Board of Directors Meeting
501 Comfort Place, Conference Room A, Mishawaka
October 23, 2013
11:30 a.m.

BOARD BRIEFING BOOK

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CHAPTER ONE

AGENDA

BOARD OF DIRECTORS MEETING
Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
October 23, 2013
7:30 a.m.

A G E N D A

1. Approval of August 21, 2013 Minutes *(action)* – Corey Cressy (2 minutes)

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

3. Finance Committee *(action)* – Wendell Walsh (10 minutes)
   (a) August and September Financial Statements
   (b) 2012 CHC Retirement Plan Audit

4. Bylaws Committee *(action)* – Corey Cressy (8 minutes)

5. Policies *(action)*
   (a) HIPAA Policies (updated)– Karl Holderman (5 minutes)

6. Hospice Foundation Update (*information*) – Terry Rodino (10 minutes)

7. Board Education – (*information*) "QAPI Updates" – Rebecca Fear, RN, CHC Nurse Educator (10 minutes)

8. Chairman's Report *(information)* – Corey Cressy (5 minutes)

Next meeting December 18, 2013 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
August 21, 2013

Members Present:	Amy Kuhar Mauro, Carmi Murphy, Corey Cressy, Jim Brotherson, Julie Englert, Mary Newbold, Terry Rodino, Tim Yoder, Wendell Walsh
Absent:	Becky Asleson, Francis Ellert, Mike Method
Guest:	Don Schumacher, President/CEO of NHPCO
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 11:30 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 06/19/13 meeting as presented. The motion was accepted unanimously.	C. Murphy motioned J. Englert seconded
3. President's Report	• July average daily census was 313, June 314. Referrals are up 10%, patients served up 6%, original admissions up 12%, patient deaths up 9%. Still seeing late referrals. About 20% non-admitted don't get in, because they die before we can get there. August ADC is 318, and we budgeted for 345. • Board member Melanie Davis resigned in July to take a new job in Chicago. • Bylaws Committee has been meeting earlier than required to look at board and officer terms and changing the board term to the fiscal year. Suggested changes will be presented at the October board meeting. The Nominating Committee is looking at potential nominees for the board for 2014. • The Mayo Clinic has approved CHC being a hospice and palliative medicine fellowship site. They will send their doctors here to be trained in hospice and palliative medicine. This was Dave Haley's idea and he made the contacts. • Enclara, our national hospice pharmacy provider, sent a letter to Dave Haley congratulating CHC on our cost efficient use of non-formulary drugs and shipping costs. We are in their top ten lists of efficient providers. Our non-formulary costs were 61% below their national average, and shipping costs were 83% below their national average. Over the past years, Dr. Gifford and Donna Tieman have been working with the nurses to keep our expenses as low as we can without affecting patient care. Nurses are trained to check meds visually the first day of the week and not just ask the family if they need refills. This will avoid next day and weekend shipping costs. We also	

Topic	Discussion	Action
	scrutinize the Enclara bill for errors. We are charged extra for shipment to nursing homes, so we make sure those charges are marked correctly. • We received a $52,000 credit settlement from Cerner, because of the problems we had at installation. We have been negotiating for this for over two years. We were sold version 5.0, a product that was not ready. Then we received our $53,000 support bill for next year, so the timing was very good. • The nursing department is in the process of planning the first on-site Certified Hospice and Palliative Nurse Study course. Our goal is all R.N.s will become certified in hospice and palliative care. We located an instructor in Fort Wayne that will come do a one-day intensive review class for the exam at a cost of $200. In the past, staff had to travel to Indianapolis for the exam. This is another area that will set us apart from our competition and help ensure we are delivering the highest level of quality care we can. • We are also providing Pediatric End-of-Life Nursing Education Consortium (ELNEC) training for our nurses. One of our agency goals is to develop a strong pediatric program. We started by sending one of our patient care coordinators and our nurse educator to become certified ELNEC trainers. Then we did a needs assessment survey of nurses' pediatric knowledge, skills, comfort level, and resources. This gave us a starting point. There are ten ELNEC modules, and we created a lecture and self-learning packet. One module is reviewed at the monthly nurses meeting. We will do a needs assessment survey at the end of the ten modules. We will then have great data to present at the national level on how to build a strong pediatric hospice program. • The iReferDR App has been created and Amy is reviewing and modifying it. It is not ready to be tested yet. The App is HIPAA compliant. The Board will be updated at the October meeting on where we see the App going, marketing, etc. • More competition is in our service area. Now up to 28 different programs. Starke County, the 82nd lowest populated county in Indiana now has 14 different hospices to choose from. There are five new hospices in our service area, four of which are for-profit. • The new Medicare rates go into effect 10/01/13. After the cuts and various calculations, we will see a very slight increase in our rates in three of our four	

Topic	Discussion	Action
	geographic areas. The St. Joseph County increase will make up about half of last year's cut. • We received a letter from a lady who grew up in what is now our guest house. A copy of the letter is in the board packet. We will invite her to tour our campus. • We have had good media coverage lately. Marketing and the Hospice Foundation are doing an excellent job. We were on the front page of the South Bend Tribune twice in two weeks. We are also very active with social media. CHC has a Facebook page and we posted a one year anniversary remembrance of our former patient, Jennifer, who we helped send to Indianapolis last year to meet Jeff Gordon. That story received over 500 hits, compared to our normal 200-300. • A copy of the April PEPPER Report is included in the board packet. CHC is well below the threshold of any concerns, but we also are looking at whether we are too conservative in admissions. Don. S. met with the CMS. If a patient is appropriate, we should admit them. One of our community liaisons is retiring, so we are in the process of recruiting for that position. We met last week with a local oncology provider and they are getting pressure from commercial insurance on when they make a referral to hospice. It is part of a cultural shift in health care. Insurance companies don't want to spend money on things that don't work.	
4. Finance Committee	• We are in good financial health and stability. Recently we rebalanced our pools and transferred $3.9 million to our investment funds. This is an equity transfer between CHC and the Hospice Foundation. • As of 07/31, total assets were $32.9 million. Operating income $1.4 million, beneficial interest $459,000, total revenue $1.8 million, total expenses $1.4 million, net gain $463,000, without the beneficial interest July had a net gain of $4,804. YTD operating income $10.1 million, interest and other income $1 million, total revenue $11.1 million, total expenses $9.6 million, net gain $1.5 million, without beneficial interest net gain $614,000. Pages 3 and 4 of the statements show the variances between actual and budget. Operating revenue is $397,000 under budget, and expenses $342,000 under budget. The last page of the statements contains information for June. • Medicare sequestration cuts for hospice began on April 1. We budgeted for the	

Topic	Discussion	Action
	sequestration for the entire year. A couple years ago we were having Receivables problems, so last year we budgeted a large reserve for uncollectible account. There is still a large reserve remaining, so any bad debt this year will be written against that reserve. This will allow us to reinvest the balances. The decision to write off bad debts is not made lightly. Staff works to collect it. Anything written off has to be signed off by the billing coordinator and then Karl. There have been times when we have written off a debt and later collected it. • A motion was made to approve the June and July financial statements as presented. The motion carried unanimously.	A. Mauro motioned M. Newbold seconded
5. Foundation Update	• The ribbon cutting and open house were held yesterday. Over 250 people attended. A hard copy of the open house program is available at your place setting today, along with a copy of the article from the South Bend Tribune article Thank you to those that attended. • The Fifth Annual Bike Michiana for Hospice is 09/15. Registration is about 25% ahead of last year. We expect over 1,000 riders. We can always use volunteers throughout the day for the event. We do have everyone sign a liability release. Most cyclists know it is not a risk free endeavor. All riders are required to wear helmets. We have liability insurance and we disclose all our events to our insurance carrier. • Fundraising continues to track about 4-5% ahead of last year. • Walk for Hospice was at Beutter Park on 08/11. Thank you for those that participated. We raised more money than last year, but with fewer walkers. There were over 400 walkers. One of the projects for our summer Film / Television interns is putting together a promotional video for next year's Walk. They are creating 30 and 60 second PSAs for our website that will hopefully run on TV as well. • Mike and other staff will be leaving on Monday for Uganda to begin work on the second documentary, "Road to Hope." The fund, which focuses on children caregivers, has raised over $10,000. The fund helps get the children enrolled in school or a boarding school and ensures they are taken care of. PCAU identifies the children, an application is submitted to Rose, and she determines whether the child will be enrolled. 14 children are using the fund	

Topic	Discussion	Action
	now. The need is not unique to Uganda, it is world-wide. That is why we will also film programs in Kenya and South Sudan and talk to people from the U.S. who have gone there to make a difference and what inspired them to do it. Actress Torrey DeVito is also going on the trip. She is the national NHPCO Ambassador for NHPCO. Don S. said what CHC has done with its FHSSA partnership is the strongest of any of the nearly 100 agencies involved in the partnership program.	
6. Board Education	• Don Schumacher gave an update on the hospice industry. The board asked about the next frontiers before we become complacent. Don said CHC is way ahead of the curve in many ways. We have wonderful management of the organization. We should stay the course and continue our current direction. He will give Mark his Power Point presentation to be posted on the CHC board website.	
Adjournment	• The meeting adjourned at 1:20 p.m.	Next meeting 10/23

Prepared by Becky Kizer for approval by the Board of Directors on 10/23/13.

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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
October 23, 2013
(*Report posted to Board Website October 17, 2013)*

This meeting takes place in Conference Room A at the Mishawaka Campus (MC) at 7:30 AM.
This report includes event information from August 22 – October 23, 2013.
The Hospice Foundation Board meeting will begin at 9:00 AM in the same room.

CENSUS

September census rebounded remarkably across all offices / locations and hit the highest levels so far for calendar year 2013 with an average daily census (ADC) of 334 – a 7% increase since July. September 25 thru September 29 saw year-to-date single day highs of 342 each day. September's ADC of 334 compares favorably to same month comparison numbers of 323 in 2012 and 310 in 2011. Year to date (YTD) through September 30, the number of patients served is running 7% ahead of last year and the number of original admissions is running 11% ahead of last year. The numbers of patients served at both Hospice Houses is also running ahead of last year. However, due to late referrals and other issues, the YTD ADC is running 6% behind YTD 2012.

September 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	431	1,583	1,243	79
Original Admissions	124	1,272	1,147	125
ADC Hospice	315.53	301.46	323.86	(22.40)
ADC Home Health	18.67	19.19	18.91	0.28
ADC CHC Total	334.20	320.65	342.77	(22.12)

August 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served		1,459	1,377	82
Original Admissions	137	1148	1,038	110
ADC Hospice	302.19	299.72	326.63	(26.91)
ADC Home Health	19.26	19.25	18.59	.66
ADC CHC Total	321.45	318.97	345.22	(26.25)

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	**2013** Sept	**2012** Oct	**2012** Nov	**2012** Dec
S.B.:	181	188	193	194	189	175	174	189	195			186
Ply:	58	54	59	60	59	61	60	57	65			64
Elk:	59	63	68	62	68	70	70	68	66			616
SBH:	6	6	6	5	6	4	5	4	5			4
EKH:	1	4	4	4	6	4	4	3	4			4
Total:	305	315	330	325	328	314	313	321	334			319

HOSPICE HOUSES

September 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%

August 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 431 patients served in September, 157 resided in facilities and of the patients served in August; 148 resided in facilities. The average daily census of patients in skilled nursing homes, assisted living facilities, and group homes during September was 117; August was 112 and YTD through September was 111.

FINANCES

Karl Holderman, CFO, reports that the September and year-to-date September 2013 Financials will be posted to the Board website on Friday morning, October 18th following Finance Committee approval. They will review both August and September at that time. The draft, non-approved August 2013 financials are below.

August 2013 Financial Information

Center for Hospice Care

(Numbers include CHC's beneficial interest in the Hospice Foundation including its loss / gain)

August Overall Revenue	$	1,287,960	Year to Date Overall Revenue	$	12,463,712
August Total Expense	$	1,467,397	Year to Date Total Expense	$	11,119,076
August Net Gain	$	(179,437)	Year to Date Net Gain	$	1,344,636

Hospice Foundation

August Development Income	$	179,297	Year to Date Development Income	$	762,648
August Investment Gains (Loss)	$	(244,205)	Year to Date Investment Income	$	898,148
August Overall revenue	$	(64,819)	Year to Date Overall Revenue	$	1,717,319
Total August Expenses	$	153,772	Total Year to Date Expenses	$	1,025,937
August Net Gain	$	(218,591)	Year to Date Overall Net	$	691,382

Combined

August Overall Revenue	$	1,441,732	Year to Date Overall Revenue	$	13,489,647
August Overall Net Gain	$	(178,437)	Year to Date Overall Net Gain	$	1,344,636

At the end of August 2013, Center for Hospice Care's Year to Date Net without the beneficial interest in the Hospice Foundation was $653,254.

