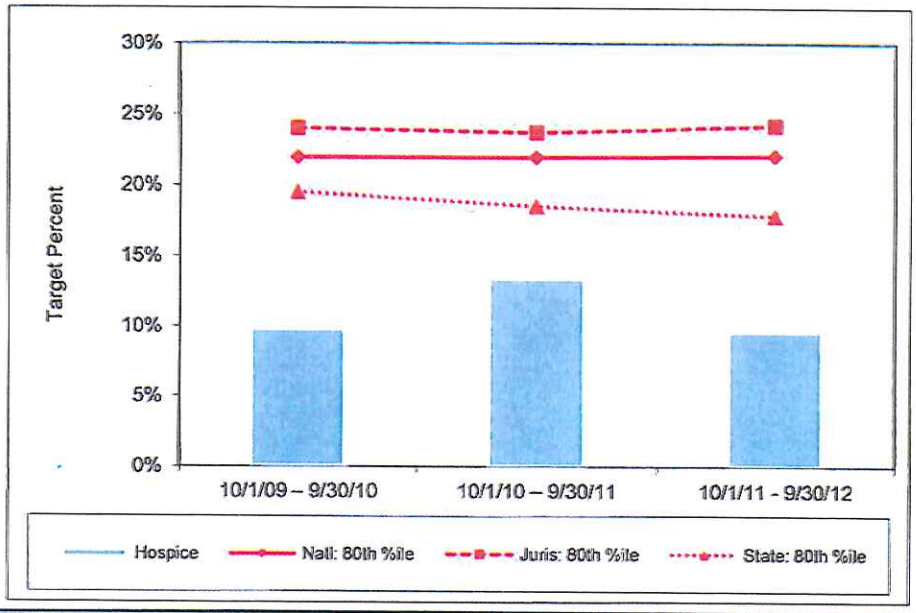
COMPARATIVE DATA			
Note: State Percentiles are zero when there are fewer than 11 hospices in the jurisdiction's state or when there are no hospices with at least 11 target claims.			
National 80th Percentile	15.9%	13.8%	11.1%
Jurisdiction 80th Percentile	20.9%	16.8%	13.3%
State 80th Percentile	13.6%	14.0%	12.5%

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

Long Length of Stay

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

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



YOUR HOSPICE	10/1/09 – 9/30/10	10/1/10 – 9/30/11	10/1/11 - 9/30/12
Target Area Percent	9.9%	13.4%	9.7%
Target Count (Numerator: count of beneficiary episodes discharged (by death or alive) by the hospice during the report period whose combined days of service at the hospice is greater than 180 days (obtained by considering all claims billed for a beneficiary by that hospice)	122	167	123
Denominator Count (see Definitions worksheet for complete definition)	1,238	1,244	1,267
Target (Numerator) Average Length of Stay	399.7	422.7	433.2
Denominator Average Length of Stay	67.7	79.2	69.9
Target (Numerator) Average Payment	$57,253	$61,766	$64,327
Target (Numerator) Sum of Payments	$6,984,829	$10,314,883	$7,912,265

*Data not available when numerator count less than 11

COMPARATIVE DATA			
National 80th Percentile	21.9%	22.0%	22.1%
Jurisdiction 80th Percentile	24.0%	23.7%	24.2%
State 80th Percentile	19.5%	18.5%	17.8%

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

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

Hospice PEPPER
Top Terminal Conditions
151501 CENTER FOR HOSPICE & PALLIATIVE CARE INC, THE

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Hospice Top Terminal Conditions, Most Recent Fiscal Year
In Descending Order by Total Decedents

Terminal Condition Description	Total Decedents for Each Condition	Proportion of Decedents for Each Condition to Total Decedents	Hospice Average Length of Stay for Condition
NonAlzheim dementia	126	10.8%	95.1
Lung & other chest cavity CA	119	10.2%	46.4
Congestive heart failure	112	9.6%	107.4
Debility NOS	84	7.2%	64.4
Failure to thrive	83	7.1%	85.1
CVA/stroke	73	6.3%	44.9
Non-infectious respiratory	62	5.3%	97.8
Colo-rectal CA	47	4.0%	59.1
Other heart disease	39	3.4%	75.0
Pancreatic CA	36	3.1%	31.6
Top Conditions	781	67.2%	74.5
All Conditions	1,163		64.6

