Board of Directors Meeting
501 Comfort Place, Conference Room A, Mishawaka
December 18, 2013
7:30 a.m.

BOARD BRIEFING BOOK

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Center for Hospice Care
choices to make the most of life

CHAPTER ONE

AGENDA

BOARD OF DIRECTORS MEETING
Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
December 18, 2013
7:30 a.m.

A G E N D A

1. Approval of October 23, 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) October and November Financial Statements
   (b) 2014 Budget
   (c) 2014 Flex Spending Account

4. QI Committee Meeting *(information)* – Julie Englert (4 minutes)

5. Policies *(action)* – Donna Tieman (7 minutes)
   (a) Availability 24/7 (new)
   (b) Dating of Medical Records (revised)
   (c) ECF Services Provided to a Hospice Patient (revised)
   (d) Elder Justice Act Reporting (revised)
   (e) Infection Control Program (new)
   (f) Plan of Care Coordination (revised)
   (g) Sanctioned Individuals (revised)
   (h) Standards of Care (revised)

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

7. Election of CHC Board members *(action)* – Amy Kuhar Mauro (4 minutes)

8. Board Education – CHC / HF Social Media Update *(information)* – Amy Tribbett and Cyndy Searfoss (10 minutes)

9. Chairman's Report *(information)* – Corey Cressy (3 minutes)

Next meeting February 19, 2014 at 7:30 a.m.

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Center for Hospice Care
choices to make the most of life

CHAPTER TWO

MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
October 23, 2013

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 7:30 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 08/21/13 meeting as presented. The motion was accepted unanimously.	W. Walsh motioned T. Yoder seconded
3. President's Report	• Average daily census today is 335. Some of the increase may be due to publicity for the new campus. YTD the number of patients served is up 7%, new admissions are up 11%, and ADC is down 6% due primarily to late referrals. For hospice patients only, the ALOS is down to 7 days and the median is 13 days, compared to 20 days last year. If all 2,000 patients were cared for three days earlier, it would be $1 million in additional revenue. One out of 12 referrals die before we get there and we get there within hours. Of those, one in five die before admitted. • There is a national update in the President's Report regarding the government shutdown, sequestration, how it affects us, sustained growth rate, physician fees, and things we will face and need to keep in mind. People are living longer. Census is down nationally. One reason has a lot to do with enormous pressure to discharge people early, being picky on who is admitted, and the large number of auditors and oversight by the government. With the poor economy, fewer people are willing to access health care on time, so they are waiting until the last minute. The ALOS for hospice patients was 67 days a year ago and now is 60 days. • The referral App is now available. We are mailing a packet to our top ten referral sources and 25 others groups. The community liaisons will be meeting with referral sources to demonstrate it. The mailer was designed by our internal web/print designer and Amy's department. You can take extra packets with you to give to your personal physician. • We are now a level four We Honor Veterans partner, which is the highest we can reach. There are 1,996 WHV partners in the country and only 96 are at level four. Amy T. has done a great job sending out press releases about the achievement,	

Topic	Discussion	Action
	which have been picked up by some news agency outside our service area. • The newest issue of the H&P newsletter contains our five service promises. The best thing board members can do is be an ambassador of our messages and what makes us different from other hospices. The H&P lists Mark's unpublished direct line for physicians to contact him at any time. • We have a signed contract with the Mayo Clinic. The first fellow will be here in March and will live at the guest house. We will be able to publicize it. They just want to see what we are sending out in advance and will get back to us within five days. • At the National Hospice Executive Roundtable (NHERT) meetings, we often have guest speakers and at the recent session, we had a representative from The Advisory Board Company. They primarily do consults with hospitals and would like to collaborate with NHERT on post-acute care. Advisory is beginning to realize how important post-acute care will be to hospitals. We are trying to get a group rate for NHERT members. Through our membership, we would be able to find out what hospitals worry about and what to talk about based on their needs and challenges. They offered us seats to attend their Post-Acute Care Collaborative in Chicago on 11/06 and Mark will attend. • Ross McCall of Whiteboard Entertainment is interested in doing a reality TV series about hospice care and to show what hospice is really about. He has been studying it for about three years. In Kansas City recently, he met with a couple people from around the country that NHPCO recommended including Mark. He asked Amy and Mark to recommend staff he could interview, which he has done by phone and Skype. He will be here for a couple days next week. He will be interviewing people from across the U.S. for the series to find out the perception of hospice that makes people reluctant to utilize it, and what needs to change to make people realize hospice is a very viable alternative and that it is not brink of death care. People will listen to authority figures advising them (doctors). With our ads, we are seeing an increase in the general public calling us rather than waiting on referral sources. We are educating the public that they have choices and options before they need them. • Education Destination – One of the things we are involved with is we have written agreements with several schools, residency programs, etc. (see President's Report for a list). We are working on educating people who want to do what we do and it is also an opportunity for potential employees for the future. We have non-written	

Topic	Discussion	Action
	agreements with Notre Dame for palliative care and Hospice 101, and with Goshen College and Valparaiso University. • Competition – Can we find out how many patients they serve and their ADC? It is difficult to determine, because we can only find out Medicare data and not commercial insurance data. Medicare's data is also old by the time it is published. The data that was just published recently is from 2011. As for market share percentage, we have something like 82% in Marshall, 72% in St. Joseph, 75% in Elkhart. Kosciusko, Starke and Fulton are low, but so is their population. Some hospices based out of Indianapolis say they have larger territories mapped out than they really serve. We never run into some of the 27 competitors that are claimed to be in our area.	
4. Finance Committee	• Financial Statements – The finance committee met last week and approved the financial statements for August and September. August had $1.5 million in operating income, beneficial interest in the Foundation was a loss of $218,591, total revenue was $1.2 million, total expenses $1.4 million, net loss of $179,436, and a net gain without beneficial interest $39,155. September operating income $1.4 million, beneficial interest in the Foundation $408,504, total revenue $1.8 million, total expenses $1.3 million, net gain $470,000, net without beneficial interest in Foundation $61,514. YTD operating income $13.1 million, beneficial interest $1 million, total revenue $14.3 million, total expenses $12.5 million, net gain $1.8 million, net without beneficial interest $714,764. A motion was made to accept the financial statements for August and September as presented. The motion was accepted unanimously • Retirement Plan Audit – In 2010 the law changed regarding 403B plans. Due to the size of our plan, we have been required to have an audit for the last few years and last year's audit was performed this summer. The value of the plan is $4.7 million in assets, which are individual owned assets of employees. These assets don't show up on our books. Culp gave an unqualified opinion. We did rely on work from our provider, Principal. At one point we offered employees up to four choices to direct their retirement funds. When the law went into effect in 2010, we saw that this would be an issue going forward, so we narrowed it down to one provider. There is still money in some of the old accounts. We hired a third party administrator to do accounting for legacy providers. A motion was made to approve the Retirement Plan Audit Report for 2010 and 2011 as presented. The motion was accepted	T. Rodino motioned C. Murphy seconded A. Mauro motioned J. Englert seconded

Topic	Discussion	Action
	unanimously.	
5. Bylaws Committee	• Thank you to everyone that helped, especially Jim Brotherson and Wendell Walsh for working on the revisions to the bylaws. Under Section III – Board of Directors, 3.30 – we are changing the term of board members to a fiscal year (January-December). Under section VII – Committees, we revised it so all board members are welcome to be on any committee as appointed by the Chairman, and the officers of the board don't have to be on all committees. Section IX – Indemnification and Conflict of Interest – Changed language. • A motion was made to accept the revised Bylaws as presented. The motion was accepted unanimously.	J. Brotherson motioned T. Yoder seconded
6. HIPAA Policies	• The updated HIPAA policies were reviewed. Our attorney at Krieg DeVault wrote the changes to bring it in line with current the requirements and recent changes to the law. The board approves policy as a main function. The board has to approve a lot of policies, because we are a Medicare provider and regulations require the convening body be involved in many things, including clinical policies. The surveyor and auditors can then see in the minutes that the board reviewed and approved the policies. • A motion was made to accept the new HIPAA policies as presented. The motion was accepted unanimously.	W. Walsh motioned J. Englert seconded
7. Hospice Foundation Update	• Through September fundraising is running 15% ahead of last year due in part to an $80,000 bequest. Take that out, and it is about a 5% increase. • Walk for Hospice raised $35,000, which is $10,000 more than last year. We also had a good turnout of people at Beutter Park. Next year we anticipate holding the event at the Mishawaka campus. • Bike Michiana for Hospice set a new record for participation—1,231 riders and raised over $83,000. A portion of that is shared with Bike Michiana Coalition. • We were involved in underwriting the 5th Biannual Palliative Care Conference in Uganda. Two staff members, Karen Smith-Taljaard and Bridget Hoch, did presentations at the conference and two staff sent poster presentations. Over 400 people from around the world attended the conference. • To date the Friends of Hospice campaign has raised $43,000, which is close to our goal of $45,000. The campaign runs through Thanksgiving. The Annual Appeal will be launched next. • The city of Mishawaka is completing its improvements on the fish ladder, river	

Topic	Discussion	Action
	walk, and fencing. They installed a sculpture by the fish ladder that matches the brick work and color of our building. We will mirror their fencing on our side along our property next spring. • A donor survey was sent to everyone in the Helping Hands Society and above, inviting them to provide input. The November e-newsletter will include a link to do the survey online, and it will also be in the fall issue of Crossroads. • Third party fundraisers: NAIFA 15th annual golf outing raised $6,000 and over the past 15 years has raised $78,000 for us. Gates Automotive Group developed a program for employee giving through payroll deduction. Employees selected four charities in the community. For the third year in a row CHC was selected. Money from employees is matched by Gates and the Toyota Foundation. • Film Projects – We are working on a couple of projects with our interns. One is for the capital campaign we will be rolling out. Editing continues on the "Road to Hope" documentary. We have over 60 hours of film to edit down to one hour. Ted Mandell is helping. We are also working with IUSB about composing an original score for it. • PCAU is working on getting the message out about hospice services and the availability of palliative care. People live in extreme poverty, but everyone has cell phones because it is a way to communicate throughout the country. So they want to do something with social media. We were very fortunate to have actress Torrey DeVitto on the trip to Africa. She posted the trip on social media, and was contacted by her friend Brandi Milloy, who is a model and TV personality. Brandi has been trying to get to Africa for four years, so we put together a plan for her to go on her own to help develop a communication strategy for PCAU that they could implement. She was with Rose Kiwanuka this summer and just returned, so we should start seeing social media from PCAU.	
8. Board Education	• The theme of the October board meeting is a QAPI update, so Rebecca Fear, Nurse Educator, did a presentation on our Quality Assessment and Performance Improvement program. There are five standards: (1) scope of program, (2) type of data and how it is used, (3) program activities, (4) performance improvement projects, and (5) executive responsibilities. We have seven active projects at this time. There is one sentence in the Medicare Conditions of Participation that the convening body is involved in and reviews the QAPI program of the organization. Julie Englert sits on the Quality Improvement Committee, which meets quarterly.	

Topic	Discussion	Action
9. Chairman's Report	• The nominating committee has been meeting with potential board members and will provide an update at the December board meeting. • Thank you to Mark and his staff for the H&P newsletter. The information is very helpful to use as an elevator speech. Our name is another area. When people think of hospice, they just assume it is CHC. So always use our full name, "Center for Hospice Care," so they know which hospice to ask for. • Okuyamba Fest is on Thursday, 11/14 at the Mishawaka campus from 5:30-7:30.	
Adjournment	• The meeting adjourned at 8:45 a.m.	Next meeting 12/18

Prepared by Becky Kizer for approval by the Board of Directors on 12/18/13.

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Julie Englert, Secretary Becky Kizer, Recording Secretary

Center for Hospice Care
choices to make the most of life

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
Hospice Foundation
President / CEO Report
December 18, 2013
(*Report posted to Board Website December 12, 2013)*

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:30 AM. This report includes event information from October 24 – December 17, 2013.
The Hospice Foundation Board meeting will begin at 9:00 AM in the same room.