At the end of August 2013, CHC and HF combined had a net without investments of $446,488.

At the end of August 2013, the Foundation's Intermediate Investments (formerly known as Pool Two) totaled $4,308,774. Long Term Investments (formerly known as Pool Three) totaled $13,995,012.

CHC's assets on August 31, 2013, including its beneficial interest in the Hospice Foundation, totaled $32.4MM. At June 30, 2013 HF's assets totaled just over $28.1MM and debt associated with the Mishawaka Campus project totaled just over $5.1MM.

CHC RETIREMENT PLAN AUDIT

Recently, the corporation's staff 403B Tax Sheltered Annuity Retirement Plan became large enough to hit a threshold under relatively new regulations to require an annual outside audit of the Plan. This 2012 audit will be on the Board Agenda. Like any financial audits, it will also be on the Agenda for the Finance Committee's Review at their meeting of October 18, 2013. We would like to have the board accept this audit at the board meeting. This audit is posted as a separate document from this report on the board website. If you have any questions regarding this audit, please direct them to Karl Holderman, CFO, or myself.

CHC VP/COO UPDATE

Dave Haley, VP/COO, reports we have received the fully executed Practice Letter of Agreement between the Mayo Clinic in Rochester, MN and CHC to allow for Hospice and Palliative Medicine Fellows to rotate for training through our agency. The first Fellow will be Dr. Jennifer Kuyava. Her rotation will be from March 17 to April 11, 2014. Additionally, Dr. Nicholas Kerr, a Family Practice Resident with St. Joseph Regional Medical Center has currently begun his rotation in Hospice and Palliative Medicine with CHC.

We have been notified by UnitedHealth Group that our agency has been approved to become one of their contracted network providers. This covers both our Home Health and Hospice services and has an effective date of November 1, 2013. This culminates a long application process we went through which began in December of 2012.

Dave Haley's Census Charts are contained as an attachment to this report.

DIRECTOR OF NURSING UPDATE

Donna Tieman, RN, DON, reports efforts continue in the development of a formal CHC Pediatric Hospice and Palliative Care program. The fourth in a ten series education module for Pediatric end of life care was attended by the nursing department. Completion of this ten module series will certify our nurses as pediatric end of life specialist. A committee of six nurses and managers are creating a pediatric hospice documentation of care tool to install into the Cerner electronic medical record. This tool will guide our nurses in providing and capturing the most appropriate, high quality care for the pediatric patient.

The 2013 flu season is underway and CHC has begun CDC recommended flu clinics to ensure our staff and patients are protected against an influenza outbreak when it occurs.

Plans are in process for the 3rd Annual CHC Blood Drive for the South Bend Medical Foundation which will occur in January, 2014. SBMF supplies life-saving blood products not only for the

South Bend area, but Elkhart and Plymouth as well. We plan two separate donation sites for the upcoming event. The original donation site will be held in the South Bend office. This year a second site will be established at the Mishawaka campus and CHC will be inviting the surrounding community to participate in this drive. Amy Tribbett, Director of Marketing and Access, will work with the Nursing department to create community education surrounding the blood drive.

HOSPICE FOUNDATION VP / COO UPDATE

Mike Wargo, VP/COO, Hospice Foundation (HF), reports…

Fund Raising Comparative Summary

Through September 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	783,993.15
September	913,852.09	671,103.04	724,782.28	736,557.59	864,352.82
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	99,331.27
September	55,710.51	85,629.27	94,000.56	92,808.58	80,405.67
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**	**760,467.43**

Special Events & Projects

In addition to the August 11th Annual Walk for Hospice, which raised $34,693 this year (a more than 10% increase over the 2012 Walk), two other major events were held in August and September. The Mishawaka Campus ribbon-cutting ceremony on August 20th welcomed more than 250 visitors to the new campus for the ceremony, an open house (which included tours of the facility) and a VIP reception. The press conference prior to the ceremony was covered by WNDU and WSBT. The event also was featured on the front page of the South Bend Tribune.

The 5th Annual Bike Michiana for Hospice on September 15th set a new record for participants with 1,231 registered riders; more than 125 people registered the day of the event to ride on a rainy day. The event raised $83,637.26. We had three riders from New York, three from Pennsylvania, one from Rhode Island and one from Arizona. The event was heavily promoted via social media and press releases to riders in the Chicago area as well as Indianapolis, Fort Wayne and Kalamazoo; this resulted in more than 85 registered riders from those locations. The event also made the front page of the South Bend Tribune the following day. WNDU and ABC57 both covered the event. We are currently surveying riders about their experience and suggestions for improving the event. The volunteer committee will hold a debriefing event in October.

FHSSA/PCAU

PCAU's 5th Bi-Annual Conference was held August 29th and 30th in Kampala. Two CHC staff members, social worker Karen Smith-Taljaard and spiritual care counselor Bridget Hoch were selected from among four CHC staff members who submitted proposals to PCAU's Scientific Committee to be presenters. During the week following the conference, Karen and Bridget worked alongside their African counterparts; Karen was at Hospice Jinja while Bridget worked with peers from Hospice Africa Uganda and Kawempe Home Care, both located in Kampala. Two other CHC employees, CHC social worker Betsy Lattanner and staff RN Karen Hudson were invited to submit posters for display at the conference.

The conference was co-sponsored in part by CHC/HF and attended by 400 delegates from Africa, Europe and the US. In addition to representation from 32 PCAU member organizations, 70 health facilities were also represented.

Road to Hope Film Documentary Project

Filming for the *Road to Hope* took place in Uganda, Kenya and South Sudan during August and early September. The film crew included: actress and national Hospice Ambassador Torrey DeVitto; Mike Wargo; Denis Kidde, HF International Programming Representative; Tim Wolfer, filmmaker with Wolfer Productions in Berrien Springs, MI; and, Marty Flavin and Collin Erker, recent Film, Television & Theater graduates from Notre Dame and summer interns with HF. The film will focus on the plight of the orphaned children who were often times the sole caregivers for their parents as they were dying.

The documentary will explore what happens to these children - where they go, how they cope, how they receive an education. It will also spotlight some of the people and organizations that are devoted to helping them move on with their lives and to become happy, healthy and productive adults. More than 60 hours of footage was filmed during the three and a half week shoot. The task

of editing has begun. Notre Dame Department of Film, Television & Theater faculty member Ted Mandell, who edited and co-directed Okuyamba, will be the film's editor. Collin and Marty will serve as assistant editors, continuing to work at least through mid-December on cataloguing, organizing and labeling clips, as well as constructing potential scenes for Ted's use in final editing. The target date for completion is August 2014, so it is ready for submission to major film festivals in time for their 2014 season.

To further extend our collaborative efforts with area universities, Mike is currently in conversation with composer and IU South Bend Dean of the Arts Marvin Curtis and two of his faculty colleagues, Jorge Muniz and Thom Limbert about composing an original score for the film. If this appears to be feasible, then it is anticipated that other IU South Bend faculty and student musicians will become involved in helping to create the finished product.

The documentary has already garnered a great deal of attention via social media thanks to Torrey's promotion of the project via Twitter and Instagram. The film's Facebook page currently has 328 likes and 144 followers on Twitter. The web site, www.roadtohopefilm.org, features a blog written by Collin Erker during the production and also contains additional information about the program and film.

Mishawaka Campus

The City of Mishawaka has completed its improvements to the fish ladder, including installation of a new sculpture, and is getting very close to completion of the River Walk extension. This has enabled us to perform final grading of our adjacent land as well as to begin installing sprinklers and some plantings before winter hits. Chris Chockley, our landscape architect, is working on construction drawings for the grounds completion phase of the project and will have budget figures to us in time for inclusion in the 2014 capital expense budget. This phase will include provisions for a veteran's memorial, wind sculpture, walking paths, brick memorial garden, sitting areas, trees, shrubbery and fencing to extend around our the entire perimeter of our property. Work on this phase is expected to commence once the ground thaws in the spring and will continue through summer 2014.

Annual Giving

Through the end of September the 2013 Friends of Hospice appeal has raised $42,512.98, which brings it very close to its goal of $45,000. 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

A donor survey has been developed and mailed to donors at the Helping Hands Society level and above ($1,000+). The survey is also available online and will be rolled out to other donor constituencies via the November e-newsletter and the fall issue of Crossroads.

The Foundation, Walk and Bike web sites continue to be updated on an on-going basis. The Walk and Bike sites feature photo galleries of this year's events. The Bike site also includes an

opportunity for participants to purchase t-shirts and jerseys still in stock; a link was included in the survey email.

The Foundation (as well as CHC) will be using an improved Vocus platform to tie together publicity and social media activities for the Foundation, CHC and Road to Hope. It is also linked to PRWeb, which distributes press releases to targeted media outlets, bloggers and others across the country and around the world. The Foundation, CHC and Road to Hope will share 10 releases per month.

Third-Party Fundraising

Highlights of third party fundraising in August and September included the 15th Annual Joseph E. Smith Charity Golf Outing held at Blackthorn Golf Course on August 7th and once again sponsored by the North Central Indiana Chapter of the National Association of Insurance and Financial Advisors (NAIFA). This year's event raised $6,000. Since the event's inception, the NAIFA golf outing has raised over $78,000 for Center for Hospice Care.

The Foundation made a presentation to Gates Automotive Group employees on September 26th as part of the organization's community giving sign-up. For the third consecutive year, Gates employees have chosen four local organizations, including Center for Hospice Care, to support through payroll deduction. Their donations will be matched by both Gates Automotive and Toyota Motor Corporation.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

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

Outreach and Liaison News in August & September

During August alone, our three fulltime Community Liaisons visited more than 100 Physician Practices and made 56 visits to ALFs / ECFs. Nearly 40 visits were made to our service area hospitals. Terri Stahl, after ten years of service, announced her retirement in September. The community liaison role was slightly modified before recruiting began for Terri's replacement. A stronger focus on a clinical/sales background was established and the search began. Dee Aguayo, RN, BSN, MBA, was hired as CHC's newest liaison, having a strong clinical/sales/marketing background. Her career has featured 20 years in the health care sales industry, including time at VITAS Hospice in Florida and Genetech in Chicago.

Referral Meetings, Lunches, Senior Networking and Speaking Engagements

- Elkhart Clinic Oncology Breakfast.
- Elkhart Clinic Internal lunch.
- Lunch and Learn at Senior Activity Center in Warsaw - Consider the Conversation. 80 attendees
- Grief Forum at Heritage House in Nappanee.
- Presentation: to more than 50 members of Notre Dame Community Outreach – Seniors
- Presentation: to Ethics class at National College

- Participant in Vendor Resource event for SJRMC Family Practice residents at SJRMC.
- Breakfast with Marshall County Family and Internal Medicine. CHC staff physician, Jon Kubley, MD was the featured speaker.
- Veteran's club at Greenleaf. Attended by veterans, we had the opportunity to talk about our special veterans' programs and hospice. They veterans really seemed to enjoy themselves. We are going to go back in November and do our Veterans Day special tribute with pinning and certificates. We will be doing the veterans clubs quarterly in various ECF's and ALF's.
- Hosted a similar vet's club at Eastlake ECF.
- Greenleaf Living Center ECF/AL – attended the Advisory Board Meeting.
- Lunches were had with Dr. Del Pilar's office, Main Street Family Medicine, Midwest Cardiology, Dr. Zibohs office, Donna Woodworth, Nurse Practioner for Pulmonology Inc. (at Memorial), Dr. Kristl, St. Joseph VNA, Senior 1 Care, Akron Family Practice, Johnson Rd Internal Med – La Porte

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

The CHC Hospice Referral App is now available in Google's Play Store for Android-based phones and tablets and at the App Store for iPhones and iPads. Rather than having to fax a written order, CHC's Hospice Referral app allows physicians to refer patients for care online wherever they are — whether visiting hospitalized patients or talking with families in the office. While we do not believe this app will change our world as we know it, we do believe that the use of the app can mean more efficient admissions, a smoother transition to hospice that maintains continuity of care, and more effective communication. We also believe there is value in CHC being the first to debut such a tool for hospice in our area. The liaison team will be meeting with area referral sources to debut the App. Marketing materials include a self-mailer with App background, a smart phone screen cleaner and a stylus. Each board member attending the board meeting will receive the self-mailer packet. The App is also featured in the fall issue of H&P, our physician newsletter, which will be mailed by October 20.