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

Hospice PEPPER
Hospice for J11 Palmetto GBA
Top Terminal Conditions

Visit PEPPERresources.org

Jurisdiction Top Terminal Conditions, Most Recent Fiscal Year

In Descending Order by Total Decedents

Terminal Condition Description	Total Decedents for Each Condition	Proportion of Decedents for Each Condition to Total Decedents	Jurisdict. Average Length of Stay for Condition
NonAlzheim dementia	48,266	11.4%	102.1
Lung & other chest cavity CA	39,817	9.4%	44.9
Congestive heart failure	30,201	7.1%	68.4
Failure to thrive	30,137	7.1%	88.2
Debility NOS	28,445	6.7%	85.4
Non-infectious respiratory	26,779	6.3%	85.8
CVA/stroke	25,383	6.0%	41.6
Other heart disease	22,468	5.3%	80.8
Alzheimer's disease	18,471	4.4%	120.2
Pneumonia	14,268	3.4%	24.4
Top Conditions Jurisdiction-wide	284,235	67.1%	76.0
All Conditions Jurisdiction-wide	423,822		66.4

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

July 22, 2013

Mr. Mark Murray
President, Center for Hospice Care
501 Comfort Place
Mishawaka, IN 46545

Dear Mr. Murray,

I'm writing to you today, on behalf of myself and my mother, to express appreciation for the beautiful renovation of our old family home, located at 301 North Cedar Street, in Mishawaka. My parents purchased this home in 1952, shortly before I celebrated my second birthday. Living there for all of my childhood and enjoying it until my father sold it in the early 1980's, to say that it is a place dear to my heart, is an understatement. The memories of times spent with family and friends, revolving around this lovely house that we called home for so many years, are forever etched in my heart.

Both my mother and I especially loved this home and I know that my mother would be particularly pleased to know how the house is being used, as it was a welcome haven for many guests, during the years that we lived there. Upon returning to St. Joseph County last summer, after many years of absence, I was delighted to learn of its intended use and to see the renovation progressing, knowing how many people might be comforted, by some time spent there. A portion of my professional career has been devoted to hospice care marketing, specifically with VITAS Hospice, both in Florida and Illinois, so I am particularly delighted that my childhood home is now being used by hospice families.

During the time that we lived there, the house was filled with lovely antiques, which highlighted the architecture. Music poured from the baby grand piano in the living room and could be heard throughout the neighborhood. It was in this home that I experienced the Cuban Missile Crisis, JFK's assassination, the first Moonwalk, many visits from Santa Claus and the Easter Bunny and my first goodnight kiss from a young man, returning me home from a date. I remember when Cedar Street was brick pavement and when the milk man delivered large blocks of ice from the back of his milk truck. I may be one of the only people left on the face of the earth, brave enough to go down into the basement! My parents were the ones who put the addition onto the back of the house, in the 1960's, to add room for my ever-expanding group of friends. This first-floor addition and the kitchen

renovation were completed as a modernization, but the remainder of the house retained the original architecture, while we lived there. I have inherited the family photos of our home, both before and after the 1960's renovation and am also proud to be a memory keeper of the entire Cedar Street neighborhood, which includes the Pugh family of Edgewater Floral and the Burkholder family, who first built the Moose Lodge building, as a ballet studio, now all properties purchased by Center for Hospice Care.

I hope this letter has provided you with a surprising and pleasant deviation, from the usual business correspondence you normally receive. As someone who understands the rigors of providing hospice care, please accept my wishes of good luck in the newly expanded endeavor you lead. Enjoy your newly constructed building along the St. Joseph River, where I played as a little girl and may your patients, families and staff all benefit from a stop into my childhood home, for a little bit of warm hospitality and a moment of peace. I trust all of you to love it, as much as I always will.

Sincerely,

Dee Aguayo

Dee (Owen) Aguayo

Easing of pain

BOB BLAKE South Bend Tribune rblake@sbtinfo.com | Posted: Saturday, July 27, 2013 8:01 am

SOUTH BEND - Nearly three years ago, Kristy Gorsuch and her family made a life-altering decision. They left family and friends behind in Florida and moved to South Bend.

What was already a difficult transition for her two, young sons soon took a heartbreaking turn. The boys' grandfather died soon after the move.

"It was really difficult for them. He was their papaw," Gorsuch said. "He used to baby-sit them, watch them and play with them a lot. When we moved away and moved here we didn't have any family in the area. It was very difficult for them to lose their papaw."

That's when Gorsuch turned to Camp Evergreen, a grief camp for youth and teens operated by the Center for Hospice Care.

"They got to ride horses. They got to do a lot of activities where they got to talk about their papaw," she said. "They experienced that time just to reflect and remember him. They made special crafts that helped them remember him. This little treasure box they came home with they could put a picture of him in and some trinkets they collected to remember him.