CENSUS

At 11/30/13, the number of patients served in 2013 is up 7% from same time last year and the number of original admissions is up 11% from same time last year. However, due to short lengths of stay and late referrals, the average daily census (ADC) is down 5% from same time last year. It should be noted that shorter and shorter median lengths of stay in hospice is an ongoing national trend which increased according to the most recent Medicare data (2012 and included as an attachment to this report). While the number of patients served in our Hospice Houses is up 6% from last year, the ADC is actually down year over year. The length of stay is shorter at this venue compared to last year as well.

November 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	428	1,861	1,735	126
Original Admissions	140	1,550	1,396	154
ADC Hospice	308.13	302.83	319.85	(17.02)
ADC Home Health	21.00	19.68	19.13	0.55
ADC CHC Total	329.13	320.65	338.98	(16.47)

October 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	439	1,721	1,621	100
Original Admissions	138	1,410	1,282	128
ADC Hospice	309.74	302.31	321.88	(19.57)
ADC Home Health	22.77	19.55	19.02	.53
ADC CHC Total	332.51	321.86	340.90	(19.04)

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	**2013** Oct	**2013** Nov	***2012*** ***Dec***
S.B.:	181	188	193	194	189	175	174	189	195	198	194	*186*
Ply:	58	54	59	60	59	61	60	57	65	61	62	*64*
Elk:	59	63	68	62	68	70	70	68	66	67	66	*61*
SBH:	6	6	6	5	6	4	5	4	5	4	4	*4*
EKH:	1	4	4	4	6	4	4	3	4	3	3	*4*
Total:	305	315	330	325	328	314	313	321	334	333	329	*319*

HOSPICE HOUSES

November 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
SB House Pts Served	30	323	287	36
SB House ALOS	3.97	5.17	5.72	(0.55)
SB House Occupancy	56.67%	71.43%	70.02%	1.14%
Elk House Pts Served	18	212	219	(7)
Elk House ALOS	4.78	5.62	5.95	(0.33)
Elk House Occupancy	40.95%	50.94%	55.61%	-4.67%

October 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
SB House Pts Served	32	297	261	36
SB House ALOS	3.50	5.22	5.64	(0.42)
SB House Occupancy	51.61%	72.89%	68.99%	3.90%
Elk House Pts Served	22	201	200	1
Elk House ALOS	4.32	5.50	6.08	(0.58)
Elk House Occupancy	43.78%	51.93%	56.96%	-5.03%

PATIENTS IN FACILITIES

Of the 428 patients served in November, 151 resided in facilities and of the 439 patients served in October, 161 resided in facilities. The average daily census of patients in skilled nursing homes, assisted living facilities, and group homes during November was 122; October was 119 and YTD through November was 113.

FINANCES

Karl Holderman, CFO, reports that the November and year-to-date November 2013 Financials will be posted to the Board website on Friday morning, December 13th following Finance Committee approval. They will review both October and November at that time. The draft, non-approved October 2013 financials are below.

October 2013 Financial Information

Center for Hospice Care

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

October Overall Revenue	$	1,909,809	Year to Date Overall Revenue	$	16,238,626
October Total Expense	$	1,465,549	Year to Date Total Expense	$	13,979,715
October Net Gain	$	444,260	Year to Date Net Gain	$	2,258,911

Hospice Foundation

October Development Income	$	57,909	Year to Date Development Income	$	896,916
October Investment Gains (Loss)	$	448,998	Year to Date Investment Income	$	1,877,942
October Overall revenue	$	508,213	Year to Date Overall Revenue	$	2,835,369
Total October Expenses	$	139,236	Total Year to Date Expenses	$	1,366,507
October Net Gain	$	368,977	Year to Date Overall Net	$	1,468,862

Combined

October Overall Revenue	$	2,049,047	Year to Date Overall Revenue	$	17,605,132
October Overall Net Gain	$	444,260	Year to Date Overall Net Gain	$	2,258,911

At the end of October 2013, Center for Hospice Care's Year to Date Net without the beneficial interest in the Hospice Foundation was $790,048.

At the end of October 2013, CHC and HF combined had a net without investment gain / loss of $380,969.

At the end of October 2013, the Foundation's Intermediate Investments (formerly known as Pool Two) totaled $4,337,086. Long Term Investments (formerly known as Pool Three) totaled $14,946,493. NOTE: $3,424,810 was transferred from CHC to HF to re-balance Investment Pools.

CHC's assets on October 31, 2013, *including* its beneficial interest in the Hospice Foundation, totaled $33.5MM. At October 31, 2013 HF's assets alone totaled just over $29.6MM and debt related to the low interest line of credit associated with the Mishawaka Campus project totaled just over $5.7MM.

2014 CHC BUDGET

The 2014 CHC budget will be reviewed by the Finance Committee on Friday morning, December 13. If passed, the budget will be posted to the board website later that morning. Despite the bi-partisan budget "deal" reached in Congress on Tuesday (12/10/13) restoring some sequestration cuts, Medicare providers were not one of those groups. Thus, the 2014 budget presented to the Finance Committee includes a continuation of the 2% Medicare reimbursement cuts which became effective for hospice providers on 4/1/13. Additionally, the budget is conservative in its census projections for 2014 – even more so than in the 2013 budget. Even with the ongoing reimbursement cuts, additional unfunded and expensive regulatory mandates, and realistic census projections, the 2014 CHC budget does show a net from operations alone.

CHC VP/COO UPDATE

Dave Haley, VP/COO, reports we had a fourth year osteopathic student from Midwestern University in Glendale, Arizona, complete a two-week palliative care rotation with our medical staff in October. A fourth year medical student for the Indiana University School of Medicine in South Bend is completing a four-week palliative care rotation during December. A Family Practice resident from Saint Joseph Regional Medical Center is currently completing a two-week Hospice and Palliative Medicine rotation this week.

On December 3, CHC Medical Director, Amber Burger, MD, was introduced by the CEO of Elkhart General Hospital to their medical staff leaders as their new Director of Palliative Care. This was received very well. Elkhart General Hospital is contracting with CHC to provide 10 hours a week of Dr. Burger's time for palliative care consultations, etc. This is a medical / administrative position and will prove to be mutually beneficial to the hospital and to CHC. We anticipate other such hospital appointments may occur over time and are gearing up a search effort to add another physician to our staff to assist with our anticipated palliative care programming needs, as well as the constant increase in unfunded regulatory requirements from CMS.

Holly Farmer was appointed to the position of Bereavement Coordinator, effective November 17. Holly has been with CHC since May of 2001 as a Bereavement Counselor. She has served as our Camp Evergreen Counselor since 2006. She has also served as Resource Bereavement Counselor since 2011. Holly has a Master of Arts in Counseling Psychology from the University of Notre Dame.

Our annual Memorial Service in memory of patients who have died in the previous year was conducted concurrently in Plymouth, Elkhart, and South Bend on Sunday, December 1. There were a record total of 720 family participants attending. Each family was presented with an angel

ornament bearing the name of their deceased family member. A total of 72 of our spiritual care, bereavement, and nursing staff and volunteers also participated.

In October, Pat Mitchell, CHC Spiritual Care Coordinator, was chosen by the University of Notre Dame to participate in their Theological Department's accreditation survey, which was conducted by the Association of American Theological Schools.

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

DIRECTOR OF NURSING UPDATE

Donna Tieman, RN, DON, reports she held small group quality improvement meetings with all full time nurses during the month of November to re-educate staff on expectations regarding documentation, including reviewing the abbreviation list and how to document quality indicators.

The IT department is collaborating with the nursing department to create mandatory documentation fields in the Cerner Nursing Assessment tool. This feature will ensure we meet both regulatory and internal quality indicator documentation requirements.

Donna is working with Dr. Burger to develop a three-part series on pain management, modeled after the pediatric ELNEC series. Rebecca Fear, RN, CHC Nurse Educator, will develop a self-learning packet and post-test. These sessions will be recorded in order to be utilized for new nurse orientation.

HOSPICE FOUNDATION VP / COO UPDATE

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

Fund Raising Comparative Summary

Through November 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	922,261.84

November	1,294,948.93	1,043,750.46	1,091,575.65	895,164.28	969,395.17
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	57,909.02
November	45,136.29	49,247.09	48,284.08	46,674.33	47,133.33
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**	**865,509.78**

Special Events & Projects

The second annual Okuyamba Fest was held at the new Mishawaka Campus on November 14th. The event was attended by 62 people and raised more than $4,000 for various PCAU-related activities. We continue to receive donations post-event as well. The evening's events included an international beer and wine tasting, hot and cold appetizers, desserts and a 90+ item silent auction featuring Ugandan art and craft items. CHC social worker, Karen Smith-Taljaard, spoke about her experiences at the 5th Bi-Annual Conference. The event also featured presentations by Mike Wargo and HF International Program Coordinator, Denis Kidde. The evening concluded with the debut of a 2:30 teaser of *Road to Hope* created by HF film intern and recent University of Notre Dame Film, Television and Theater graduate, Collin Erker.

The Bike Michiana for Hospice Bike committee held a debriefing/initial planning meeting in October. Of primary concern at this time is the lack of a firm schedule for Notre Dame football during the month of September 2014, which is critical to scheduling our ride date.

FHSSA/PCAU

Brandi Milloy, perhaps best known as a finalist on ABC Television's Oprah's Big Give where she traveled the nation making dreams come true and rallying communities together to give back for a good cause, spent two weeks in Uganda doing a communications audit for PCAU. In addition to the audit, she provided PCAU staff with hands-on training in social media and publicity/ communications. Brandi continues to be involved in PCAU's social media outreach from her Los Angeles, CA home base, writing newsletter articles and helping organize outreach and fundraising activities.

A 20-page "Five-Year Partnership Report" brochure was printed in November and will be mailed to PCAU donors and other key supporters in December, along with a letter thanking them for the support. A PDF has been made available to PCAU and copies of the report will be in Uganda for their use in the first quarter of 2014.

Film Production/Road to Hope Program

Notre Dame film interns, Collin Erker and Marty Flavin spent October and November cataloging and organizing the raw footage taken in Uganda, Kenya and South Sudan during filming for *Road to Hope*. The documentary has already garnered a great deal of attention via social media thanks to promotion of the project via Twitter and Instagram by actress and hospice ambassador Torrey DeVitto, among others. The Facebook page continues to gain "likes" and is now up to 363. The web site, www.roadtohopefilm.org continues to be updated on a weekly basis. It now includes stories of some of the children in the program. More will be added in December. Other additions to the site are the new teaser and updates to the program information. An eight-page brochure was produced for Okuyamba Fest and as a leave-behind piece for those interested in the program. It features information about the program, children currently in the program and the upcoming documentary. The filming also garnered a mention in FHSSA's "FHSSA Partners Focusing on Compassion" in its fourth quarter newsletter.

A hard copy of both the five-year partnership report and Road to Hope brochure will be available at the board meeting.

Mishawaka Campus

We are working with Jeff Helman and Brad Sechrist of Helman Sechrist Architects to develop conceptual designs for Phase II of the Mishawaka Campus. Chris Chockley, Landscape Architecture Department Manager at Jones Petrie Rafinski, is also developing plans for the green space between the buildings and the riverfront area.

Annual Giving

The 2013 Friends of Hospice mail campaign from May / June exceeded its $45,000 goal, coming in at $45,602.37. This year's Annual Appeal was mailed the week of Thanksgiving. It features the stories of Alyssa Peterson, a former Camp Evergreen camper and current "buddy" and Jennifer Dalkowski, a CHC patient who saw her dream of meeting NASCAR race driver Jeff Gordon come true, thanks in part to the dedication of CHC employees and the "We Believe" program. This is the first Annual Appeal to feature the new "Champion" giving level, set at $25,000 in annual, cumulative donations. The goal for this year's Annual Appeal is $100,000.