CHC ATTAINS LEVEL FOUR PARTNERSHIP IN NATIONAL "WE HONOR VETERANS" PROJECT

To reach this highest pinnacle level, CHC focused on increasing access to and improving the quality of care Veterans received throughout our eight-county service area in northern Indiana. Our staff and volunteers have worked very hard to make this happen and many steps were taken, including increasing the integration of Veteran-specific education for staff and volunteers, evaluating and growing our Veteran-to-Veteran Volunteer Program, developing resources to help our Veterans and their families' access benefits, along with continually evaluating and implementing better ways to improve care and service to Veterans and their families throughout our organization. Nationally, there are nearly 2,000 We Honor Veterans Partners and only 96 have achieved the We Honor Veterans Partner Level 4. This is a huge accomplishment not only for our agency, but for the deserving Veterans we serve each and every day. We Honor Veterans is a national hospice provider awareness program conducted by the National Hospice and Palliative Care Organization in collaboration with the Department of Veterans Affairs.

CHC IS AN EDUCATION DESTINATION

As a point of information, please know that CHC now has formal written agreements to provide education and training with the following educational organizations.

Physician Education

Mayo Clinic
Indiana University School of Medicine
Residency Programs of Memorial Hospital and SJRMC
Midwestern University (Glendale, AZ)

Nursing Education

Ball State
Bethel College
ITT Institute
Grace College
Indiana University South Bend
Saint Mary's College
Indiana Wesleyan

Social Work

Indiana University South Bend

Spiritual Care

Moreau Seminary

Health and Human Services

Western Michigan University

CHC also has non-written but collaborative educational affiliation arrangements and experiences with the following institutions in various discipline areas.

University of Notre Dame
Ball State University
Goshen College
Valparaiso University

NATIONAL UPDATE: GOVERNMENT SHUTDOWN ENDS; DEFAULT AVOIDED

With assistance by way of being a board member of the national Hospice Action Network (HAN) -- the National Hospice and Palliative Care Organization's (NHPCO), legislative advocacy

corporation -- I am pleased to provide a quick update of the 10/16/13 Capitol Hill activity and what it means to the hospice industry.

As we all know, the immediate national crisis has been averted, but all Medicare providers will remain exceptionally vulnerable while the various deadlines play out and deficit reduction negotiations continue.

A Deal is Reached

Congress has passed, and the President has signed into law, a package to temporarily lift the debt ceiling and end the 16 day government shutdown. The last-minute deal provides the economy with stability through the end of the year by doing the following:

1. Funding the government at current (FY2013) levels through a Continuing Resolution (CR) to January 15, 2014
2. Extending the nation's borrowing authority under the debt ceiling through February 7, 2014.
3. Requiring the appointment of a bipartisan, bicameral committee to create a detailed tax and spending deal for the next decade by December 13
4. Requiring income verification for premium subsidies for the health insurance exchanges in the Affordable Care Act

What it Means for Hospice

In the short-term, payments to Medicare providers, including hospice, will not be interrupted. Hospices will continued to be paid at the same Medicare reimbursement rates that they were prior to October 1, including the 2% deduction from the ongoing sequester.

In the coming weeks, Congress will grapple with the above issues, in addition to the ongoing matter of whether or not to permanently replace the physician's formula for Medicare reimbursement (commonly referred to as "SGR" for Sustained Growth Rate), as well as how / if to replace the sequester.

NHPCO and HAN have been preparing for these scenarios all year and generated the data and materials to support our messaging strategy on the Hill. Through our national voice, we will continue to take the following messages to the Hill through the end of the year and until this round of crisis economic negotiations pass: (There are live Internet links in the bullet points below)

1. The Medicare Hospice Benefit provides high-quality, cost-effective end of life care to patients and their families.
   MHB Overview
   Mt. Sinai Study on Hospice Cost Effectiveness
   Key Points on Hospice Cost Effectiveness

2. The hospice community is hurting, and no additional cuts or changes to the community should happen without adequate data to measure impact on access.

NHPCO's Economic Impact Study *(forthcoming)*
Moran Hospice Margin Analysis

3. Medicare Reform Efforts should continue to treat hospice as it is now for deductibles and copays.
   Hospice and Medicare Reform

4. The hospice community is proactively pushing to Congress some program integrity proposals to convince them that hospice need not be cut to weed out any unscrupulous providers.
   Hospice Program Integrity Proposals

I am committed toward keeping the CHC board informed with additional information as these issues continue to unfold in the coming months.

CHC SELECTED FOR MEDICAID INTEGRITY AUDIT

At each board meeting for the last several years we have been discussing increased scrutiny of hospice providers by various government agencies and contracted auditors. We have spent a great deal of time going through the various alphabet soup of potential auditing agencies that have been hitting hospices across the nation in an attempt to retroactively recoup funds paid for patient care going back many years. During the week of October 7, CHC was notified that it had been selected for a Medicaid Integrity Audit (MIC) to determine hospice eligibility for hospice Medicaid patients from October 1, 2008 – February 29, 2012. The audit will be conducted in-person by representatives of Health Integrity, LLC, a for-profit government contractor responsible for these audits across all provider types for the state of Indiana. We are to receive additional information in a few weeks. While we have been through many different types of audits previously, including Medicaid audits, this is the first MIC audit our program has experienced.

Briefly, the Medicaid Integrity Program was established under the 2005 Deficit Reduction Act as a method to give CMS greater direction to act within the states to enforce Medicaid eligibility and compliance rules – traditionally, the federal government had not interfered in the state's control of the Medicaid program, even though Medicaid funding is 60% federally supported. With CMS involved, contracted entities were needed to provide the audit and enforcement activities on behalf of CMS. Health Integrity, LLC (www.healthintegrity.org) owns the Audit MIC for Indiana. Audit MICs review Medicaid claims and associated documentation – they can look back as far as is permitted by state statute. Unlike some other government contracted auditors, the MIC vendors do not operate under a contingency and do not receive a percentage of recoupments identified. When MIC audits first began, the Office of Inspector General was critical of the process because they frequently didn't find anything to recoup and were advised to look closer. Identified overpayments under a MIC audit are processed by the state paying any overpayment recoupment directly to the feds (CMS) and then the state must seek payment from the provider at that point.

We will keep you posted. We do believe that this may be the beginning of a long line of distractions as we begin to experience what so many other hospices – as well as healthcare

providers of all types – are currently going through with the increased scrutiny of Medicare and Medicaid.

REVISED HIPAA POLICIES ON AGENDA FOR APPROVAL

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. CHC 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. Due to the size of these policies and related documents, they are a separate document download on the board website. Ziel skillfully assisted CHC through its HIPAA breach circumstances in August of 2011. A conference call with Ziel and the Administrative Team and our internal Security and Privacy officers was held to review the policy changes followed by training of staff at our September 25, 2013 All Staff Meeting. All of our HIPAA policies are now in compliance with the revised regulations. As with all CHC policies, we ask the board to approve these policies at our upcoming meeting. Karl Holderman, CHC Privacy Officer for HIPAA purposes will present these policies. These policies and their changes are required under updated regulations which went into effect on September 23, 2013. CHC has been and is currently operating under DRAFT policies that meet the regulations until the board passes the policies at this meeting.

REVISED BYLAWS ON AGENDA FOR APPROVAL

The Bylaws Committee, consisting of Jim Brotherson, Corey Cressy, Julie Englert, Amy Kuhar Mauro, Mary Newbold, Terry Rodino, and Wendell Walsh, met recently – a year prior to the required Bylaws review as mandated within the Bylaws – and has some recommendations for changes at this time. The Committee met primarily to suggest changes to the start / end time to board terms to bring them in line with our fiscal year, open up Board Committee membership, and remove responsibilities that are now assumed by the creation of the Hospice Foundation. There are also some clean-up recommendations made. A redlined copy of the CHC Bylaws is included as an attachment to this report.

2012 IRS FORM 990 TO BE INCLUDED AS PASSWORD PROTECTED .PDF FILE ON FLASH DRIVE TO BE MAILED TO BOARD ON 10/25/2013

Although not required under any IRS regulation, the CHC Executive Committee and HF Board met with David Culp and Co, LLP on Wednesday, October 9th for a summary review of the Form 990s (the IRS non-profit "tax" return) for CHC and for the Hospice Foundation – two separate Form 990s. In addition to the annual audit, Culp also prepares our 990. The 40+ page 990 is largely comprised of the 2012 audited financials which the board accepted earlier this year and contains a great deal of financial information. As we have done in previous years, the CHC Form 990 will be

mailed on a flash drive to the 2012 CHC Board and likewise the HF Form 990 will be mailed to the HF board on 10/25/2013. The filing deadline is November 15, 2013. This 1GB CHC logo flash drive is yours to keep. Although password protected, we recommend you delete the 990 before putting the flash drive into personal use. The password for the CHC 990 .pdf will be " 2012_C4HC990f! " without the quotation marks.

If you have any questions about the 990(s) or the flash drive, please directly contact Karl Holderman, CFO, or myself. Karl and I are the only two staff members employed by both corporations and the only staff members involved with both documents.

OUT AND ABOUT

I attended the NHPCO / NHF / HAN, FHSSA, and Council of States Combined Board and Committee meetings during the Clinical Team Conference in Kansas City, MO September 24 – 28.

Six staff members, including CHC staff physician, Amber Burger, MD, attended the NHPCO Clinical Team Conference in Kansas City, MO, September 26 – 28. Dr. Burger also attended a two-day pre-conference intensive on pediatric palliative care.

CHC staff physician, Amber Burger, MD, participated in "Expert Panel Discussion: Palliative and End of Life Care" at the Beacon Board Forum, October 4 and 5 in Chicago, IL.

CHC staff physician, Amber Burger, MD, spoke at Memorial Children's Hospital Pinwheel Symposium on Pediatric Palliative Care on October 12 here in South Bend.

I attended the National Hospice Executive Roundtable (NHERT) meeting in Clearwater, FL October 13-15 held at Suncoast Hospice, the largest not-for-profit hospice program in the U.S. The meeting included a tour of one of their inpatient units and their PACE program. For benchmarking and best practice discussions, the 11 NHERT member programs also included their lead clinical staff member during one full day of meetings. CHC's Donna Tieman, DON, joined me and presented to the full group of CEOs and Clinicians on October 15.

CHC Chief Medical Officer, Greg Gifford, MD, presented at the Michiana Gerontology Institute Conference on "Choosing How to Live: Using POST to Become the Compassionate Community" at Holy Cross College on October 23.

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

Dave Haley's Census Reports.

Article of interest, "Minorities Unlikely to Choose Hospice Care" from MedPage Today

Book excerpt, "Knocking on Heaven's Door: The Path to a Better Way of Death"

Article of interest, “Trends in Cancer Care Near the End of Life: A Dartmouth Atlas of Health Care Brief.”

Article from “The Commitment,” the IUSMSB-ND School of Medicine newsletter regarding CHC and the school working together.

ADDITIONAL MATERIALS FOR THIS MEETING POSTED TO THE BOARD WEBSITE

Due to its size, the revised HIPAA policies are posted as a stand-alone and separate file from this President’s Report.

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

September 2013 and Year to Date Financials.

Promotional materials for “Healthy Grieving” session held in Lagrange, the “Age of Champions” lunch and a movie, and the CHC App marketing package.

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, December 18, 2013 at 7:30 AM** in Conference Room A, 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 .

# # #

9-16-13

South Bend TRIBUNE

SouthBendTribune.com @ SouthBendTribune @ SBTribune

'MIDWEST'S PREMIER RIDE'

Cyclists ride north on Laurel Road near St. Patrick's County Park on Sunday during the fifth annual Bike Michiana for Hospice Ride, which benefits the Center for Hospice Care and the Bike Michiana Coalition. **SBT Photos/MIKE HARTMAN**

Record numbers participate in Bike Michiana for Hospice Ride

By Christian Sheckler
CSheckler@SBTinfo.com

LEFT: A bicyclist stops for a drink of water Sunday afternoon at Elbel Golf Course. ABOVE: Mark Zalewski of SRAM Neutral Race Support repairs an inner tube for Joe Urbanski.

SOUTH BEND — Fresh off a 100-mile bicycle ride under gloomy, drizzly skies, Sandy Zielinski hopped off her road bike Sunday afternoon at St. Patrick's County Park.

"Whew, that was fun!" she exulted.

Zielinski, of South Bend, was among a record-setting number of cyclists, from families to hardcore riders, who participated in this year's Bike Michiana for Hospice Ride, which benefits the Center for Hospice Care and Bike Michiana Coalition, organizers said.

The fifth annual ride drew an estimated 1,100 to 1,200 cyclists and likely outraised last year's fundraising total of $54,000, said Cyndy Searfoss, director of communications and annual giving with the Center for Hospice Care.

"We know we set a record as far as attendance," Searfoss said. "We've seen a lot of growth every year — we bill ourselves as the Midwest's premier ride."

Since 2009, when the ride debuted with fewer than 500 cyclists, it has grown to become the Center for Hospice Care's second-largest fundraiser after the agency's annual spring dinner, Searfoss said. Last year, the event drew about 974 participants, she said.