"One of my boys collected little airplanes and their papaw gave him an airplane so he put that in there to remember him. They still pull those boxes down off their window sill and open them up to remember him."

On Friday, Gorsuch and her boys were among nearly 200 people celebrating in the Upper Deck Suite at Stanley Coveleski Regional Stadium as those involved celebrated 20 years of Camp Evergreen.

"What we find is often their families are grieving too so their usual support system may be having a hard time giving them support," Holly Farmer, the camp director, said. "We talk about grief. We talk about coping skills. We also give them opportunities to talk about who died and how they died and also a chance to make something in memory of their loved one."

Younger children come for a daylong camp. Teenagers come for a weekend, Farmer said. The losses run the gamut -- parents, grandparents, siblings, friends. No matter who the child is grieving or the manner of death, the camp provides a safe, understanding environment to talk about the loss and grieve.

"We also want them to have fun while they're there," Farmer said. "We focus on grief and then we give an opportunity to have fun. We let them know it's okay to laugh, it doesn't mean you don't miss them."

Over the course of its 20 years, Camp Evergreen has helped more than 700 teens and youth. The program is offered free of charge once a year, usually in June, Farmer said.

Carolyn Pritchard, the camp's first director, said she never imagined the program she helped launch would still be going strong two decades later.

"We knew that children experience grief and there was nothing in the community to really address that need," Pritchard said. "It was a great experience and it's just incredible that it's still going."

Pritchard and Farmer said it's the volunteers that really make the camp so successful.

Kristine Kalber, of South Bend, has been volunteering for 13 years..

"My father died when I was 6. I always felt sort of lost after that," Kalber said. "When I heard about Camp Evergreen I really thought it was a way to give something back. I could give something back, teach someone or help someone, give someone what I didn't have at that time."

Holly Farmer speaks during the Camp Evergreen reunion event for campers, volunteers and staff Friday at Coveleski Stadium in South Bend.
SBT Photo/ROBERT FRANKLIN

Camp Evergreen counselors Jenny Hellyer and Mike Voll look through a photo album during the reunion event for campers, volunteers and staff Friday at Coveleski Stadium in South Bend. SBT Photo/ROBERT FRANKLIN

MONDAY 08.12.13 TODAY HIGH 82, LOW 60 A9

South Bend TRIBUNE

People throw rose petals into the St. Joseph River in memory of their loved ones Sunday as they participate in the 28th annual Walk for Hospice at Beutter Park in Mishawaka. Organizers said the walk, which benefits the Center for Hospice Care, drew about 400 participants. SBT Photos/MIKE HARTMAN

community

WALKING FOR HOSPICE

Hundreds take part as loved ones remembered

By Christian Sheckler
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MISHAWAKA

Several hundred people took part in a walk Sunday to help raise money for the Center for Hospice Care and remember loved ones who died while receiving care from the area nonprofit.

The organization, which provides end-of-life care to people in St. Joseph and surrounding counties, marked its 28th annual Walk for Hospice at Beutter Park in downtown Mishawaka, as an estimated 400 supporters walked a loop along the St. Joseph River.

"We want people to have a reason to come together who have lost somebody who was in Hospice care," said Lisa Kelly, special event coordinator with the Hospice Foundation, the nonprofit's fundraising arm. "Many times, it's the only time everyone gets together, other than the funeral service."

See WALKING, A2

Supporters of the Center for Hospice Care cross the Beutter Park bridge.

FROM PAGE A1

Walking

Kelly said people who have loved ones in Hospice care often develop a close bond with caregivers.

Junell Broskey, who walked with her husband and two daughters, said she had a grandfather and father-in-law who died while receiving Hospice care.

"We wanted to participate because Hospice has touched each of our families, and all the services Hospice provides for the community," Broskey said. "They've offered my mother-in-law grief counseling, and it's really helped her cope."

The Center for Hospice Care accepts Medicare, Medicaid and most private insurance, but it also provides free or discounted care for patients with expenses not covered by insurance, Kelly said.

> "We wanted to participate because Hospice has touched each of our families, and all the services Hospice provides for the community."
>
> — Junell Broskey

Hospice Foundation COO Mike Wargo said the center gave away more than $1.1 million in free and discounted care in 2012 but raised just over $1 million. While the organization's cash reserves helped make up for the deficit, the shortfall makes fundraising events even more important, Wargo said.

The walk is among the Center for Hospice Care's three biggest fundraisers of the year, including its annual spring dinner and the "Bike Michiana for Hospice" ride in September, Wargo said.

At one time, the walk could have raised more than $100,000 each year, but that's decreased to about $40,000 in a good year as more nonprofits stage competing summer events, he said.