Communications

The first donor survey, which has been rolled out in phases to donors and supporters, continues to generate responses. To date, all have been positive. Circle of Caring donors received a mailed survey; it's also available online and has been announced via the email newsletter. It will also be in the Fall/Winter issue of Crossroads, which will be mailed in December.

The Foundation, Walk and Bike websites continue to be updated on an on-going basis. The Foundation site is undergoing a design revision to reflect the updated logo colors.

The Foundation (as well as CHC) has been 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. The Foundation, CHC and Road to Hope share 10 PRWeb releases per month.

Collin Erker and Marty Flavin filmed and/or edited a variety of in-house projects including interviews for an internship education/promotion video, capital campaign fundraising campaign interviews and :30/:60 spots for Walk for Hospice and Bike Michiana for Hospice. The duo also worked on our 20th Anniversary Camp Evergreen video this summer.

Third-Party Fundraising

Plans for a Hollywood gala to raise funds for Road to Hope are in the preliminary discussion phase, thanks in great part to actress and hospice ambassador, Torrey DeVitto.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

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

Outreach and Liaison News in October & November

Amy Tribbett was named to the Board of Directors for the local chapter of the Michiana AARP. She was also named to the Advisory Board for 2014 & 2015 for the Notre Dame Chapter of Camp Kesem. Camp Kesem is a college student run summer camp for kids with a parent who has (or has had) cancer.

Referral Meetings, Lunches, Senior Networking and Speaking Engagements

- Lunch inservice with Osceola Family Practice.
- Lagrange County Senior Expo (125+ in attendance) – This was the first time Lagrange County Council on Aging held a Senior Health Fair.
- Lunch and Learn at Greencroft – Consider the Conversation program. We had to cut off a week prior for food count. There were 26 people in attendance.
- RSVP Senior Expo with more than 120 in attendance.
- Biz-Ness Expo – Elkhart Chamber. Several hundred in attendance. CHC had a booth for exposure and interaction with key people in Elkhart area.
- Grief Forum in Warsaw. Good attendance for this event at 13.
- Warsaw Tigers Retirement Community – Presentation on hospice. Ten in attendance.
- Hospice 101 presentation at Hillcrest United Methodist Church in Elkhart 35 in attendance.
- Siemens Health Fair in Elkhart – 40 in attendance with positive feedback regarding our services from families who have used us as well as current recipients.
- Hospice 101 Presentation at Council on Aging's new site in new area of Elkhart at the Tolson Center. Very well received with 24 in attendance and we are going back in January for a Consider the Conversation presentation follow up.

- Veterans program at Eastlake Terraces Assisted Living in Elkhart with 45 in attendance. This was the kick-off of their new Veterans Club which will meet quarterly.
- Presentation to ALS Support Group. The first time the group met at Sprenger Health Care, a partnership CHC initiated.
- Mishawaka Lions Club with about 40 members attending. The group asked perceptive questions and individuals kept our staff for about 20 minutes afterwards to share their compliments for CHC.
- Eastlake Terraces Assisted Living Elkhart - Veterans Club special Veterans Day Recognition Ceremony with 45 in attendance.
- Veterans Club special Veterans Day Recognition Ceremony at Riverside Village in Elkhart with 21 in attendance.
- Presentation at Concord Rotary Club in Elkhart with 35 in attendance.
- Veterans Club special Veterans Day Recognition Ceremony at Beardsley House AL in Elkhart (13) – able to meet briefly with Administrator and new DON. Very appreciative of us coming in for the program and looking forward to us attending quarterly.
- Veterans Club special Veterans Day Recognition Ceremony at Greenleaf in Elkhart with 38 in attendance. We were able to have a brief meeting with the Administrator, DON, and Social Services Director. A Win-Win-Win: Veterans getting deserved recognition, good recognition for CHC, and opportunities to interact with key personnel in the facility that are often are difficult to pin down.
- Veterans Club special Veterans Day Recognition Ceremony at Woodland Manor in Elkhart.
- Valley View Elkhart for 19 people - Veterans Day Ceremony.
- Millers Merry Manor Wakarusa- Veterans Club special Veterans Day Recognition Ceremony with 35 attending.
- Attended Elkhart County TRIAD meeting in Goshen with 15 people to make a short presentation on our We Honor Veterans Designation and our special Veterans Club in area CHC contracted facilities.
- Presentation to Pierceton Senior Center – Hospice 101.
- Presentation to IUSB Elkhart Campus Death and Dying Class – Elkhart for 36 students.
- Presentation to all care staff at ADEC in Bristol with 65 attendees for Hospice 101 and grief.
- Southgate Rotary Club presentation
- Marshall Co. Senior Expo – 1,500 plus people attended. Many conversations regarding hospice in general, differences of hospice programs etc.
- Hospice 101 x 3 at Catherine Kasper Home with 39 attending.
- Veterans Pinning at Pilgrim Manor with seven attending
- Vet Pinning at The Whitlock – Bremen with 14 attending
- Presentation at Woodlawn Oncology in Rochester with seven staff members attending.
- Cambridge Independent Living Apartments for 14 plus their Navigator attended. We were told our presentation had the most residents engaged in a conversation/presentation.

<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. The liaisons are in the process of rolling it out to our top referral sources. Jesse Hsieh, MD, is President of the Board of Trustees at The South Bend Clinic and has been involved with Memorial Hospital, Oncology Advisory (Indiana University Medical School), Medical Education Foundation (Indiana University Medical School), and Project Future. He is a Clinical Associate Professor at Indiana University School of Medicine

and the Medical Editor for Family Magazine (for which CHC has provided advertising and content). He had the following "review" of the app. In two short sentences he succinctly provided the perfect quote by saying, *"It worked great, was easy, and the rest of the staff used it. I give it an 'A'"*.

NEW AND UPDATED CLINICAL POLICIES

There are eight policies on the agenda for your approval. Brief highlights below:

"Availability 24/7" (new) – While not required by any regulation, this policy spells out our desire to have the whole core interdisciplinary hospice team available at all times and not merely nursing and physician. This puts one of our new hospice service promises into policy format.

"Dating of Medical Records" (revised) – revised to include more direction for CHC's electronic medical record.

"ECF Services Provided to a Hospice Patient" (revised) – removed superfluous sections regarding ECF responsibilities which did not belong in a CHC policy.

"Elder Justice Act Reporting" (revised) – revised to meet recent changes in Indiana Law.

"Infection Control Program" (new) – consolidation of policies into a single program policy to meet current regulatory expectations and current CHC practice.

"Plan of Care Coordination" (revised) – removed nebulous phrase.

"Sanctioned Individuals" (revised) – changed to reflect current practice of more frequent checks.

"Standards of Care" (revised) – removed unnecessary and inappropriate "hospice" language for what is a home health care agency policy under our home health license.

ELECTION OF NEW BOARD MEMBERS FOR 2014

The Nominating Committee consisting of Corey Cressy, Julie Englert, Amy Mauro, Mary Newbold, Terry Rodino, and Wendell Walsh have been meeting since July. The process was started earlier this year due to the expected and recently approved bylaws changes which now call for effective board terms beginning three months earlier. The committee was also able to enhance the process of bringing new board members onto CHC board. Over the last six months the committee has been suggesting and researching potential new board members, meeting identified potential members for breakfast and lunch meetings, and proposing a final slate of candidates for 2014. The slate for next year consists of four outstanding candidates who have all agreed to serve. The slate was formally approved by the Executive Committee on 11/18/13. The CHC Board needs to ratify / pass the slate of candidates at this upcoming meeting. Additionally, the CHC Treasurer, Wendell Walsh, will need to be elected for another three-year term. For 2014 there are no changes to the board officers or executive committee of the board. The New Board Member Orientation meeting with the CHC Administrative Team is scheduled for Thursday, January 16 at 7:30 AM. Their first board meeting will be February 19, 2014.

NATIONAL MEDICARE HOSPICE STATISTIC FOR 2012 RELEASED

Attached to this report is the 2013 version of "NHPCO Facts and Figures: Hospice Care in America" which provides an annual overview of important trends in the growth, delivery and quality of hospice care across the country. This overview provides specific information on: hospice patient characteristics (e.g., gender, age, ethnicity, race, primary diagnosis, and length of service); hospice provider characteristics (e.g., total patients served, organizational type, size, and tax status); location and level of care, and many other items. The data is comprised primarily of very recently released Medicare data for calendar year 2012.

Of particular interest…

- The total number of days a hospice patient receives care is referred to as the length of stay. Length of stay can be influenced by a number of factors including disease course, timing of referral, and access to care. The median (50th percentile) length of stay in 2012 was 18.7 days which continues an ongoing downward trend (a decrease from 19.1 days in 2011 and 19.7 days in 2010). Sadly, during 2012 half of hospice patients in the U.S. received care for less than three weeks.

- The number of hospice programs nationwide continues to increase. The first program opened in 1974 and today we have over 5,500. This estimate includes both primary locations and satellite offices (for example, CHC would count as three programs).

- Hospice agencies are organized into three tax status categories:
  1. Not-for-profit [charitable organization subject to 501(c)3 tax provisions]
  2. For-profit (privately owned or publicly held entities)
  3. Government (owned and operated by federal, state, or local municipality).

  Based on analysis of CMS's Provider of Service file, 32% of active Medicare Provider Numbers are assigned to providers that held not-for-profit tax status and 63% held for-profit status in 2012. Government owned programs, (e.g., hospices operated by state and local governments), comprise the smallest percentage of hospice providers (about 5% in 2012.). The number of for-profit Medicare-certified hospice providers has been steadily increasing over the past several years. In contrast, the number of Medicare certified not-for-profit or government providers has begun to decline over the same period. When I started in this industry in 1990, 88% of all hospice programs were nonprofit and today it's less than one-third.

NATIONAL UPDATE: HOSPICE PROVIDER ECONOMIC IMPACT REPORT

I have attached the 2013 NHPCO Economic Impact Report. The economic impact survey was conducted to investigate the impact on hospice operations of current and proposed regulatory changes, together with the general economic environment. The survey queried providers about operational consequences of existing and impending changes in payment and regulations, as well as the current economic climate. The survey was distributed to hospice CEOs or their designees from within the NHPCO membership database. The results of the survey reveal the hospice industry is experiencing substantial financial burden as a result of reductions in payment and increased expenditures related to regulatory requirements, which holds the potential for significant negative

impact on hospice operations and practice. The attached document has not been widely released yet. It's only four pages, but it clearly reflects the current situation facing U.S. hospice programs. As a board member of the national Hospice Action Network (HAN, the advocacy arm of NHPCO), I was able to review a comprehensive executive summary of the raw data, which showed that 68.52% of the responding hospice programs were nonprofit. Thus, we are primarily looking at what our peers are seeing, feeling and planning.

The following bullets highlight items of most interest from the HAN executive summary report:

- ☐ 75% of hospices have increased caseloads / workloads instead of hiring more staff
- ☐ Almost 50% have consolidated clinical positions – primarily management
- ☐ Almost 50% have delayed hiring new clinical positions or frozen hiring altogether
- ☐ Almost half have "modified" salary increases
- ☐ More than two-thirds have cut staff education
- ☐ 42% went into more debt and plan to do so again in 2014
- ☐ 18% see a change in ownership within two years
- ☐ 13% foresee possible closure in five years

OUT AND ABOUT

I attended The Advisory Board Company's Post-Acute Care Collaborative meeting as their guest on November 6 in Chicago, IL.

HF staff Mike Wargo, Chris Taelman, HF Chief Development Officer, Dave Haley and I attended the annual 'Faithful Lives" Dinner to benefit the Foundation of Saint Joseph's Regional Medical Center on November 7. Michiana Hematology Oncology was recognized at the event.