Cyclists flock to the ride for its well-planned course, which offers unique food offerings and live music at rest stops along the way, not to mention the satisfaction that comes with helping a good cause.

"The routes are amazing, the roads are good, everybody who's riding is so nice and friendly," said Zielinski, who has participated each of the past three years. "Plus the food is wonderful, and it's a good cause."

Joe and Joyce Dunfee, of South Bend, said they enjoyed the ride itself but also like to support the Center for Hospice Care because some of their family members have received Hospice care.

"We enjoy being outside, we do cycle and we like to support Hospice, so it's a trifecta," Joyce Dunfee said.

Organizers said the ride, which is co-sponsored by the Bike Michiana Coalition, also draws many out-of-town and out-of-state cyclists, largely because of the unique rest stops, known to cyclists as "support and guidance," or SAGs.

Judy Lee, of the Bike Michiana Coalition, said the ride has drawn many participants from Chicago and Indianapolis, along with others from Michigan, Wisconsin, Illinois and even as far as Rhode Island.

"Every year we get people from outside the community — probably states I don't even know yet because I haven't seen the final roster," Lee said.

Distance options for the ride range from as short as 3 1/2 miles to 125 miles. Most years, the 40- and 60-mile routes are the most popular, Lee said. The SAG stops, placed roughly every 20 miles, each featured local fare, from Irish to Jimmy Buffett-themed. An Austrian-themed stop offered brats, sauerkraut and polka music.

"I especially enjoyed the German 'oom-pah-pah" band at Spicer Lake," said Lynn Schram, or Granger. "That was a nice touch."

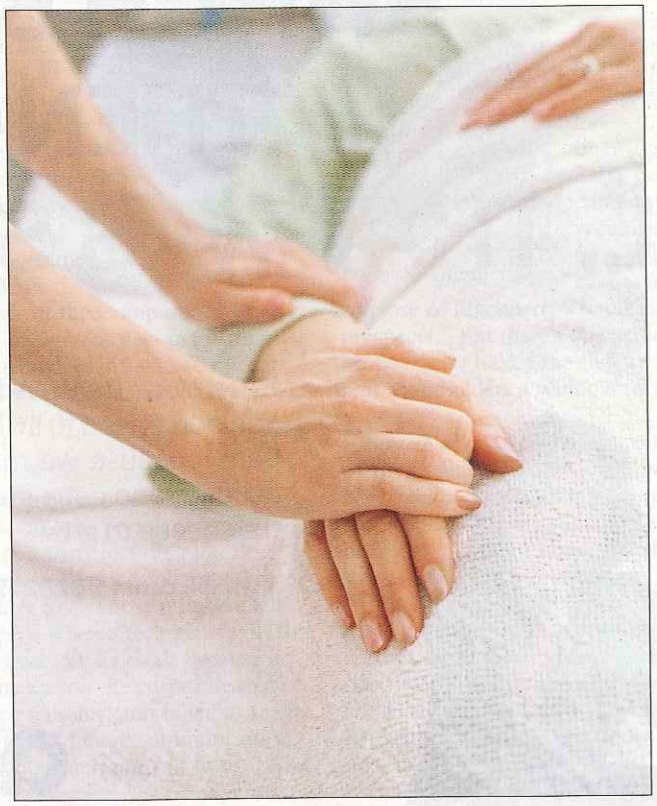
As cyclists enjoyed food and beer at the post-ride party at St. Patrick's, Zielinski said her 100-mile ride was a fitting end to the cycling season.

"It's easier to do the longer distance toward the end of the season because that's what we work toward," she said. "It's a fun way to end the cycling season."

A better way of death

My mother faced death on her own terms, said Katy Butler, and in doing so set a good example for all of us.

MY MOTHER DIED shortly before her 85th birthday, in a quiet hospital room in Connecticut. One of my brothers was on the phone down the hall, telling me to jump on a plane. We were not a perfect family. She did not die a perfect death. But she avoided what most fear and many ultimately suffer: dying "plugged into machines" in intensive care, or being shocked during a futile cardiopulmonary resuscitation, or dying demented in a nursing home. She died well because she was willing to die too soon rather than too late.



'The way we say we want to die': At home, with loved ones

Don't get me wrong: My mother, Valerie de la Harpe Butler, loved life. She and my father, Jeffrey, left their South African homeland in their 20s, bursting with immigrant vigor, raised three children (all of whom ultimately moved to California), and built a prosperous life in the U.S. My father became a college professor. My mother, an amateur artist, practiced Japanese calligraphy and served tea at four without fail. She got breast cancer in her 40s, and after two mastectomies and radiation, she put up her blonde-streaked hair in its classic French twist and returned to the world as the beautiful woman she'd always been. Even as she approached 80, she hiked two miles a day, weeded her garden, and stained her own deck.

She also spent six years as a family caregiver, after my father had a crippling stroke when he was 79 and she was 77. A hastily inserted pacemaker forced his heart to outlive his brain. His medically prolonged dying made her painfully aware of health care's default tendency to promote maximum longevity and maximum treatment. It wasn't what she wanted for herself.

She was not alone. In California, my home state, a 2012 survey by Lake Research Partners and the Coalition for Compassionate Care of California found that 70 percent of state residents want to die at home, and national polls have registered even higher proportions. But in fact, nationally, less than a quarter of us do. Two fifths die in hospitals, and a tragic one fifth in intensive care. This is an amazing disconnect in a society that prides itself on freedom of choice.

This disconnect has ruinous economic costs. About a quarter of Medicare's $550 billion annual budget pays for medical treatment in the last year of life, and during that time, one third to one half of Medicare patients spend time in an intensive care unit, where 10 days of futile flailing can cost as much as $323,000. Overtreatment costs the U.S. health-care system an estimated $158 billion to $226 billion a year.

WHY DON'T WE die the way we say we want to die? Because we say we want good deaths but act as if we won't die at all. Because lifesaving technologies have erased the line between saving a life and prolonging a dying. Because saying "Just shoot me" is not a plan. The decisions we make and refuse to make long before we die help determine our pathway to the final reckoning. In the movie *Little Big Man*, the Indian chief Old Lodge Skins says, as he goes into battle, "Today is a good day to die." My mother lived that way, and it allowed her to claim a version of the good death our ancestors prized.

In the early spring of 2009, I discovered that my mother, then 84, could no longer walk far without catching her breath. She had developed two perilously stiff and leaky heart valves. In a pounding rainstorm, I drove her to Boston's Brigham and Women's Hospital, where the surgeon told her that if she survived valve replacement surgery, she could live to be 90. Without it, she had a 50-50 chance of dying within two years. My mother weighed the risks of stroke and dementia. Then she said no.

Her later cardiologists were disturbed by her decision, and so was I. But I would later discover that people of my mother's age are often like Humpty Dumpty, seemingly vigorous until a mishap or traumatic surgery sets them on a rapid downward spiral. One of my friends watched her 87-year-old mother die gruesomely after exactly the surgery my mother rejected.

When my mother's "heart failure management" nurse urged me to get her to reconsider, I called and said, "Are you sure? The surgeon said you could live to be 90."

"I don't want to live to be 90," she said.

"I'm going to miss you," I said, weeping. "You are not only my mother. You are my friend."

THIS WAS NOT the world of our ancestors. From the plagues of the Black Death through the 19th century's epidemics of typhoid, childbed fever, and tuberculosis, they helplessly watched people die, from youth to old age. By necessity, they learned how to sit at a deathbed and how to die.

That changed in the 1960s, when doctors and inventors in the U.S. and Europe cobbled together astonishing new medical contraptions, using materials first invented or pressed into military service during World

Media Bakery

War II—nylon, Dacron, silicon, plastics.

Dialysis, open-heart surgery, CPR, the 911 system, defibrillators, safer surgical techniques, pacemakers—a whole panoply of lifesaving inventions transformed medical practice and all but abolished natural death. Dying moved from the home to the hospital, obliterating Western death rituals, and changing the way everyone behaved at the deathbed. Dying was transformed from a spiritual ordeal into a technological flail.

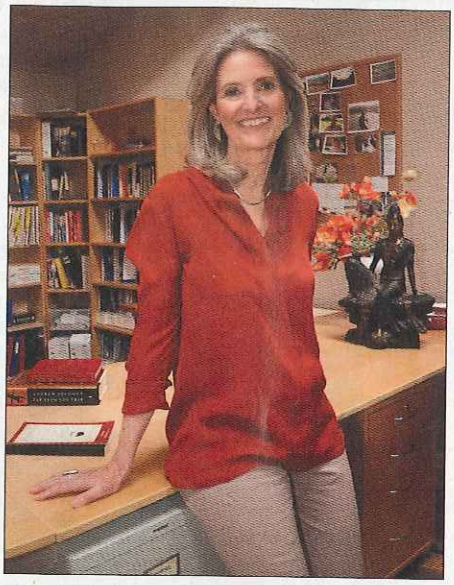
Family members were restricted to visiting hours. Often there were no "last words" because the mouths of the dying were stopped with tubes and their minds sunk in chemical twilights to keep them from tearing out the lines that bound them to earth. Months after an ICU death, family members experience high rates of anxiety, depression, and symptoms of post-traumatic stress.

As this technology spread around the world, it transformed the look of the dying body as well. "When I first started out washing and coffining corpses early in 1965, the majority of cases were home deaths," wrote the Japanese Buddhist mortician Shinmon Aoki. "[The bodies] looked like dried-up shells, the chrysalis from which the cicada had fled.... Along with the economic advances in our country, though, we no longer see these corpses that look like dead trees," he wrote in his memoir, *Coffinman*. "The corpses that leave the hospital are all plumped up, both arms blackened painfully by needle marks made at transfusion, some with catheters and tubes still dangling. This tells us that our medical facilities leave us no room to think of death."

In the 1400s, a best-selling how-to book called *The Art of Dying* offered a road map to the deathbed—framed not as a place of meaningless suffering but as a transcendent battleground where angels and demons struggled for control of the soul. Family and friends gathered at the bedside and recited prescribed prayers, giving the dying person reassurance, faith, and hope. Because we do not have such pathways now, it's no surprise that relatives often panic and insist that "everything be done," even things that are torturous and futile. Any plan seems better than no map at all.

That spring my mother fixed cracked windows in her basement and threw out files for the book my father never finished writing. She told someone she didn't want to leave a mess for her kids. Her chest pain worsened, and her breathlessness grew severe. "I'm aching to garden, to tidy up the neglect of my major achievement," she wrote in her journal. "Without it the place would be so ordinary and dull. But so it goes. ACCEPT ACCEPT ACCEPT."

In July, a new cardiologist suggested inserting an experimental mitral valve replacement, performed by floating the device down a vein. "When I mentioned stroke risk," he wrote in his clinical notes, "she immediately was turned off and did not want to pursue further discussion, again desiring only palliative care."



Courtesy of the author

Katy Butler: We need an Art of Dying *for our age.*

THAT AUGUST, SHE had a heart attack. The next day I got a call from yet another cardiologist who had been handed my mother's case. They were preparing her for heart bypass surgery and valve replacement—the very surgery she had rejected five months before.

She seemed to be heading down the greased chute toward a series of "Hail Mary" surgeries—risky, painful, and harrowing, each one increasing the chance that her death, when it came, would take place in intensive care. I later discovered that the cost to Medicare would probably have been in the $80,000 to $150,000 range.

Burning with anger, I told the astonished cardiologist that my mother had rejected surgery when she had a far better chance of surviving it, and I saw no reason to subject her to it now. I later found that in a major study, 13 percent of patients over 80 who underwent combined valve and bypass surgeries died in the hospital. In a smaller study, 13 percent died in the hospital and an additional 40 percent were discharged to nursing homes.

I called my mother in the hospital. I said, "I think we're grasping—"

"—at straws," she finished my sentence. She was quiet. "It's hard to give up hope."

Four hours later she called back. "I want you to give my sewing machine to a woman who really sews. It's a Bernina. They don't make them like this anymore. It's all metal, no plastic parts."

"I'm ready to die," she went on. I could barely recognize my stoic and reserved mother. "Cherish Brian," she said, speaking of my long-term partner. "I *love* Brian. I *love* Brian for what he's done for you."

My mother came home tethered to a portable oxygen tank. She updated her will. A hospice nurse cut off her long white hair. She took digitalis and squirted morphine under her tongue to manage her intense heart pain.

She pulled out her Japanese ink stone and calligraphy brushes and brushed out a final one-stroke circle, what the Japanese call an *enso*. Below it she wrote, "For my memorial service."

I was making flight plans when we talked on the phone for the last time. In an outpouring, I told her how I treasured the memory of her ritual teas and regretted not having picked up more of her domestic elegance.

"But Katy," she said, her voice weak. "You're good at other things. There isn't much time."