"This walk was one of the first charity walks back when it first started, and now lots of charities use walks to raise funds," he said.

Jeff Miller and his wife, Cheryl, were sporting bright blue Walk for Hospice T-shirts, available to anyone who donated $35 or more, as the participants began their walk to the blaring of a single bagpiper.

Miller said his wife signed him up for the walk earlier this year as a Father's Day gift because they each lost a parent who was receiving Hospice care and had thought about participating in the walk each of the past few years.

"We both had parents who passed while under Hospice care, and it's just our way of thinking about them and supporting other families," Jeff Miller said. "We're having fun, and we'll be back every year."

Young Palliative Care Patients Receive Support from Local Organizations

Goshen Hospital & Health Care Foundation provides grant funding to Center for Hospice Care for its work in providing palliative and hospice care to children.

Center for Hospice Care receives $11,000 to provide care for young patients in need of palliative care

Mishawka, IN (PRWEB) August 14, 2013

The sad, difficult reality is that children are sometimes in need of relief from the symptoms that a life-limiting illness can bring. Palliative care can improve the quality of living for whatever time a child may have remaining. Unfortunately, not all families can afford this type of treatment. Center for Hospice Care (CHC) provides comprehensive physical, emotional and spiritual support for anyone eligible for their services, including children facing life-limiting illnesses, regardless of their ability to pay.

To support pediatric patients in Elkhart County, Goshen Hospital and Health Care Foundation recently awarded a grant in the amount of $11,000 from the HOPE Project fund and 2013 Gala proceeds to provide palliative care services through Center for Hospice Care.

The mission of Goshen Hospital & Health Care Foundation is to assist and support the healthcare needs of the men, women and children living in our communities. Lynette Mischel, Executive Director, notes the Foundation's mission, as measured against need, is more relevant and urgent than ever as poverty is still on the rise in Elkhart County, even with the economy improving. This negatively impacts healthcare choices for those with limited incomes.

For 33 years, Center for Hospice Care has provided compassionated, skilled hospice and palliative care to anyone eligible for its services, regardless of their ability to pay. CHC serves an eight-county region in Northern Indiana, including Elkhart County. The organization is headquartered in South Bend, IN and has offices in Elkhart, Mishawaka and Plymouth as well as two Hospice Houses.

Mishawaka, IN (PRWEB) August 15, 2013

Center for Hospice Care and The Hospice Foundation Announce the Grand Opening of their New Mishawaka Campus

Official ribbon cutting ceremony for Center for Hospice Care and the Hospice Foundation's new Mishawaka Campus to be held Tuesday, August 20.

The new Center for Hospice Care Mishawaka Campus sits along the St. Joseph River near downtown Mishawaka

"Phase I of our project brings three rented offices to a more centralized location permitting us to immediately save significant monthly lease expenses."

On Tuesday, August 20, The Hospice Foundation and Center for Hospice Care (CHC) are hosting an official ribbon cutting ceremony at the new CHC Mishawaka Campus. Don Schumacher, President and CEO of the National Hospice and Palliative Care Organization, will be speaking at this event.

The official ribbon cutting ceremony is at 4:00 p.m. with a public open house immediately following until 5:30 p.m. All events take place at CHC Mishawaka Campus, 501 Comfort Place (along the river with access to parking off of Cedar Street).

CHC's new campus is on the northern banks of the St. Joseph River, nestled between Central Park and Cedar Street, with the physical address of 501 Comfort Place. The campus is scheduled to be completed in three phases. The first phase includes two buildings, which house administrative offices for CHC, the Life Transition Center (providing bereavement services to anyone who has lost a significant loved one) and Hospice Foundation offices. The buildings replaced office space previously leased at various locations in Mishawaka. Phase II will house CHC medical staff and a Hospice House and will be built as soon as funds are raised.

The new campus emerged through a public-private partnership between the Hospice Foundation and the City of Mishawaka; it was in the planning phases for more than three years.

Schedule at a glance:
4:00 p.m. Ribbon Cutting
4:30 p.m. Open House
5:30 p.m. Event Ends

For more information, contact Lisa Douglass at DouglassL(at)centerforhospice(dot)org or 574.243.3119.

Center for Hospice Care is a premier not-for-profit, community-based agency improving the quality of living through hospice, home health, grief counseling, and community education. With offices in South Bend, Plymouth, Elkhart, and Mishawaka, Center for Hospice Care serves St. Joseph, Marshall, Elkhart, Fulton, Kosciusko, LaGrange, LaPorte and Starke Counties in Indiana.