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

Dave Haley's Census Reports.

Biographic Sketch on each of the four new CHC Board Members

NHPCO's Facts and Figures: Hospice Care in America 2013 Edition

NHPCO Economic Impact Survey – 2013

Article from "Boomer" magazine on the Bike Michiana for Hospice 2013

Copy of printed program for the Mishawaka Riverwalk Dedication event on Saturday, November 23 at 9 AM. The program features the new CHC Campus and the event was attended by HF staff Mike Wargo, Chris Taelman and me.

Compliance Committee Minutes 10/29/13

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

October, November and Year-to-Date 2013 Financials.

Promotional materials for “PCAU 5-Year Partnership Report” and “The Road to Hope.”

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, February 19, 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.

# # #

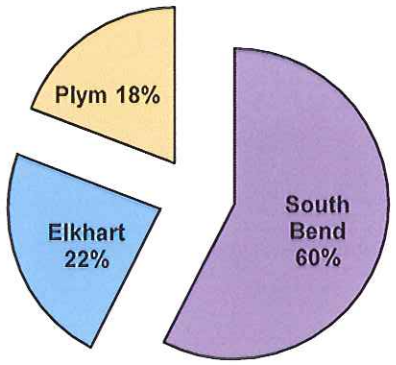
Center for Hospice Care

2013 YTD Average Daily Census (ADC)

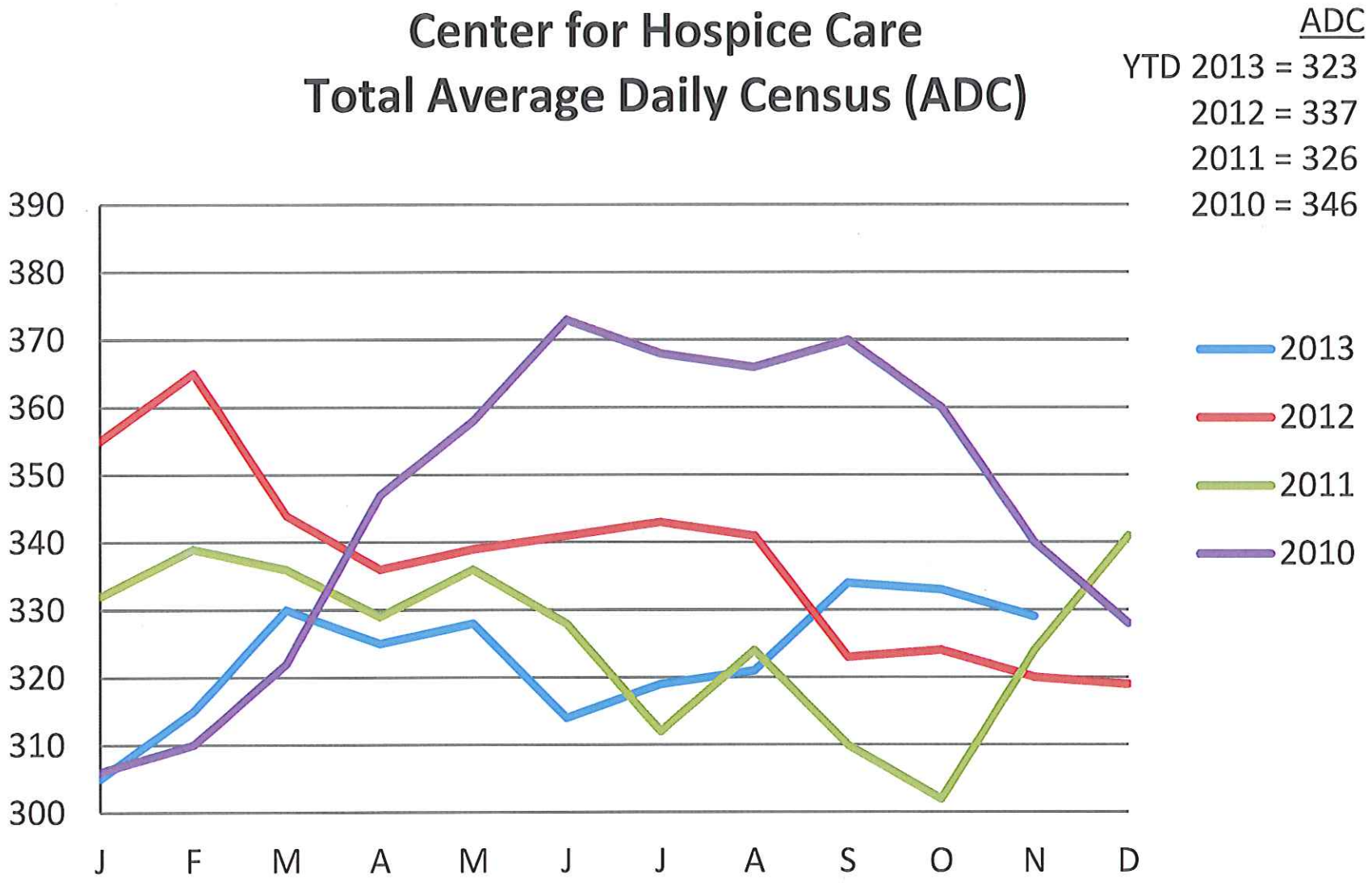
(includes Hospice House and Home Health)

	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	333	202	70	61
N	329	198	69	62
D				
2013 YTD Totals	3553	2135	763	654
2013 YTD ADC	**323**	**194**	**69**	**59**
2012 YTD ADC	339	201	73	65
YTD Change 2012 to 2013	-16	-7	-4	-6
YTD % Change 2012 to 2013	**-4.7%**	**-3.4%**	**-5.0%**	**-8.5%**

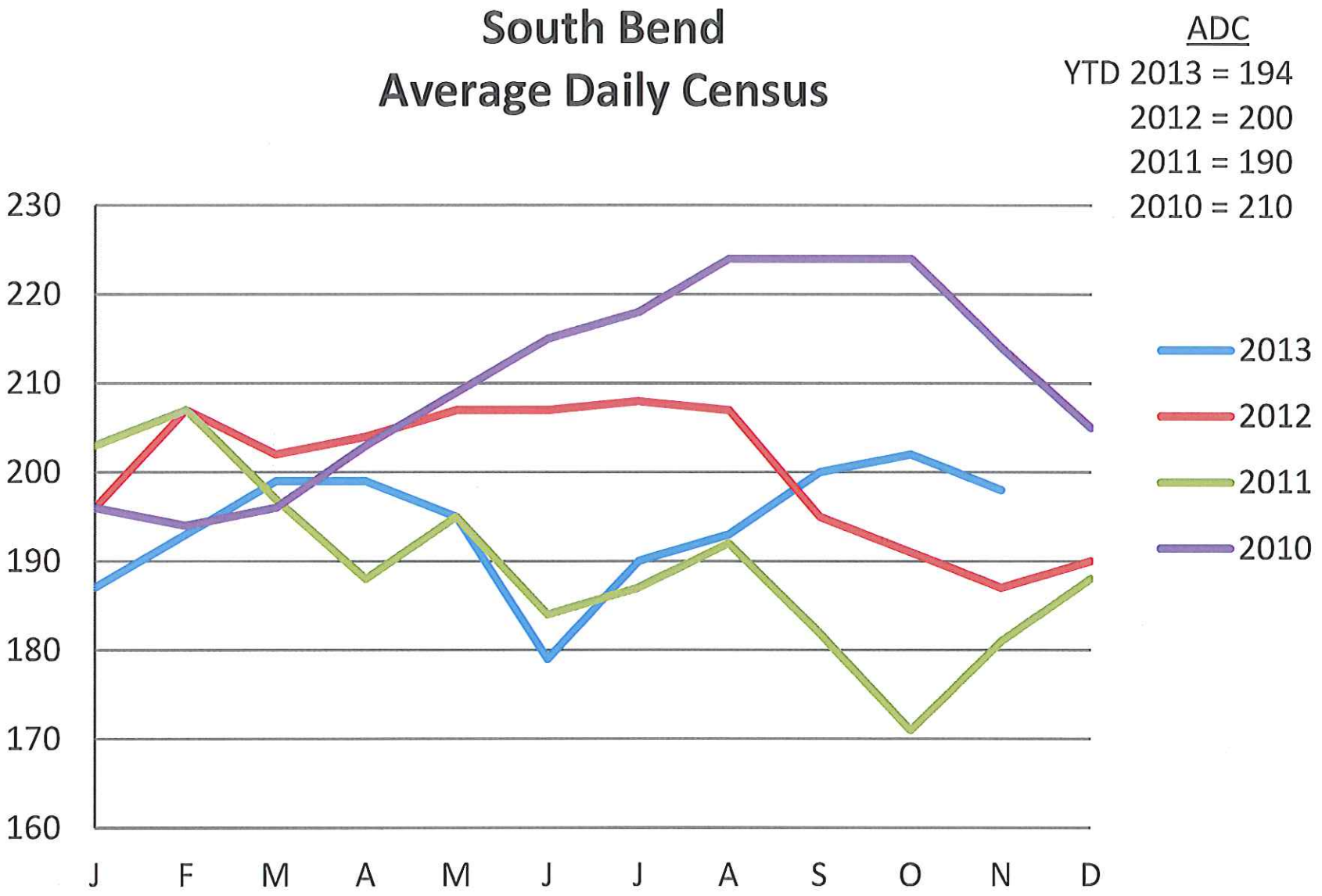
2013 YTD ADC by Branch	
South Bend	60.1%
Elkhart	21.5%
Plymouth	18.4%
All	100%



Center for Hospice Care
Total Average Daily Census (ADC)