That night she was taken to the inpatient hospice unit, with one of my brothers following the ambulance. Once settled into her bed, she took off her hammered silver earrings and said to the nurse, "I want to get rid of all the garbage." Naked she had come into the world, and naked she would return. The next morning she told my brother to call his two siblings in California. By the time he got back, she was dead. He broke into sobs.

She died too soon for my taste. But she died the death she chose, not the death anyone else had in mind. Her dying was painful, messy, and imperfect, but that is the uncontrollable nature of dying. I tell you her story that we may begin to create a new *Art of Dying* for our biotechnical age.

THE DARTMOUTH INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE
Where Knowledge Informs Change
A Report of the Dartmouth Atlas Project

Trends in Cancer Care Near the End of Life

A Dartmouth Atlas of Health Care Brief

September 4, 2013

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Editor: Kristen K. Bronner, MA

Over half a million Americans die each year from cancer.[1] While progress has been made over the last two decades in addressing patient preferences near the end of life, much more needs to be done. Most patients with cancer who are approaching the end of their lives prefer supportive care that minimizes symptoms and their days in the hospital. Unfortunately, the care patients receive does not always reflect their own preferences, but the prevailing styles of treatment in the regions and health care systems where they happen to receive cancer treatment.[2,3]

In analyses of Medicare data that control for patient age, sex, race, tumor type, and non-cancer chronic conditions, the chances that a patient with advanced cancer died in the hospital in 2010 varied from one in eight (13%) to one in two (50%) depending on the medical center providing their care, even among National Cancer Institute-designated Cancer Centers. Similarly, the number of days patients spent in intensive care units (ICUs) in the last month of life varied more than fivefold across these centers. The chances of a patient receiving hospice care differed by a factor of five.

This Atlas Brief and the accompanying data released on the Dartmouth Atlas web site (www.dartmouthatlas.org) report the latest findings on end-of-life cancer care. Since the last Dartmouth Atlas report,[4] the trends in end-of-life cancer care across the country have been mixed (see table).[5] While patients are spending fewer days hospitalized in the last month of life, the number of days in ICUs has increased. Hospice days have also increased, but a growing proportion of patients begin receiving hospice services in the last three days of life, a time period often too short to provide patients the full benefit of hospice care.

Overall Change in Cancer Care

- Nationally, the percent of cancer patients dying in the hospital decreased more than four percentage points, from an average of 28.8% of patients during the period from 2003 to 2007 to 24.7% of patients in 2010. There was also a substantial increase—from 54.6% to 61.3% (more than six percentage points)—in the percent of patients who were enrolled in hospice in the last month of life.

- There was an increase of more than five percentage points in the percent of patients admitted to an ICU during the last month of life, from 23.7% to 28.8%. The percent of patients for whom hospice was initiated during the last three days of life—i.e., the percent receiving a hospice referral very close to death, indicating less opportunity for meaningful palliative care—also increased, from 8.3% to 10.9%.

- The percent of patients who saw ten or more different physicians during the last six months of their lives rose from 46.2% to 58.5%, an increase of more than twelve percentage points, suggesting that more patients may have experienced fragmented care.

- The use of potentially life-sustaining treatments—including endotracheal intubation, feeding tube placement, and cardiopulmonary resuscitation—during the last month of life remained relatively unchanged. Similarly, the average percent of patients receiving chemotherapy during the last two weeks of life was virtually unchanged.

- Most importantly, the pace of improvement was uneven and varied markedly across regions and hospitals, including academic medical centers and NCI-designated Cancer Centers. In the Rochester, New York hospital referral region, the percent of cancer patients dying in the hospital increased more than five percentage points between 2003-07 and 2010, from 25.4% to 30.5%; meanwhile, the percent experiencing death in the hospital fell nearly seven percentage points in East Long Island —from 42.5% to 35.6%—even as the rate in East Long Island remained among the nation's highest. The percent receiving a life-sustaining procedure during the last month of life rose from about 11% to more than 16% of patients receiving their cancer care at the University of Alabama Hospital in Birmingham. During the same period at the H. Lee Moffitt Cancer Center in Tampa, Florida, the percent receiving life-sustaining treatment declined from 14.1% of patients to 8.3%.

Table. National trends in selected measures of the care of cancer patients near the end of life

Measure	2003-07	2010	Percent change, 2003-07 to 2010
Number of deaths among cancer ill patients*	235,821	212,322	-10.0%
Hospital utilization			
Percent of deaths occurring in hospital	28.8	24.7	-14.4%
Percent hospitalized, last month of life	61.3	62.2	1.5%
All hospital days per patient, last month of life	5.1	4.8	-5.2%
Percent admitted to ICU, last month of life	23.7	28.8	21.6%
ICU days per patient, last month of life	1.3	1.6	21.2%
Cancer treatment			
Percent receiving life-sustaining treatment, last month of life	9.2	9.4	3.1%
Percent receiving chemotherapy, last two weeks of life	6.0	6.0	0.7%
Supportive care			
Percent enrolled in hospice, last month of life	54.6	61.3	12.2%
Hospice days per patient, last month of life	8.7	9.1	4.3%
Percent enrolled in hospice within three days of death	8.3	10.9	30.9%
Physician utilization			
Percent seeing 10 or more physicians, last six months of life	46.2	58.5	26.8%

*The estimate for 2003-07 was created by summing a 20% sample over five individual years.

Patients with cancer want to understand their chances and treatment options and to participate in decisions about their care. This is particularly true for those with advanced cancer who need to plan their last months or weeks of life. Some patients elect to continue aggressive care aimed at prolonging life for as long as possible, but most prefer supportive measures that minimize pain and days in the hospital.[2,3] Generally, patients want to spend as much time as possible in a home-like environment close to family and friends.

While there is increased awareness of the importance of discussing personal care preferences with cancer patients, deficiencies in communication are common. In a recent study, the majority of patients with advanced lung and colorectal cancer did not understand that chemotherapy was unlikely to cure their cancer.[6] The good news is that patients who have end-of-life conversations with their clinicians have a greater chance of receiving the type of care they prefer.[7,8] These discussions, especially when occurring relatively early in the course of illness, are associated with greater use of palliative care and hospice and with less aggressive end-of-life care,[9,10] countering a general trend towards more aggressive care in the last months of life.[11,12] High-intensity end-of-life care, by contrast, is associated with poor quality of life and of death, as well as higher costs, and, in some cases, reduced survival.[13,14,15]

Despite the increased frequency of end-of-life discussions, cancer treatment has become more aggressive in general. It could be that some patients prefer more aggressive care, or do not fully understand—or accept—that their life expectancy is limited when expressing their preferences.[7,8] Alternatively, end-of-life discussions may occur too late in the course of illness to have a serious impact on treatment.[9] Previous research has also shown that regional supply of health care resources, such as hospital and intensive care beds and imaging equipment, is one driver of the intensity of care, irrespective of the patient's particular condition or illness level.[16,17] Regardless of the cause, the findings presented in this brief suggest that there is more work to be done to ensure the wishes of cancer patients facing the end of their lives are elicited, understood, and honored.

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Minorities Unlikely to Choose Hospice Care

Published: Sep 13, 2013 | Updated: Sep 15, 2013
By Salynn Boyles, Contributing Writer, MedPage Today

Reviewed by F. Perry Wilson, MD, MSCE; Instructor of Medicine, Perelman School of Medicine at the University of Pennsylvania and Dorothy Caputo, MA, BSN, RN, Nurse Planner

Cancer patients were more likely to enter hospice than patients with other diagnoses (OR 3.66; 95% CI 1.77-7.59), and older patients were significantly more likely than younger ones to receive hospice care following the consult (OR 1.05; 95% CI 1.01-1.08), assistant professor of gerontology Susan Enguidanos, PhD, of USC Davis School of Gerontology in Los Angeles, and colleagues, wrote online the *Journal of Hospital Medicine*.

The study was small with a single-cohort design, but the findings suggest that inpatient palliative care consultations can increase access to hospice care among minority groups, the researchers noted.

"We know that people who get inpatient palliative care consults are more likely to be discharged to hospice and they are more likely to be on hospice for a longer time," Enguidanos told *MedPage Today*. "This study suggests that these consults can overcome some of the ethnic barriers to hospice use."

Study after study has shown significant racial disparities in the utilization of hospice care by race.

A 2012 report by the National Hospice and Palliative Care Organization (NHPCO) found that of the 1.65 million terminally ill patients in the U.S. who received hospice care in 2011, close to 83% were white, 8.5% were African American, 6.2% were Hispanic, and less than 3% were members of other ethnic groups.

Racial differences in hospice usage have been reported for many diseases, including advanced heart failure and cancer.

Inpatient palliative care (IPC) programs were developed with the dual goal of improving pain and symptom management and providing patients and their loved ones with the information they need to make decisions about future care.

"Although significant evidence of IPC program effectiveness in improving patient outcomes exists, studies have not examined the ability of IPC programs to diminish ethnic disparities in access to hospice care," the researchers wrote.

Their retrospective study included seriously ill patients who were ages 65 or older treated at a nonprofit medical center with hospice and palliative care programs. All patients in the study received IPC consultations and all survived to hospital discharge.

From 2007 to 2009, 408 patients at the medical center received IPC consults and were discharged, but 44 had missing data on ethnicity or discharge disposition.

Of the 364 remaining patients, 42.6% were white, 25.5% were Latino, 23.1% were African American, and 8.8% were from other ethnic groups. The mean age of the patients was 80 (standard deviation=8.2), and 48.9% were female.

The primary diagnosis included cancer for 33.8% of the cohort, congestive heart failure for 17.4%, coronary artery disease for 12.6%, dementia for 12.4%, chronic obstructive pulmonary disease for 6%, cerebral vascular accident for 5.2% and other conditions for 13.6%.

More than half of the patients were discharged to hospice care, while 15.4% were discharged to home-based palliative care, which is similar to hospice but does not include the stipulation that patients must forego curative care. Another 14.6% were discharged to nursing facilities, while 8.2% were discharged to home with usual outpatient care, and 4.1% received home care with additional healthcare.

"Do not resuscitate" and other code status orders were discussed with 81% of patients, either by the IPC team during the consults or at some other time.

Among the findings:

- Patients discharged to hospice were slightly older (80.8, SD=8.4 vs 79.1, SD=7.8).
- The were also more likely to have cancer (71.%), or cerebral vascular accident (79.5%), and less likely to have end-stage renal disease (28.6%) or coronary heart disease (39%).
- Hospice patients were also more likely to have had a code discussion (85.8%) than patients who did not enter a hospice program.
- No significant differences were seen between hospice users and nonusers with regard to gender, marital status, ethnicity, and number of chronic conditions.

Study limitations included the lack of a comparison group and the study's small size. But Enguidanos said she hopes the findings will lead to more research which could prove that IPC consults increase hospice use by nonwhites.

"These inpatient consults took, on average, about an hour and a half with the goal of improving knowledge about not only the patient's condition, but their options moving forward," Enguidanos said. "Sometimes lack of knowledge serves as a huge barrier to care."

Action Points

- Note that this retrospective cohort study demonstrated no difference in rates of discharge to hospice after inpatient palliative care consultation across ethnic groups.
- Be aware that, in the absence of a control group who did not receive an IPC, we can not firmly conclude that IPC increases hospice use among minorities.

Minorities with life-ending diseases are less likely to enter hospice care than whites, but palliative care consultation may be an effective strategy to address this ethnic disparity, new research suggested.

When 364 terminally ill patients and their families received inpatient palliative care consults, no significant difference in hospice enrollment was found using adjusted, regression analysis for blacks

(OR 0.67; 95% CI 0.37-1.21), Latinos (OR 1.24; 95% CI 0.68-2.25), or other ethnic groups (OR 0.78; 95% CI 0.35-1.56), compared with whites.

Center for Hospice Care

choices to make the most of life

IUSM-SB and Hospice **WORK TOGETHER**

Indiana University School of Medicine-South Bend (IUSM-SB) and the Center for Hospice Care have signed an affiliation agreement that will place IUSM-SB medical students in Hospice facilities to learn about hospice and palliative care.

The agreement opens the way for a new clinical education rotation available for fourth year medical students. All IUSM-SB clinical rotations place third and fourth year medical students with physician-instructors in a myriad of clinical specialties and in settings ranging from physician offices to clinics to hospitals.

"This agreement with Hospice will allow our students to learn first-hand about end-of-life treatment, and to communicate closely with patient families," said Rudolph M. Navari, MD, Ph.D., FACP.

But the elective will be useful for students pursuing a broad range of specialties including psychiatry, oncology, family medicine, gerontology and general internal medicine, said Stacey Jackson, director of medical education.