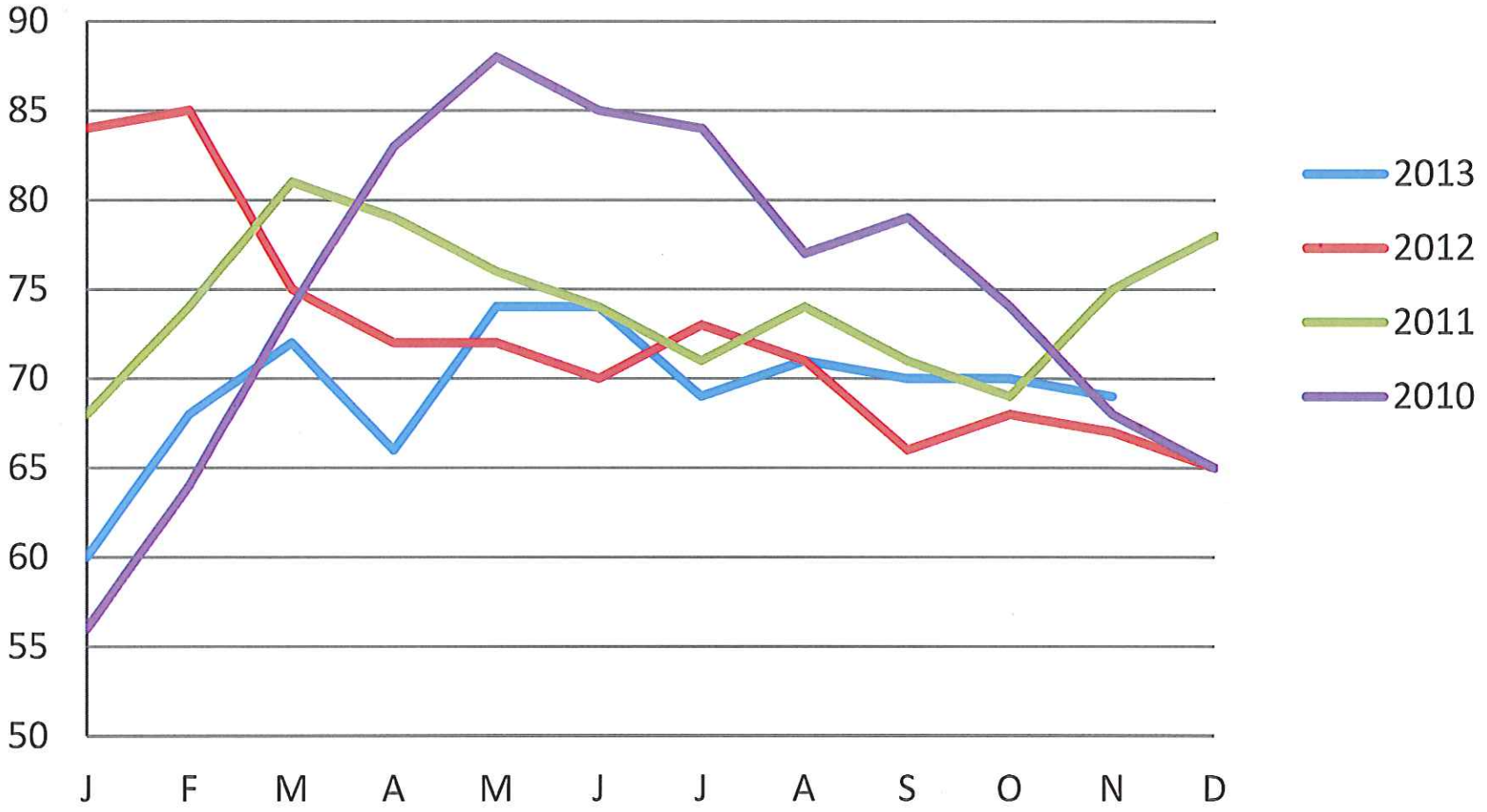


South Bend
Average Daily Census

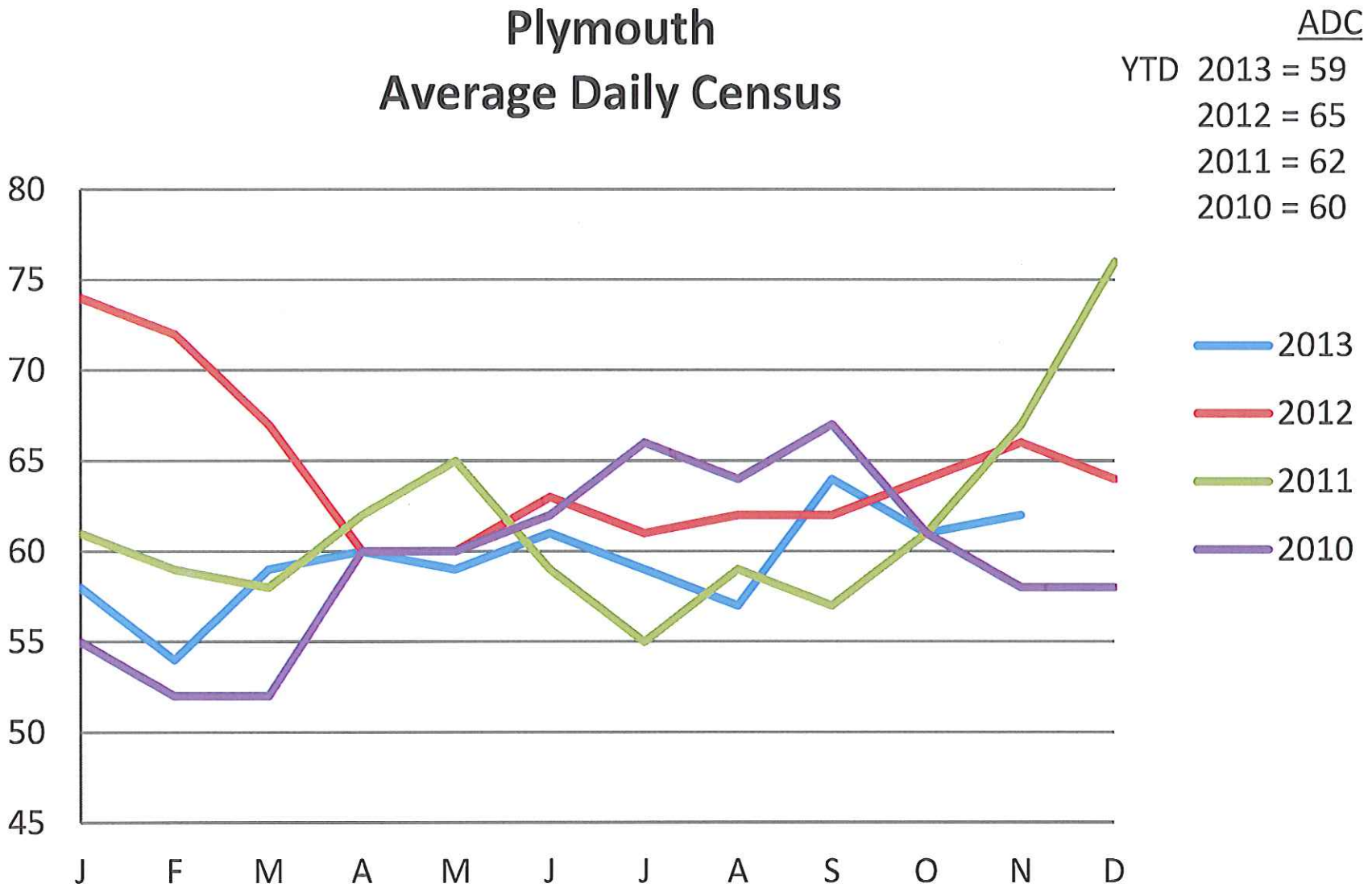


Elkhart
Average Daily Census

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



Plymouth
Average Daily Census



NHPCO's Facts and Figures

Hospice Care in America

2013 Edition

2013

National Hospice and Palliative Care Organization

Table of Contents

Introduction

About this Report

NHPCO Facts and Figures: Hospice Care in America provides an annual overview of important trends in the growth, delivery and quality of hospice care across the country. This overview provides specific information on:

- Hospice patient characteristics (e.g., gender, age, ethnicity, race, primary diagnosis, and length of service)
- Hospice provider characteristics (e.g., total patients served, organizational type, size, and tax status)
- Location and level of care
- Role of paid and volunteer staff

Please refer to "Data Sources" (page 16) and to the footnotes for the source information and methodologies used to derive this information. Additional resources for NHPCO members are also provided on page 14.

What is hospice care?

Considered the model for quality compassionate care for people facing a life-limiting illness, hospice provides expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well.

Hospice focuses on caring, not curing. In most cases, care is provided in the patient's home but may also be provided in freestanding hospice centers, hospitals, nursing homes, and other long-term care facilities. Hospice services are available to patients with any terminal illness or of any age, religion, or race.

How is hospice care delivered?

Typically, a family member serves as the primary caregiver and, when appropriate, helps make decisions for the terminally ill individual. Members of the hospice staff make regular visits to assess the patient and provide additional care or other services. Hospice staff is on-call 24 hours a day, seven days a week.

The hospice team develops a care plan that meets each patient's individual needs for pain management and symptom control. This interdisciplinary team, as illustrated in Figure 1 below, usually consists of the patient's personal physician, hospice physician or medical director, nurses, hospice aides, social workers, bereavement counselors, clergy or other spiritual counselors, trained volunteers, and speech, physical, and occupational therapists, if needed.

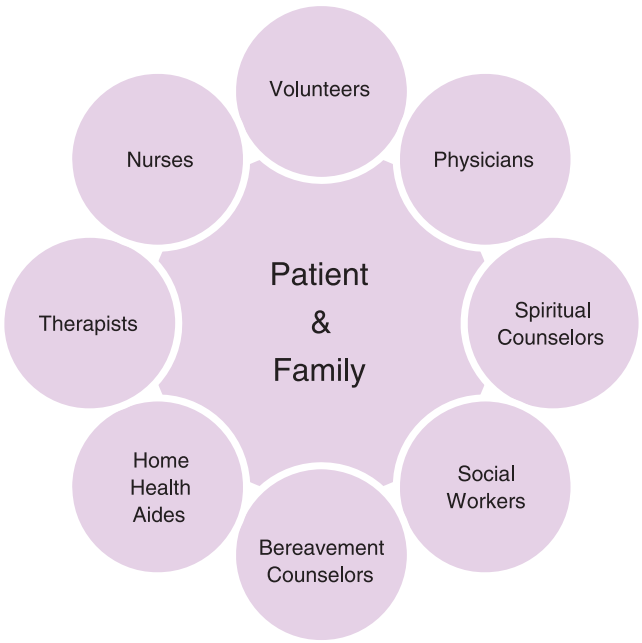


Figure 1. Interdisciplinary team

Who Receives Hospice Care?

How many patients receive care each year?

In 2012, an estimated 1.5 to 1.6[1] million patients received services from hospice (Figure 2). This estimate includes:

- patients who died while receiving hospice care
- patients who received care in 2011 and who continued to receive care into 2012 (known as "carryovers")
- patients who left hospice care alive in 2012 for various reasons including extended prognosis, desire for curative treatment, and other reasons (known as "live discharges")

As shown in Figure 2, the number of patients and families served by hospice has steadily increased over the past several years.

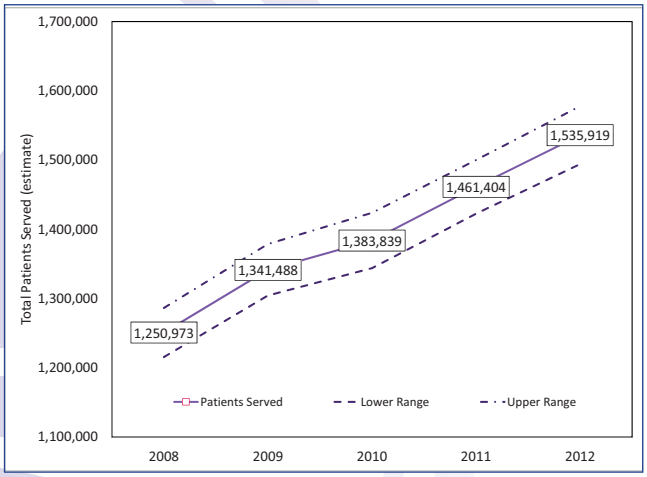


Figure 2. Total Hospice Patients Served by Year [1]

NHPCO continually examines, and when appropriate, revises the methodology employed in its data analysis. The estimate of patients served was generated utilizing a statistical model that NHPCO believes allows a better representation of the number of patients and families accessing hospice services. This model, derived from a combination of NHPCO and CMS data, produces a range of possible values for the estimate rather than a single number.

What proportion of U.S. deaths is served by hospice?

The percent of U.S. deaths served by hospice is calculated by dividing the number of deaths in hospice (as estimated by NHPCO) by the total number of deaths in the U.S. as reported by the Centers for Disease Control and Prevention. NHPCO estimates that approximately 1,113,000 deaths occurred in the U.S. while under the care of hospice. However, currently CDC data on the number of U.S. deaths in 2012 is not available. Therefore, NHPCO is not able to report on the estimated percentage of all deaths while under the care of hospice. This report will be updated when the CDC data becomes available.

Hospice Use by Medicare Decedents

Over the past decade, the hospice industry has been marked by substantial growth in the number of hospice programs and patients served. In an independent analysis of Medicare claims data, Dr. Joan Teno found similar growth in the proportionate use of the Medicare hospice benefit. Of all Medicare decedents in the year 2001, 18.8% accessed hospice for three or more days. By 2007 the proportion of Medicare decedents accessing three or more days of hospice services had increased to 30.1%.

Examination of the number of Medicare decedents with a cancer diagnosis found that 36.6% accessed three or more days of hospice care in 2001. The percentage grew to 43.3% in 2007 for Medicare decedents who received

three or more days of hospice. A similar growth in hospice use was noted for decedents with advanced cognitive impairment and severe functional limitations (dementia). In 2001, only 14.4% of Medicare decedents with a dementia diagnosis received three or more days of hospice care. By the year 2007, that proportion had grown to 33.6%. This trend in hospice use for Medicare decedents from 2001 to 2007 is illustrated in Figure 4.

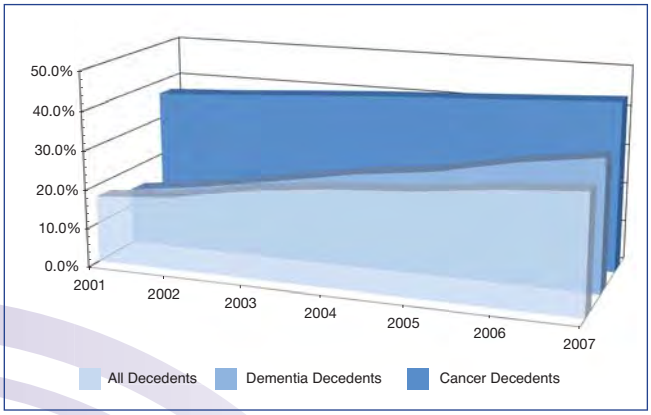


Figure 3. Proportion of Medicare Decedents Accessing Three or More Days of Hospice Care

How long do most patients receive care?

The total number of days that a hospice patient receives care is referred to as the length of service (or length of stay)*. Length of service can be influenced by a number of factors including disease course, timing of referral, and access to care.

The median (50th percentile) length of service in 2012 was 18.7 days, a decrease from 19.1 days in 2011[1]. This means that half of hospice patients received care for less than three weeks and half received care for more than three weeks. The average length of service increased from 69.1 days in 2011 to 71.8 in 2012 (Figure 4)[1]. Over the past several years the median length of service has declined while the average length of service increased.

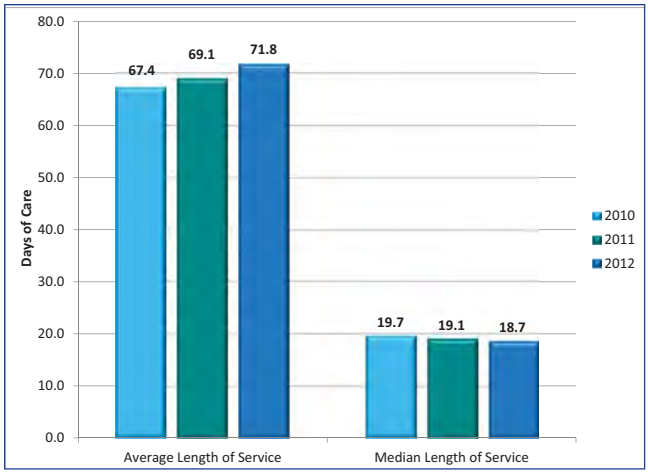


Figure 4. Length of Service by Year [1]

Short and Long Lengths of Service

In 2012, approximately the same proportion of hospice patients (approximately 35.5%) died or were discharged within seven days of admission when compared to 2011 (35.7%)[1]. A slightly smaller proportion of patients died or were discharged within 14 days of admission when compared to 2011 (49.5% in 2012 and 50.1% in 2011)[1]. Approximately the same proportion of patients remained under hospice for longer than 180 days (11.4% in 2011 and 11.5% in 2012)[1].

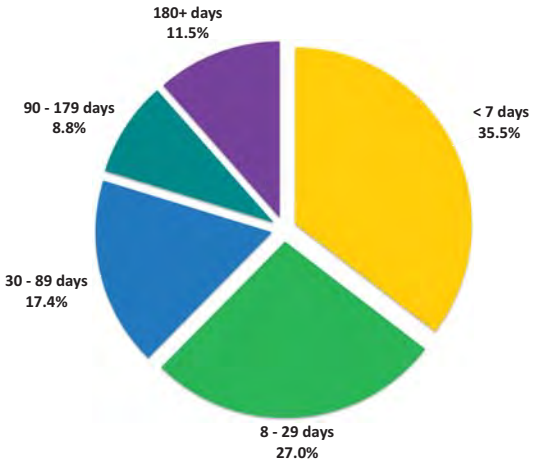


Figure 5. Proportion of Patients by Length of Service in 2012 [1]

* Length of service can be reported as both an average and a median. The median, however, is considered a more meaningful measure for understanding the experience of the typical patient since it is not influenced by outliers (extreme values).

Where do most hospice patients receive care?

The majority of patient care is provided in the place the patient calls "home" (Table 1). In addition to private residences, this includes nursing homes and residential facilities. In 2012, 66.0%[1] of patients received care at home. The percentage of hospice patients receiving care in a hospice inpatient facility increased from 26.1% to 27.4%[1].

Table 1. Location of Hospice Patients at Death [1]

Location of Death	2012	2011
Patient's Place of Residence	66.0%	66.4%
Private Residence	41.5%	41.6%
Nursing Home	17.2%	18.3%
Residential Facility	7.3%	6.6%
Hospice Inpatient Facility	27.4%	26.1%
Acute Care Hospital	6.6%	7.4%

Inpatient Facilities and Residences

In addition to providing home hospice care, about one in five hospice agencies also operate a dedicated inpatient unit or facility[1]. Most of these facilities are either freestanding or located on a hospital campus and may provide a mix of general inpatient and residential care. Short-term inpatient care can be made available when pain or symptoms become too difficult to manage at home, or the caregiver needs respite.

Hospice in the Nursing Home

As the average life span in the United States has increased, so has the number of individuals who die of chronic progressive diseases that require longer and more sustained care. An increasing number of these individuals reside in nursing homes prior to their death. This rise has been mirrored by growth in the number of hospice patients who reside in nursing homes.

A 2010 study by Miller et al., examined the growth of Medicare-certified hospices providing hospice in the nursing home from 1999 to 2006. Using Medicare's minimum data set (MDS), the study found that the proportion of nursing home decedents who received hospice care rose from 14.0% in 1999 to 33.1% in 2006; a growth rate that closely paralleled the increase in Medicare-certified hospice programs. The demographic characteristics of hospice patients in the nursing home changed little during that time and are very similar to the overall characteristics of hospice patients. Most nursing home hospice decedents were female (67%), white (90%), and were older than 85 years (55%)[5].

What are the characteristics of the hospice patient population?

Patient Gender

More than half of hospice patients were female (Table 2).

Table 2. Percentage of Hospice Patients by Gender [1]

Patient Gender	2012	2011
Female	56.4%	56.4%
Male	43.6%	43.6%

Patient Age

In 2012, 83.4%[1] of hospice patients were 65 years of age or older—and more than one-third of all hospice patients were 85 years of age or older (Table 3). The pediatric and young adult population accounted for less than 1% of hospice admissions.

Table 3. Percentage of Hospice Patients by Age [1]

Patient Age Category	2012	2011
Less than 24 years	0.4%	0.4%
25 - 34 years	0.4%	0.4%
35 - 64 years	15.7%	16.0%
65 - 74 years	16.3%	16.3%
75 - 84 years	27.7%	27.6%
85+ years	40.5%	39.3%

Patient Ethnicity and Race

Following U.S. Census guidelines, NHPCO reports Hispanic ethnicity as a separate concept from race. In 2012, more than 6%[1] of patients were identified as being of Hispanic or Latino origin (Table 4).

Table 4. Percentage of Hospice Patients by Ethnicity [1]

Patient Ethnicity	2012	2011
Non-Hispanic or Latino origin	93.1%	93.8%
Hispanic or Latino origin	6.9%	6.2%

Patients of minority (non-Caucasian) race accounted for less than one fifth of hospice patients in 2012 (Table 5)[1].

Table 5. Percentage of Hospice Patients by Race [1]

Patient Race	2012	2011
White/Caucasian	81.5%	82.8%
Multiracial or Other Race	6.7%	6.1%
Black/African American	8.6%	8.5%
Asian, Hawaiian, Other Pacific Islander	2.8%	2.4%
American Indian or Alaskan Native	0.3%	0.2%

Primary Diagnosis

When hospice care in the United States was established in the 1970s, cancer patients made up the largest percentage of hospice admissions. Today, cancer diagnoses account for less than half of all hospice admissions (36.9%)[1] (Table 6). Currently, less than 25 percent of U.S. deaths are now caused by cancer, with the majority of deaths due to other terminal diseases.[4]

The top four non-cancer primary diagnoses for patients admitted to hospice in 2012 remained debility unspecified (14.2%), dementia (12.8%), heart disease (11.2%), and lung disease (8.2%).[1]

Table 6. Percentage of Hospice Admissions by Primary Diagnosis [1]

Primary Diagnosis	2012	2011
Cancer	36.9%	37.7%
Non-Cancer Diagnoses	63.1%	62.3%
Debility Unspecified	14.2%	13.9%
Dementia	12.8%	12.5%
Heart Disease	11.2%	11.4%
Lung Disease	8.2%	8.5%
Other	5.2%	4.8%
Stroke or Coma	4.3%	4.1%
Kidney Disease (ESRD)	2.7%	2.7%
Liver Disease	2.1%	2.1%
Non-ALS Motor Neuron	1.6%	1.6%
Amyotrophic Lateral Sclerosis (ALS)	0.4%	0.4%
HIV / AIDS	0.2%	0.2%

Who Provides Care?

How many hospices were in operation in 2012?

The number of hospice programs nationwide continues to increase — from the first program that opened in 1974 to over 5,500 programs today (Figure 6). This estimate includes both primary locations and satellite offices. Hospices are located in all 50 states, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands.

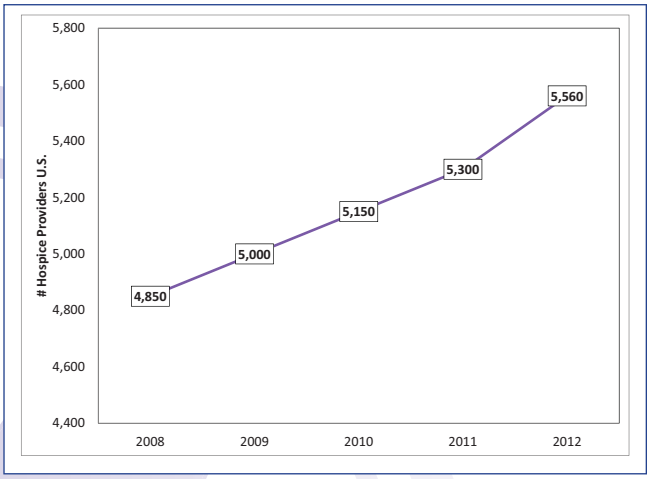


Figure 6. Total Hospice Providers by Year [1]

Agency Type

The majority of hospices are independent, freestanding agencies (Table 7). The remaining agencies are either part of a hospital system, home health agency, or nursing home.

Table 7. Agency Type [1]

Agency Type	2012	2011
Free Standing/Independent Hospice	57.4%	57.5%
Part of a Hospital System	20.5%	20.3%
Part of a Home Health Agency	16.9%	16.8%
Part of a Nursing Home	5.2%	5.2%

Agency Size

Hospices range in size from small all-volunteer agencies that care for fewer than 50 patients per year to large, national corporate chains that care for thousands of patients each day.

One measure of agency size is total admissions over the course of a year. In 2012, 77.4%[1] of hospices had fewer than 500 total admissions (Table 8).

Table 8. Total Patient Admissions [1]

Total Patient Admissions	2012	2011
1 to 49	15.7%	15.4%
50 to 150	28.7%	29.3%
151 to 500	33.0%	34.2%
501 to 1,500	17.7%	16.7%
> 1,500	4.9%	4.4%

Another indicator of agency size is daily census, which is the number of patients cared for by a hospice program on a given day. In 2012, the mean average daily census was 148.5[1] patients and the median (50th percentile) average daily census was 92.2[1] patients. More than one third of providers routinely care for more than 100 patients per day (Figure 8).