The elective is open to all students in IUSM's regional campuses and Indianapolis. The Center for Hospice Care is an independent, community-based, not-for-profit organization that provides hospice, home health, grief counseling, and education to residents of Northern Indiana.

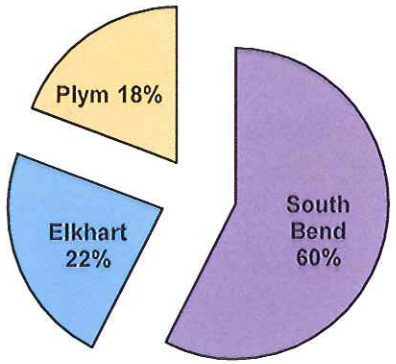
Center for Hospice Care

2013 YTD Average Daily Census (ADC)

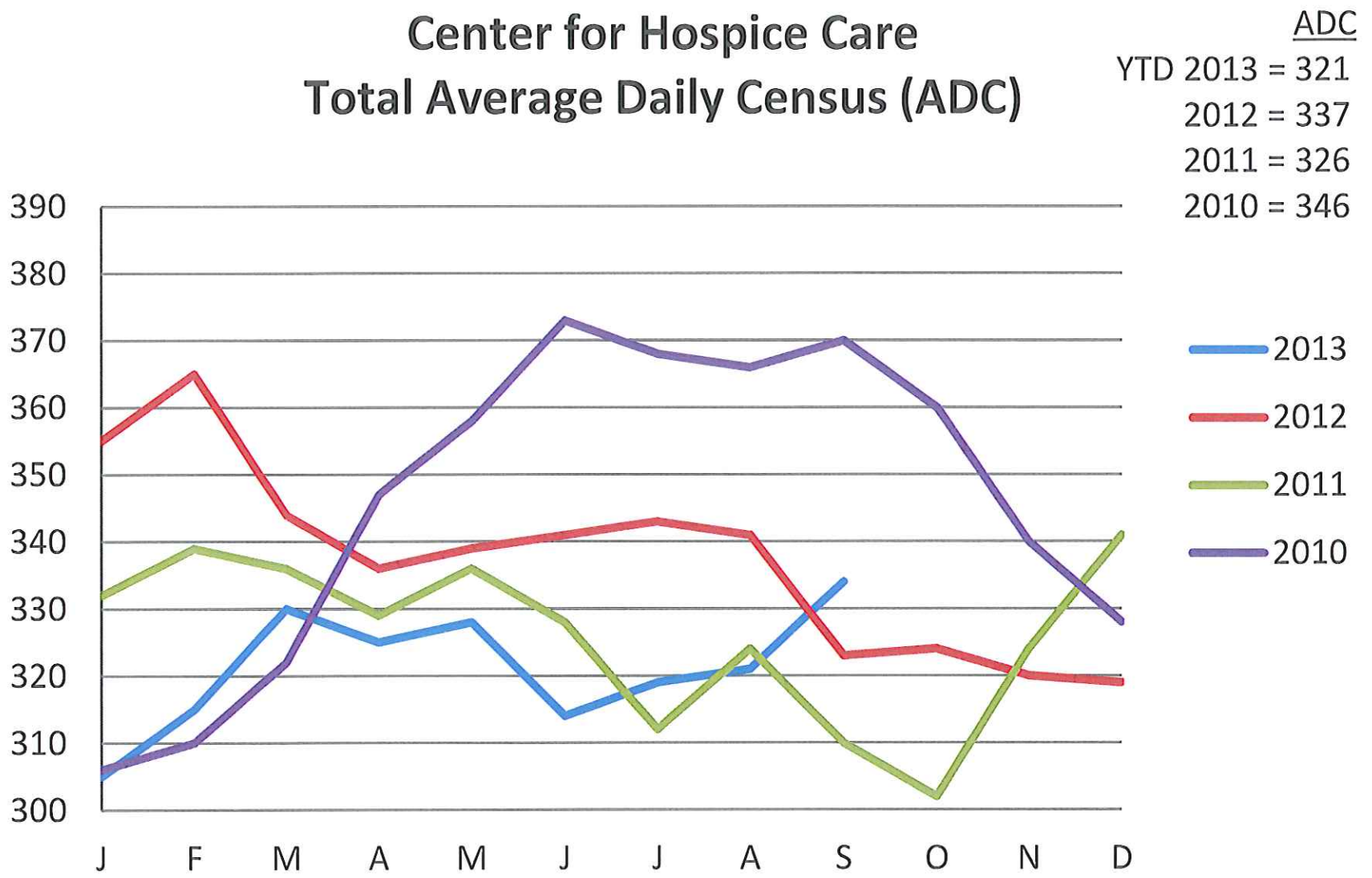
(includes Hospice House and Home Health)

	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	321	193	71	57
S	334	200	70	64
O				
N				
D				
2013 YTD Totals	2891	1735	624	531
2013 YTD ADC	**321**	**193**	**69**	**59**
2012 YTD ADC	343	204	74	65
YTD Change 2012 to 2013	-22	-11	-5	-6
YTD % Change 2012 to 2013	**-6.3%**	**-5.5%**	**-6.3%**	**-9.2%**

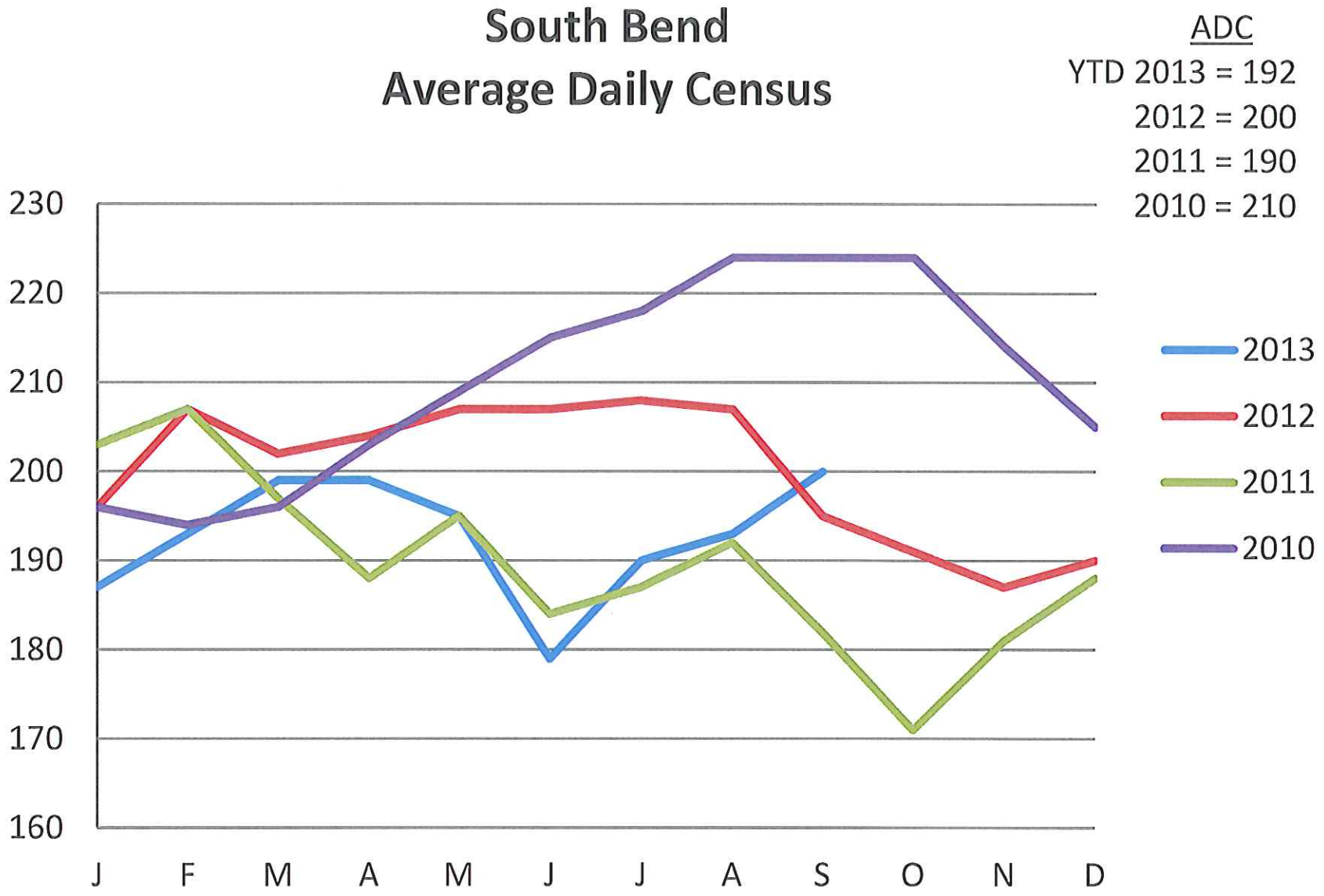
2013 YTD ADC by Branch	
South Bend	60.0%
Elkhart	21.6%
Plymouth	18.4%
All	100%



Center for Hospice Care
Total Average Daily Census (ADC)