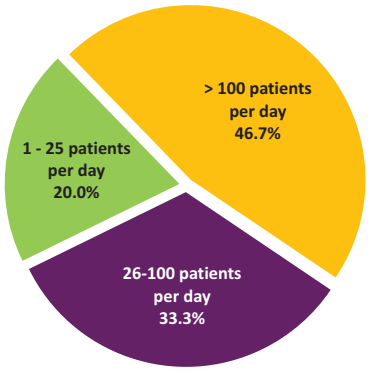


Figure 7. Average Daily Census [1]

Organizational Tax Status

Hospice agencies are organized into three tax status categories:

1. Not-for-profit [charitable organization subject to 501(c)3 tax provisions]
2. For-profit (privately owned or publicly held entities)
3. Government (owned and operated by federal, state, or local municipality).

Based on analysis of CMS's Provider of Service (POS) file, 32%[2] of active Medicare Provider Numbers are assigned to providers that held not-for-profit tax status and 63%[2] held for-profit status in 2012. Government-owned programs, (e.g., hospices operated by state and local governments), comprise the smallest percentage of hospice providers (about 5%[2] in 2012.).

The number of for-profit Medicare-certified hospice providers has been steadily increasing over the past several years (Figure 8). In contrast, the number of Medicare-certified not-for-profit or government providers has begun to decline over the same period.

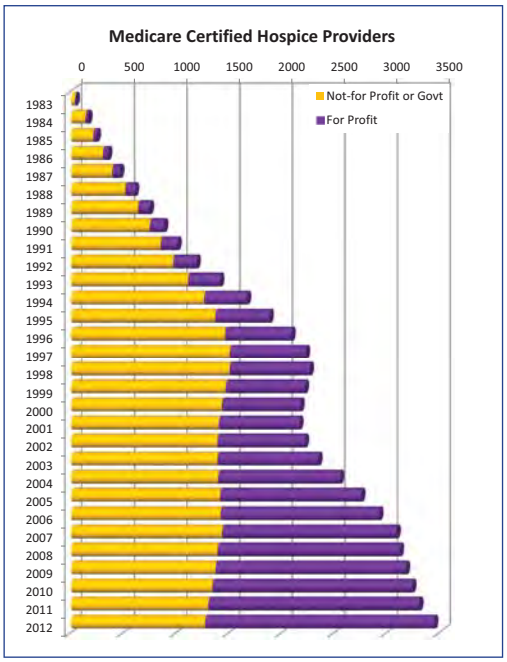


Figure 8. Growth in Medicare-Certified Hospice Providers[2]

Who Pays for Care?

Financial concerns can be a major burden for many patients and families facing a terminal illness. Hospice care is covered under Medicare, Medicaid, and most private insurance plans, and patients receive hospice care regardless of ability to pay.

Hospice Participation in Medicare

The Medicare hospice benefit, enacted by Congress in 1982, is the predominate source of payment for hospice care. The percentage of hospice patients covered by the Medicare hospice benefit versus other payment sources was 83.7%[1] in 2012 (Table 9). The percentage of patient days covered by the Medicare hospice benefit versus other sources was 89.0%[1] (Table 10).

Table 9. Percentage of Patients Served by Payer [1]

Payer	2012	2011
Medicare Hospice Benefit	83.7%	84.0%
Managed Care or Private Insurance	7.6%	7.7%
Medicaid Hospice Benefit	5.5%	5.2%
Uncompensated or Charity Care	1.2%	1.3%
Self Pay	0.9%	1.1%
Other Payment Source	1.2%	0.7%

Table 10. Percentage of Patient Care Days by Payer [1]

Payer	2012	2011
Medicare Hospice Benefit	89.0%	87.9%
Managed Care or Private Insurance	4.4%	5.0%
Medicaid Hospice Benefit	4.3%	5.0%
Uncompensated or Charity Care	0.8%	1.0%
Self Pay	0.6%	0.5%
Other Payment Source	0.9%	0.6%

Most hospice agencies (93.1%[1]) have been certified by the Centers for Medicare and Medicaid Services (CMS) to provide services under the Medicare hospice benefit. In 2012, there were more than 3,700[2] certified hospice agencies. Figure 9 shows the distribution of Medicare-certified hospice providers by state.

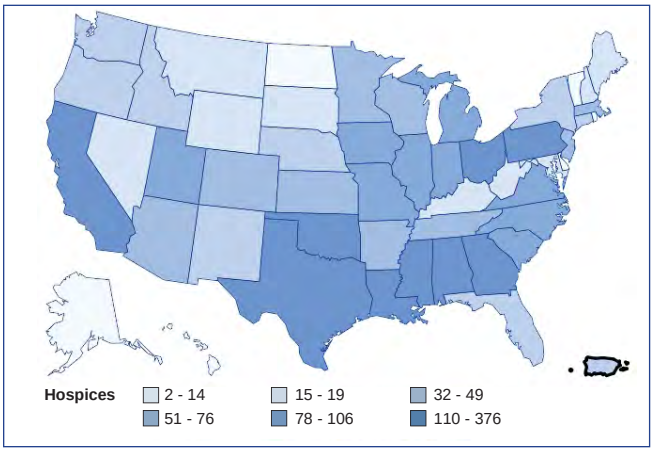


Figure 9. Medicare-Certified Hospices by State [2]

Non-certified providers fall into two categories:

1. Provider seeking Medicare certification (e.g., a new hospice);
2. Provider not seeking certification. This group includes providers that (1) may have been formerly certified by Medicare and voluntarily dropped certification, or (2) have never been certified. The provider may have an arrangement with a home health agency to provide skilled medical services, or it may be an all-volunteer program that covers patient care and staffing expenses through donations and the use of volunteer staff.

How Much Care is Received?

What services are provided to patients and families?

Among its major responsibilities, the interdisciplinary hospice team:

- Manages the patient's pain and symptoms
- Assists the patient with the emotional, psychosocial and spiritual aspects of dying
- Provides needed drugs, medical supplies, and equipment
- Instructs the family on how to care for the patient
- Delivers special services like speech and physical therapy when needed
- Makes short-term inpatient care available when pain or symptoms become too difficult to treat at home, or the caregiver needs respite
- Provides bereavement care and counseling to surviving family and friends.

What level of care do most hospice patients receive?

There are four general levels of hospice care:

Home-based Care

1. Routine Home Care: Patient receives hospice care at the place he/she resides.
2. Continuous Home Care: Patient receives hospice care consisting predominantly of licensed nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home.

Inpatient Care

3. General Inpatient Care: Patient receives general inpatient care in an inpatient facility for pain control or acute or complex symptom management which cannot be managed in other settings.
4. Inpatient Respite Care: Patient receives care in an approved facility on a short-term basis in order to provide respite for the caregiver.

In 2012, routine home care comprised the vast majority of hospice patient care days (Table 11).

Table 11. Percentage of Patient Care Days by Level of Care [1]

Level of Care	2012	2011
Routine Home Care	96.5%	97.1%
General Inpatient Care	2.7%	2.2%
Continuous Care	0.5%	0.4%
Respite Care	0.3%	0.3%

Staffing Management and Service Delivery

Hospice team members generally provide service in one or more of the following areas:

- Clinical care, including patient care delivery, visits, charting, team meetings, travel, and the arrangement or coordination of care
- Non-clinical care, including administrative functions
- Bereavement services.

Hospice staff time centers on direct care for the patient and family: 70.4%[1] of home hospice full-time equivalent employees (FTEs) were designated for direct patient care or bereavement support in 2012.

The number of patients that a clinical staff member is typically responsible for varies by discipline. In 2012, the average patient caseload for a hospice aide was 11.0[1] patients, 11.3[1] patients for a nurse case manager, and 26.5[1] patients for a social worker.

Volunteer Commitment

The U.S. hospice movement was founded by volunteers and there is continued commitment to volunteer service. NHPCO estimates that in 2012, 400,000[1] hospice volunteers provided 19 million[1] hours of service. Hospice volunteers provide service in three general areas:

- Spending time with patients and families ("direct support")
- Providing clerical and other services that support patient care and clinical services ("clinical support")
- Helping with fundraising efforts and/or the board of directors ("general support").

In 2012, most volunteers were assisting with direct support (60.8%[1]), 18.6%[1] provided clinical care support, and 20.7%[1] provided general support.

Hospice is unique in that it is the only provider whose Medicare Conditions of Participation requires volunteers to provide at least 5% of total patient care hours.

In 2012, 5.4%[1] of all clinical staff hours were provided by volunteers. The typical hospice volunteer devoted 44.4[1] hours of service over the course of the year and patient care volunteers made an average of 21[1] visits to hospice patients.

Bereavement Support

There is continued commitment to bereavement services for both family members of hospice patients and for the community at large. For a minimum of one year following their loved one's death, grieving families of hospice patients can access bereavement education and support.

In 2012, for each patient death, an average of 1.7[1] family members received bereavement support from their hospice. This support included follow-up phone calls, visits and mailings throughout the post-death year.

Most agencies (92.5%[1]) also offer some level of bereavement services to the community; community members account for about 13.5%[1] of those served by hospice bereavement programs.

Assessing the Quality of Hospice Care

A system of performance measurement is essential to quality improvement and needs to be a component of every hospice organization's quality strategy. For optimal effectiveness, performance measurement results should include internal comparisons over time as well as external comparisons with peers.

NHPCO offers multiple tested performance measures that yield useful, meaningful, and actionable data that can be used to:

- Identify components of quality care
- Discover what areas of care delivery are effective
- Target specific areas for improvement.

NHPCO also provides comparative reporting of results for these performance measures as a member benefit. In addition, NHPCO is engaged in the development of new performance measures, plus ongoing refinement and enhancement of the current measures. Several examples of NHPCO measures can be found in Table 12.

Table 12. Sample NHPCO Hospice Performance Measures

Performance Measure	2012
Family Evaluation of Hospice Care (FEHC)	
Overall Rating *Percent of individuals rating the quality of hospice care "excellent"*	73.5%
Composite Score *Global measure of hospice quality based on 17 core measures*	85.8%
Family Evaluation of Bereavement Services (FEBS)	
How well services met the needs of the bereavement client (% "Very Well")	75.8%
Comfortable Dying Measure	
Patient's pain brought to a comfortable level within 48 hours of initial assessment	66.7%
Patients still uncomfortable due to pain 48 hours after initial assessment	12.6%

Additional Statistics for NHPCO Members

National Summary of Hospice Care

Active hospice and palliative care provider members of the National Hospice and Palliative Care Organization may access additional statistics in NHPCO's ***National Summary of Hospice Care***. This annual report includes comprehensive statistics on provider demographics, patient demographics, service delivery, inpatient services, and cost of care. It is provided exclusively to NHPCO members at no cost, and it can be downloaded from the National Data Set survey webpage at www.nhpco.org/nds.[i]

A partial list of summary tables includes:

- Inpatient facility statistics
  - Level of care
  - Length of service
  - Staffing
- Length of service by
  - Agency size
  - Agency type
  - Primary diagnosis
- Palliative care services
  - Percent providing palliative consult services
  - Percent providing palliative care services at home or in an inpatient facility
  - Percent of physician hours devoted to palliative clinical care
- Patient visits
  - Visits per home care admission
  - Visits per day
  - Visits per week
- Payer mix by
  - Agency tax status
  - Agency type
- Revenue and expenses

NHPCO Performance Measure Reports

NHPCO members also have access to national-level summary statistics for the following NHPCO performance measurement tools:

1. Patient Outcomes and Measures (POM) (www.nhpco.org/outcomemeasures)
   - Pain relief within 48 hours of admission (NQF 0209)
   - Avoiding unwanted hospitalization
   - Avoiding unwanted CPR
2. Family Evaluation of Bereavement Services (FEBS) (www.nhpco.org/febs) [ii]
3. Family Evaluation of Hospice Care (FEHC) (www.nhpco.org/fehc) [iii]
4. Survey of Team Attitudes and Relationships (STAR) [iv] (www.nhpco.org/star)
   - Job satisfaction (hospice-specific)
   - Salary ranges
   - Provider-level results

[i] A valid NHPCO member ID and password are required to access the NHPCO National Summary of Hospice Care report. This report is only available to current hospice and palliative care members of NHPCO.
[ii] Participating agencies receive provider-level reports comparing their hospice's results to national estimates.
[iii] Participating agencies receive provider-level reports comparing their hospice's results to national estimates and peer groups.
[iv] The STAR national summary report is available for purchase by both NHPCO members and non-members through NHPCO's Marketplace.