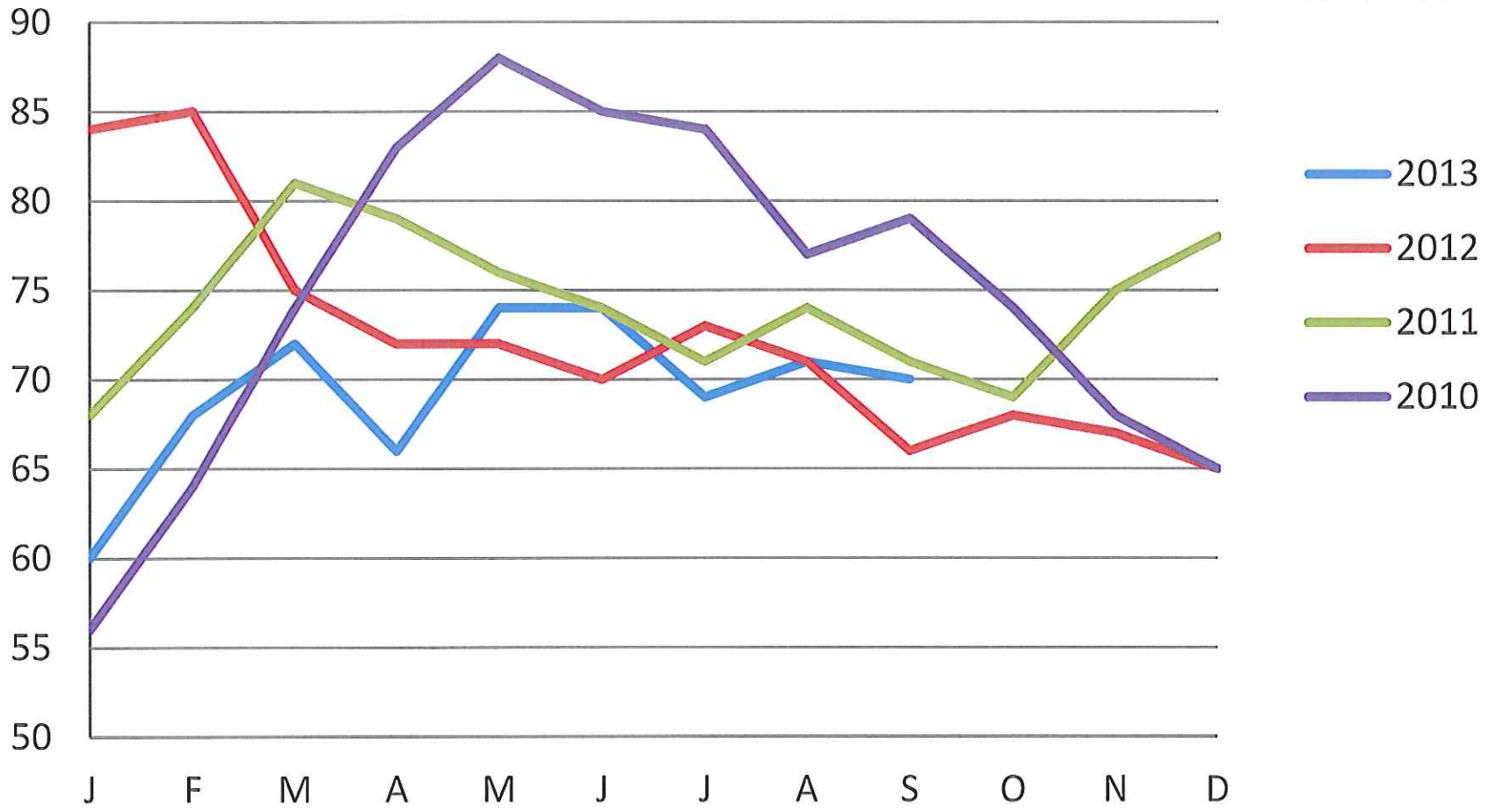


South Bend
Average Daily Census

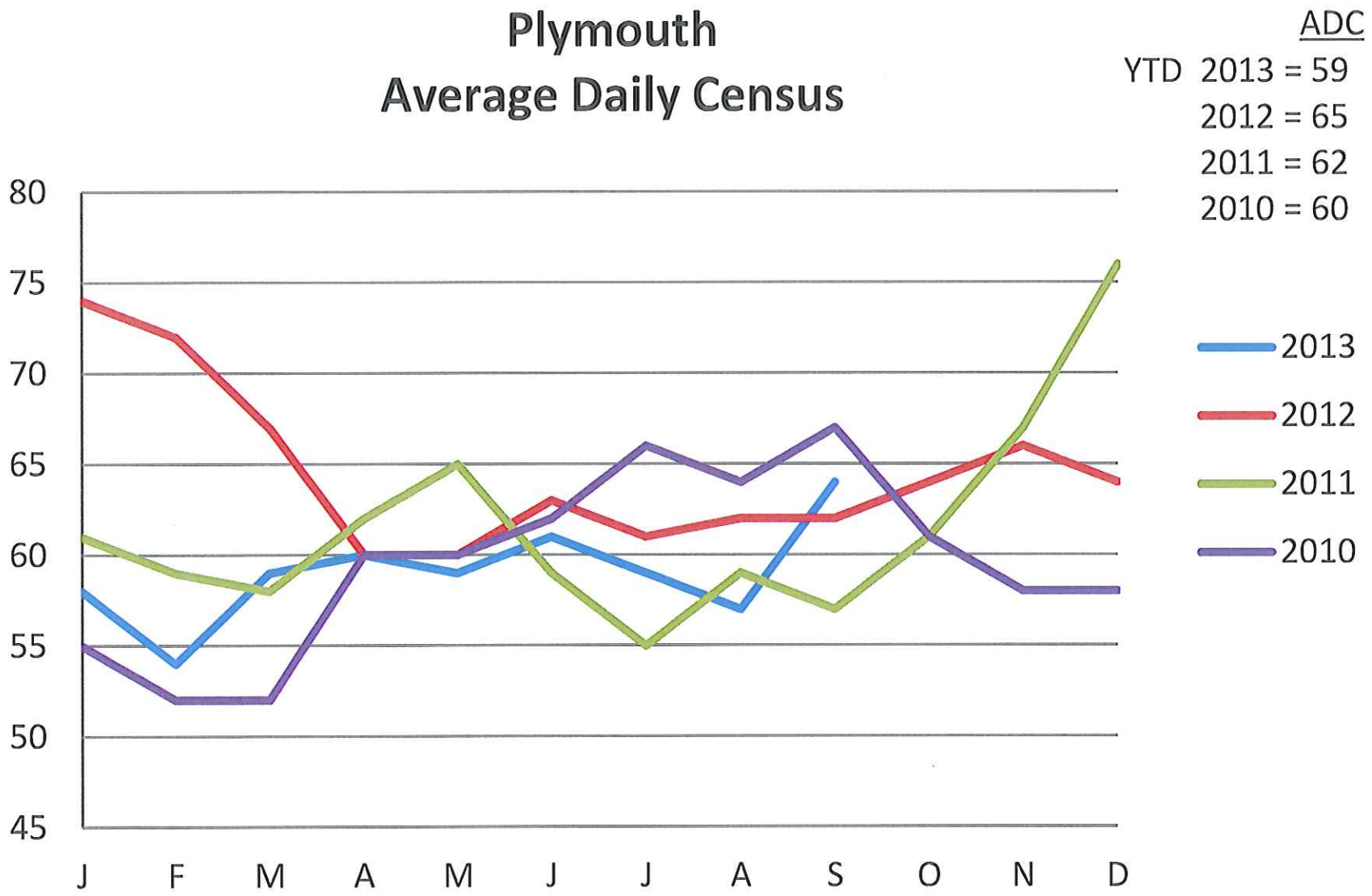


Elkhart
Average Daily Census

ADC
YTD 2013 = 70
2012 = 72
2011 = 74
2010 = 75



Plymouth
Average Daily Census



Center for Hospice Care
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CHAPTER FOUR

BY-LAWS

THE CENTER FOR HOSPICE AND PALLIATIVE CARE, INC.

BY-LAWS

I. TITLE: NAME, AIMS, AND PURPOSES

1.10 Name

The name of this Corporation shall be The Center for Hospice and Palliative Care, Inc., ~~with~~ d/b/a ~~of~~ Center for Hospice Care (hereinafter referred to as "Corporation").

1.20 Aims, Purposes, and Powers

Corporation is a not-for-profit, non-political organization serving citizens of St. Joseph, Marshall, Starke, Fulton, Elkhart, LaPorte, Kosciusko and LaGrange Counties in the State of Indiana. Its aims, purposes, and powers are:

1.21 To improve the quality of living.

1.22 To operate primarily as a state licensed and Medicare certified hospice, but also provide palliative care programs and services for persons with life threatening illnesses and their families as a state licensed and Medicare certified home health agency.

1.23 To have and exercise all the general rights, privileges and powers permitted under The Indiana Nonprofit Act of ~~1992~~1991, as amended, (hereinafter referred to as the "Act") ~~—~~provided that it shall engage in no ~~such~~ activity ~~shall be such as~~ which is not permitted by a corporation which is~~in~~ exempt from Federal Income Tax under Section 501(c)(3) of the Internal Revenue Code of 1954 or any corresponding future provision of the Revenue Code (hereinafter referred to as the "Code"). The Corporation shall not intervene in, or participate in, any political campaign on behalf of any candidate for public office. No part of the net earnings of this Corporation shall inure to the benefit of any private individual and no director or officer of the Corporation shall receive any pecuniary benefit from the Corporation, except such reasonable compensation as may be allowed for services actually rendered to the Corporation.

II. MEMBERSHIP

2.10 Membership in Regional and/or National Organizations

The Corporation may maintain membership in other regional and/or national organizations whose purposes are consistent with those of the Corporation. The Corporation may support financially such an organization to the degree deemed appropriate and as allowed by the Act and the Code.

2.20 Management

Management of the Corporation shall rest with the Board of Directors elected by the procedures set forth in Article 3.00 of these By-laws.

2.30 Fiscal Year

The fiscal year shall begin January 1st and end on December 31st of each calendar year.

III. BOARD OF DIRECTORS

3.10 Government

The management of the affairs of the Corporation and corporate power shall be vested in a Board of Directors. New members of the Board of Directors shall be elected by current Board Members at the Annual Meeting of the Board of Directors and at other times throughout the year, as the Board may deem appropriate.

9.20 Disqualification of Board Members ***(Move Section 9.20 to III and make it 3.20)***

No individual, who is a Director of the Corporation, can at the same time be an employee of the Corporation.

If any situation should arise in which a board member may have interests in conflict with the interests of the Corporation, such board member shall promptly report such conflicts of interests to the Board of Directors and shall be disqualified from voting or otherwise acting for and on behalf of the Corporation with respect to that matter. The Board of Directors shall approve a formal Conflict of Interest Policy that shall be reviewed every three years during the triennial review of these By-laws.

3.32~~2~~0 Number

The Board of Directors shall consist of not less than twelve (12) nor more than twenty-one (21) members. The terms of office for members of the Board of Directors shall be three (3) years. Board members may serve no more than two (2) consecutive three (3) year terms. The term of a board member shall commence at the first board meeting of the fiscal year. If a board member is serving as an officer of the board at the expiration of his second board term, then his board term shall be extended to coincide with the expiration of his position as an officer of the board. In addition, former Board members shall be eligible for re-election to the Board of Directors following a lapse of one year as a member of the board.

3.4030~~0~~ Duties

The duties of the Corporation's Board of Directors include the following:

3.431 To review and approve the annual operating budget of Corporation.

3.432 To be charged with the responsibility of reviewing, approving, and developing a total program of quality services.

3.433 To assess community needs for services to patients with a life threatening illness and their families.

3.344 To review and approve program planning and development of long range objectives to meet those identified needs.

3.435 To recommend implementation, modification, termination, or monitoring of programs and services of the Corporation.

3.436 To hire and discharge the President/CEO based upon recommendations from the Executive Committee of the Board of Directors.

3.347 To support The Hospice Foundation in its efforts to raise and allocate funds in the best interest of the Corporation's mission

3.348 To perform any other duties the Board of Directors of a non-profit Corporation can perform consistent and in accordance with the Act.

3.540 Resignation

A director may resign at any time by filing his/her written resignation with the secretary of the Board of Directors.

3.650 Removal

Any director may be removed for cause by the affirmative vote of the majority of the Board of Directors of the Corporation. Any director who has been absent from three (3) consecutive regular meetings may be removed by the affirmative vote of the majority of the Board of Directors present at the meeting. In other respects, a member of the Board of Directors can be removed as allowed by the Act.

3.760 Vacancy

Any vacancy in the Board of Directors caused by death, resignation, increase in number of directors or otherwise may be filled by appointment by the Board of Directors for the remainder of the vacated term.

3.870 Order of Business

Robert's Rules of Order are to apply at all meetings of the Board of Directors unless waived

by a majority of Directors present.

3.980 Delegation of Authority Among the Board of Directors

It is agreed that the Board of Directors shall elect, at its annual meeting each year—applicable to the two-year term of the position, a Chairman, Chairman Elect, Immediate Past Chairman, Secretary, and Treasurer of the Board of Directors to assume and perform the following responsibilities:

3.981 Chairman of the Board of Directors

The Chairman shall preside at all meetings of the Board of Directors. S/he shall have chief official responsibility for directing and implementing each meeting of the Board of Directors, and shall be responsible to perform other duties as may be prescribed from time to time by the Board of Directors, by the By-laws, or the Articles of Incorporation of the Corporation, or as deemed appropriate within the discretion of said Chairman.

3.982 Chairman Elect of the Board of Directors

The Chairman Elect shall assist in the discharge of the duties of the Chairman of the Board of Directors, and shall serve as the Chairman of the Board of Directors in the Chairman's absence. Said Chairman Elect shall perform such other duties and responsibilities as may be prescribed from time to time by the Board of Directors, by the By-laws, or the Articles of Incorporation.

3.893 Secretary of the Board of Directors

The Secretary of the Board of Directors shall keep correct and complete record of all of the proceedings of the Corporation and shall, in general, perform all of the duties which are incident to the office of Secretary of the Board of Directors and prescribed from time to time by the Board of Directors, the By-laws, or the Articles of Incorporation.

3.984 Treasurer of the Board of Directors

The Treasurer shall have supervisory responsibility and control of all Corporate funds and assets belonging to the Corporation subject to the authority of the Board of Directors of the Corporation. An account of the financial conditions of the Corporation shall be rendered to the Chairman and other directors at the regular meeting of the Board of Directors and whenever requested by them.

3.985 Immediate Past Chairman of the Board of Directors

The Immediate Past Chairman shall continue to serve as a member of the Executive Committee for the two-year period immediately following his/her service as Chairman of the Board. The primary purpose of this position is to ensure continuity and to serve in

an advisory capacity.

3.986 Right to Vote

The Chairman, Chairman Elect, Immediate Past Chairman, Secretary, and Treasurer of the Board of Directors shall be members of the Board of Directors and shall be entitled to vote on all matters submitted for a vote of the Board of Directors.

3.9100 Election of Officers on Board of Directors

The Chairman, Chairman Elect, Secretary, and Treasurer of the Board of Directors shall be elected by the Board of Directors at the time of the Annual Meeting of the Board of Directors for two (2) year terms.

IV. OFFICERS OF CORPORATION

4.10 Appointment

The officers of the Corporation shall include a President/CEO, a Vice-President/COO, and a Chief Financial Officer. The President/CEO shall be appointed by the Board of Directors based upon a recommendation from the Executive Committee and according to Board approved policy in place at the time. The President/CEO shall appoint a Vice-President/COO, a Chief Financial Officer and shall be responsible for the hiring and discharging of all paid staff of the Corporation.

4.20 Duties

The principle duties of the officers ~~respectively~~ are as follows:

4.21 President/CEO

The President/CEO shall attend all meetings of the Board of Directors. The President/CEO shall be the chief executive officer of the Corporation and shall have the general supervision, direction, and active management of the property, affairs and business of the corporation subject to the discretion, control and approval of the Board of Directors. S/he shall perform such other duties as may be prescribed from time to time by the Board of Directors, by the By-laws, or the Articles of Incorporation of the Corporation. S/he shall be a non-voting member of the Board of Directors and all standing committees. The President/CEO shall also be the President/CEO of The Hospice Foundation and shall be responsible for the overall relationship between the two entities.

4.22 Vice-President/COO

The Vice-President/COO shall help with the discharge of duties of the President/CEO and shall serve in his/her absence and shall perform such additional duties as may be

prescribed from time to time by the Board of Directors, by the By-laws, or by the Articles of Incorporation. The Vice-President/COO shall be a non-voting member of the Board of Directors and standing committees as appointed by the President/CEO.

4.23. Chief Financial Officer

The Chief Financial Officer shall help with the discharge of duties in the absence of both the President/CEO and the Vice-President/COO and shall perform such additional duties as may be prescribed from time to time by the Board of Directors, by the By-laws, or by the Articles of Incorporation. The Chief Financial Officer shall be responsible and accountable for the receipt of the Corporation's funds and pay out of the same under policies approved by the Board of Directors and under the direction of the President/CEO. The Chief Financial Officer shall be accountable for the deposit of all moneys, checks and other credits to the account(s) of the Corporation in accordance with policies approved by the Board of Directors. The Chief Financial Officer shall enter regularly into the books of the Corporation to be provided for that purpose a full and accurate account of all moneys received and paid out on account of the Corporation. The Chief Financial Officer shall be a non-voting member of the Board of Directors and standing committees as appointed by the President/CEO. The Chief Financial Officer shall also be the Chief Financial Officer of The Hospice Foundation and be responsible and accountable for the financial relationship between the two entities.

4.30 Vacancies

Whenever any vacancies occur in the office of the President/CEO of the Corporation, such vacancy shall be filled by the appointment of an Interim President/CEO as detailed within Board approved policy in place at the time.

4.40 Loans to Officers and Directors

No loans of money or property shall be made to any officer or director by the Corporation.

V. AUTHORITY TO OBLIGATE CORPORATION

5.10 Checks, Drafts, and Similar Negotiable Instruments

The President/CEO, the Vice-President/COO, and the Chief Financial Officer of the Corporation shall have authority to sign checks or similar negotiable instruments on behalf of the Corporation. Any of the three can sign checks up to $25,000.00 for ordinary budgeted items. Any check over $25,000.00 would require two of the three signatures.

5.20 Authority to Borrow Funds

The President/CEO of the Corporation along with the Chairman of the Board of Directors or the Treasurer of the Board of Directors shall have the authority to obligate the Corporation for

lending transactions on behalf of the Corporation as approved by the Board of Directors from time to time.

5.30 Execution of Documents

The President/CEO of the Corporation shall have the authority to bind the Corporation, to contracts or other similar business agreements entered during the ordinary course of the Corporation's business.

VI. MEETINGS

6.10 Annual Meeting

The Annual Meeting of the Board of Directors shall be the final meeting of the fiscal year~~held no later than May 31st of each year~~ and shall be designated as the Annual Meeting for election of directors, officers of the Board of Directors and the Corporation, and for ~~the conduction of~~conducting any other business that may come before the Board of Directors.

6.20 Regular Meetings

Regular meetings of the Board of Directors shall be held at least four (4) times a year. Directors shall be notified, in writing, in advance of all meetings.

6.30 Special Meeting of Board of Directors

Special meetings of the Board of Directors may be called by the President/CEO or on written application of five (5) directors made to the Secretary who shall mail notices to all Board members not less than one (1) week prior to the meeting stating the purpose of the meeting, unless waived. No other business may be transacted at a special meeting.

6.40 Quorum for Board Meetings

A majority of the Directors shall constitute a quorum. Directors must be present, in person.

6.50 Voting

Each director shall have one (1) vote on all issues presented for the vote of the Board of Directors of the Corporation.

VII. COMMITTEES

7.10 Standing Committees

All Standing Committees, except for the Executive Committee, ~~the Personnel Committee and the Nominating Committee,~~ shall be appointed by the Chairman of the Board of Directors for one (1) year terms and may be reappointed, and may have non-directors as members.

7.11 Executive Committee

The Executive Committee shall consist of the Chairman, Chairman Elect, Immediate Past Chairman, Secretary, and the Treasurer of the Board of Directors. The committee shall perform the duties of the Board of Directors in the interim between board meetings and shall report all actions for ratification at the earliest meeting of the Board of Directors.

The Executive Committee of the Board of Directors shall make recommendations with regard to hiring and termination of the President/CEO according to Board approved policy in place at the time. The full Board of Directors shall have final determination. The Executive Committee shall have the sole authority to conduct reviews of the President/CEO's performance and determine compensation and benefits according to the Board approved policies in place at the time.

7.12 Finance Committee

The Finance Committee shall consist of the Treasurer of the Board of Directors who will Chair the Committee and other appointees by the Chairman of the Board of Directors. This committee is responsible for review and recommendations to the Board of Directors regarding the financial matters of the Corporation. Specifically, this committee shall:

Review budgets for proposed lands and projects, review and approve annual recommended budget proposals to be submitted to the Board of Directors and review the annual audit after each fiscal year.

~~Review and pass all extraordinary expenses of unbudgeted items, manage all investments and capital or designated funds for the Board of Directors.~~

Review and plan long-range financial goals for the Corporation.

7.13 Personnel Committee

The Personnel Committee shall consist of ~~the Executive Committee and other~~ appointees by the Chairman of the Board of Directors, and be chaired by the Chairman of the Board of Directors. This committee shall concern itself with the review and recommendations for approval of the Personnel Policies governing the staff of the Corporation.

7.14 Professional Advisory Group

This Committee shall advise the Corporation on professional clinical issues, participate~~s~~ in the review of the Corporation's clinical programming, patient care policies, procedures and clinical records as required by the federal and/or state Home Health regulations.

Membership is to include but not be limited to:

- At least one physician
- One registered nurse
- Appropriate representatives of disciplines involved in delivery of Home Health services under the Corporation's state home health license and federal certification to provide home healthcare services.

The chairman shall be the Corporation's current Chief Medical Officer. Other members are appointed for one (1) year terms by the Chairman of the Board of Directors and may be reappointed.

7.15 Nominating Committee

The Nominating Committee shall consist of ~~the Executive Committee of the Corporation and other~~ appointees by the Chairman of the Board of Directors in such numbers as they deem necessary. It shall have responsibility ~~of~~for nominating candidates for positions on the Board ~~as well as for~~and officers of the Board of Directors.

7.20 Special Committees

Special committees may be appointed by the Chairman of the Board of Directors as the need arises.

7.30 Appointment of Permanent Committees

New permanent committees, as needed, may be appointed by a majority vote of a quorum of the Board of Directors from time to time.

7.40 Terms

Terms of all committees shall expire at the annual meeting of the Board of Directors.

VIII. NONDISCRIMINATION PRACTICES

8.10 Services

There shall be no discrimination in service based on sex, race, color, creed, age, sexual orientation, national origin, or physical disability.

8.20 Employment

There shall be no discrimination with regard to hiring, assignment, promotion, or other condition of staff employment on the basis of sex, race, color, creed, age, sexual orientation, national origin, or physical disability.

IX. INDEMNIFICATION AND CONFLICT OF INTEREST

9.10 Indemnification of Representatives

The Corporation shall indemnify its employees, officers, directors and agents from any claim, lawsuit, administrative action or other proceeding, provided that

(a) Such indemnification shall be entirely covered by policies of insurance purchased by the Corporation, and

(b) The indemnified persons' conduct for which indemnity is provided meets the standards set forth in Indiana Code Section 23-17-16-8, as it may be amended form time to time.

The Corporation may purchase policies of insurance which shall include, but not be limited to, general liability, medical or health care malpractice, and directors' and officers' liability.

This section of the Corporation's by-laws shall not obligate the Corporation to purchase any of the foregoing insurance coverage but shall, provided any coverage is purchased, permit and require any insurance company or surety to fulfill its coverage obligations under the policies issued to the Corporation, as provided in Indiana Code Section 23-17-16-14. This section of the Corporation's by-laws shall not prevent the Corporation from providing indemnification which exceeds the scope of the foregoing insurance coverage, but any such excess indemnification must be provided only by special resolution of the Corporation's Board of Directors.

~~any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative (other than an action by or in the right of the corporation) by reason of the fact that said person is or was a director, officer, employee, or agent of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise, against expenses (including attorney's fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by such person in connection with such action, suit, or proceeding.~~

~~Any expenses incurred in defending a civil or criminal action, suit, or proceeding shall be paid by the corporation in advance of the final disposition of such action, suit, or proceeding, when expenses are incurred.~~

~~The indemnification provided above, shall not be deemed exclusive of any other rights to which those seeking indemnification may be entitled under any statute, By-Law, agreement, vote of disinterested directors, or otherwise, both as to action in such persons official capacity and as to action in another capacity while holding such office, and shall continue as to a person who has ceased to be director, officer, employee, or agent of the corporation, and shall inure to the benefits to the heirs, executors, and administrators of such person.~~

~~The representatives set forth above shall have all of the rights of indemnification as allowed~~

~~by the Act, as amended.~~

9.20 Disqualification of Board Members ***(Move to Section 3.10 and make it 3.20)***

~~*No individual, who is a Director of the Corporation, can at the same time be an employee of* ***the Corporation.***~~

~~*If any situation should arise in which a board member may have interests in conflict with the interests of the Corporation, such board member shall promptly report such conflicts of interests to the Board of Directors and shall be disqualified from voting or otherwise acting for and on behalf of the Corporation with respect to that matter. The Board of Directors shall approve a formal Conflict of Interest Policy that shall be reviewed every three years during the triennial review of these By-laws.*~~

X. DISSOLUTION OF CORPORATION

10.10 Resolution to Dissolve

In the event that proceedings for dissolution of the Corporation are undertaken according to law, the Board of Directors shall set forth a summary of the assets of the Corporation after providing for the payment of creditors and the approximate value thereof, together with the resolution of the Board of Directors to dissolve the corporation as provided by the laws of the State of Indiana. Any monies or properties remaining after all amounts designated in this section shall have been paid shall be transferred to a local not-for-profit agency providing health services consistent with the purposes of the Corporation.

10.11 Winding Up

During the dissolution process, the ~~c~~Corporation shall continue the ~~c~~Corporation's corporate existence, but shall not carry on any activities except those appropriate to winding up and liquidating the ~~c~~Corporation's affairs.

10.12 Administrative and Judicial Dissolution

The ~~c~~Corporation shall also be dissolved by administrative dissolution and judicial dissolution in addition to voluntary dissolution.

XI. REQUIREMENTS AS TO OPERATIONS

11.10 Investment and Distribution of Income and Prohibitions

11.11 All income of the ~~c~~Corporation for each taxable year shall be managed, invested, distributed and maintained in such a manner, and shall be distributed at the appropriate time and manner so as to not subject the ~~c~~Corporation to tax under Section 4942 of the Code, as amended, or any other tax.

11.12 The corporation is prohibited in engaging in any act of self dealing (as defined in Section 4941(d) of the Code, as amended, from obtaining any excess business holdings as defined in Section 4943(c) of the Code, as amended, from taking any investments in such manner as to subject the ~~c~~Corporation to tax under Section 4944 of the Code, as amended, and for making any taxable expenditures as defined in Section 4945(d) of the Code, as amended.

XII. AMENDMENTS

12.10 Procedure

These By-laws may be altered, amended, or repealed in any regular or special meeting of the Board of Directors, in which a quorum is present by a vote of two-thirds (2/3) of those directors present. At least ten (10) days advanced written notice of proposed changes and of the time and the place of the meeting to amend the By-laws shall be required. Said notice shall state that the purpose of the meeting is to consider proposing amendment to the By-laws. Additionally, the notice must contain or be accompanied by a copy of a summary of the amendment(s) or state the general nature of the amendment(s) to the By-laws of the ~~c~~Corporation.

12.20 Review

These By-laws shall be reviewed by a committee appointed by the Chairman of the Board of Directors not less than every three (3) years beginning with 1994.

These By-laws were approved at a meeting of the Board of Directors on the 6th day of July, 1978, were first amended by the Board of Directors on the 18th day of September, 1990, amended a second time by the Board of Directors on the 17th day of May, 1994, amended a third time on the 24th day of March, 1998, amended a fourth time on the 19th of September, 2000, amended a fifth time on the 16th day of September, 2003, amended a sixth time on the 19th day of April, 2005, amended a seventh time on the 20th day of May, 2008, ~~and~~ amended an eighth time on the 16th day of February, 2011, and amended a ninth time on October 23, 2013.

SIGNATURES ON NEXT TWO PAGES

THE CENTER FOR HOSPICE AND PALLIATIVE CARE, INC.

By:_____ _____
President/CEO Date

_____ _____
Chairman, Board of Directors Date

_____ _____

Board Member Date

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Board Member Date

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Board Member Date

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Board Member Date

ATTEST:

By:_____ _____

Secretary, Board of Directors Date