Suggested citation:

NHPCO Facts and Figures: Hospice Care in America. Alexandria, VA:
National Hospice and Palliative Care Organization, October 2013.

Questions may be directed to:

National Hospice and Palliative Care Organization

Attention: Research

Phone: 703.837.1500

Web: www.nhpco.org/research

Email: Research@nhpco.org

Appendix 1: Data Sources

1. 2012, NHPCO National Data Set and/or NHPCO Member Database.
2. 1st Quarter 2012, Centers for Medicare and Medicaid Services (CMS) Provider of Service File (POS).
3. Hoyert DL, Xu J,. *Deaths: Preliminary Data for 2011*, National Vital Statistics Reports, vol 61 no 6. National Center for Health Statistics, CDC, available online at: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf.
4. Murphy SL, Xu J, Kochanek KD. *Final Data for 2010*, National Vital Statistics Reports, vol 61 no 4. National Center for Health Statistics, 2013
5. Miller SC, Lima J, Gozalo PL, Mor V. *The Growth of Hospice Care in U.S. Nursing Homes*. JAGS. 2010 58:1481-88.

Appendix 2: How Accurate are the NHPCO Estimates?

Estimation, especially when performed on a national level, is a challenging undertaking. NHPCO is continuously working to improve and validate the estimates that are provided to members and the greater hospice community. However, many of the national estimates rely on a less-than-optimal convenience sample of hospices voluntarily submitting data to the NHPCO National Data Set (NDS).

In the fall of 2010, NHPCO performed a comparative analysis with data obtained through a probabilistic sampling methodology – considered the gold standard sampling method – performed by the National Center for Health Statistics (NCHS). Earlier that year, the NCHS released data from its 2007 National Home and Hospice Care Survey (NHHCS). NHPCO first performed a complete analysis of hospice data from the 2007 NHHCS and then compared the results to estimates from the 2007 National Summary of Hospice Care.

The findings of the comparison provide strong corroborating evidence in support of NHPCO's national estimates. Analysis of similar data between the two data sets describes program and patient characteristics of very similar distributions. For statistical comparison, 95% confidence intervals (95% CI) were included in the estimates generated from the NHHCS data. When comparing results, most point estimates generated from the NDS data fell within the 95% CI of the NHHCS results. All such results are considered to be not appreciably different. Even those point estimates landing outside the 95% CI were often very close and also likely not to be statistically significantly different. However, statistical significance testing is needed to confirm that results are, in fact, not statistically significantly different.

An example of the representativeness of the NDS is the distribution of hospices by size, as measured by total unique patient admissions during a year. Table 1 shows the side-by-side comparison of estimates of the distribution of hospice sizes by total admissions generated from NHHCS and NDS data. In all cases, the NDS-based point estimates of the proportion of hospices in each size category were within the 95% CI of the estimate generated from the probabilistic-based NHHCS data. Comparison of results for the distribution of agencies by ownership type [freestanding NHHCS 56.3 (48.4 – 64.2) vs NDS 58.3 | non freestanding NHHCS 41.1 (33.6 – 48.7) vs. NDS 41.8] shows that differences between the two estimates are not appreciably different. Comparable variables were not available for other agency-level characteristics.

Table 1. Distribution of Hospice Size by Total Patient Admissions (2006)

Total Patient Admissions	NHHCS Percent (95% CI)	NDS Percent
0 to 49	15.9% (10.5 – 21.2)	17.9%
50 to 150	31.7% (23.7 – 39.7)	29%
151 to 500	30.9% (23.3 – 38.5)	34.1%
501 to 1,499	11.1% (7.2 – 15.1)	14.5%
1,500 or more	4.2% (2.5 – 5.9)	4.5%

Results for estimates of patient characteristics were also comparable between NDS and NHHCS data. Tables 2 through 4 show estimates of the distribution of patient characteristics. In all cases, the point estimates

generated from NDS data fall within the 95% CI of estimates generated from NHHCS data. These again are a strong corroborative indication that the characteristics of patients represented in the NDS are representative of patients on a national level.

Table 2. Percent of Non-Death Discharges

NHHCS Percent (95% CI)	NDS Percent
15.6% (13.8 - 17.4)	15.9%

Table 3. Patient Demographics

Gender	NHHCS Percent (95% CI)	NDS Percent
Male	44.9% (42.4 - 47.4)	46.1%
Female	55.1% (52.6 - 57.6)	53.9%
Age (yrs)		
0 - 24	0.27% (0.03 - 0.52)	0.5%
25 - 34	0.29% (0.02 - 0.57)	0.4%
35 - 64	16.4% (14.5 - 18.2)	16.5%
65 - 74	15.4% (13.6 - 17.2)	16.2%
75 - 84	29.5% (27.2 - 31.7)	30%
≥ 85	38.2% (35.7 - 40.7)	36.6%

Not all comparisons were as closely matched as the examples above. In some cases, point estimates generated from NDS were outside the 95% CI of estimates from NHHCS data on one or more characteristics. Table 4 illustrates one such example. The NDS-based estimates for the proportion of patients whose primary payment source was either Medicare, Medicaid, Self-pay, or Other were all outside of the 95% CI of the estimates based on NHHCS data. In this example, it cannot be assumed that the proportion estimates are the same (not statistically significantly different); however, the NDS-based estimates were so close to the 95% CI that it is likely they are still not statistically significantly different. The result of the comparison of estimates of primary payment source is therefore inconclusive.

Table 4. Percent of Patients by Primary Payment Source

Payment Source	NHHCS Percent (95% CI)	NDS Percent
Medicare	79.3% (77.2 – 81.4)	83.6%
Medicaid	3.82% (2.9 – 4.8)	5.0%
Managed Care/ Private Insurance	9.2% (7.7 – 10.7)	8.5%
Self Pay	0.79% (0.32 – 1.26)	0.9%
Uncompensated/ Charity	0.61% (0.23 – 0.98)	1.3%
Other	2.1% (1.4 – 2.7)	0.7%

The tables provided are a sample of the total analysis performed by NHPCO. Overall, the estimates generated from NDS data are very similar to those generated from NHHCS data. These results provide evidence that, although derived from a convenience sample of data, the estimates NHPCO generates in its National Summary of Hospice Care and distributed in this Facts and Figures report are reliable and accurate.

Introduction

The NHPCO 2013 Economic Impact Survey was conducted to investigate the impact on hospice operations of current and proposed regulatory changes, together with the general economic environment. The survey queried providers about operational consequences of existing and impending changes in payment and regulations, as well as the current economic climate. The survey was distributed to hospice executive directors or their designees with a valid email address in the NHPCO membership database.

The results of the survey reveal that the hospice industry is experiencing substantial financial burden as a result of reductions in payment[1] and increased expenditures related to regulatory requirements[2], which holds the potential for significant negative impact on hospice operations and practice.

[1]Reductions in payment include: (a) Budget Neutrality Adjustment Factor (BNAF; -4.2% overall through 2016), (b) Productivity Adjustment Factor (-11.8% overall through 2022), and (c) Sequestration (-2% per year through 2022).

[2]New regulatory requirements include the Face-to-Face requirement, disallowing debility and failure to thrive as primary diagnoses for hospice patients, and additional data and quality reporting requirements.

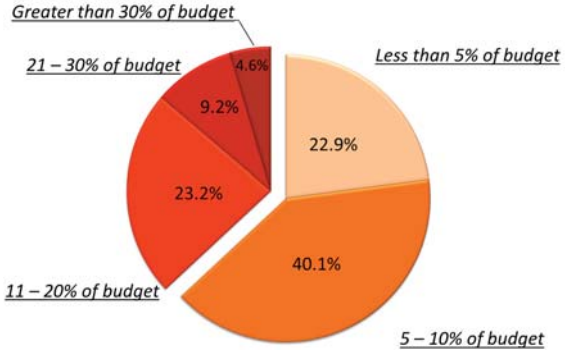
NHPCO ECONOMIC IMPACT SURVEY–2013

Reductions in Revenue

Virtually all hospices report some degree of negative effect on operating budgets because of reductions in revenue due to the Budget Neutrality Adjustment Factor (BNAF), productivity adjustment, and sequestration. Over three-quarters report a moderate to severe effect for 2013, and even more (86.4%) anticipate a similarly significant effect in 2014.

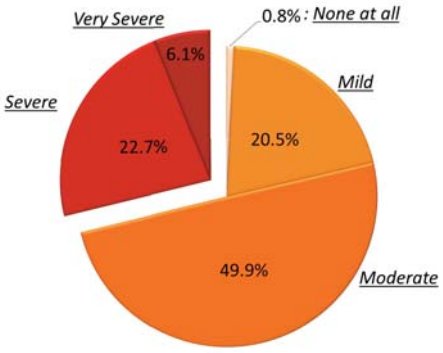
Hospices also report decreased revenue in 2013 due to multiple additional causes, most prominently reduction in number of referrals, sustained reduction in average daily census, and reduction in number of patient days. Close to 80% of hospices estimate that, taken together, reductions in revenue represent over 5% of their annual operating budget and greater than 30% of their budget.

Percent of Budget Represented by Lost Revenue

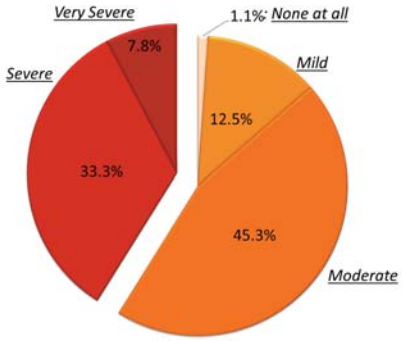


"This year has been the most financially challenging I have experienced in leading a hospice program--now over 30 some years. We have made it through, but hanging by a thread. We will be unable to sustain reduced revenues without extensive program cuts."

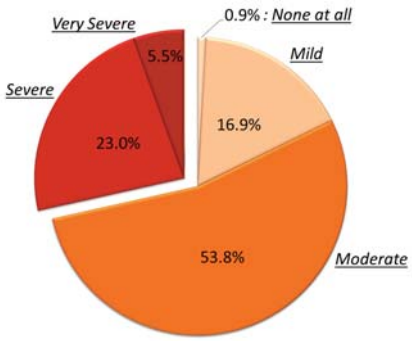
Severity of Effect on 2013 Budget: Reductions in Revenue



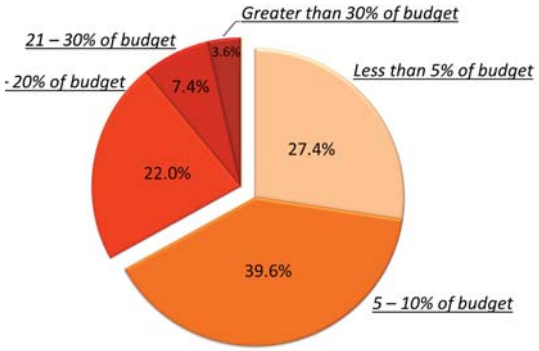
Severity of Effect on 2014 Budget: Reductions in Revenue



Severity of Effect on 2014 Budget : Increases in Expenditures



Percent of Budget Represented by Increased Expenditures



Increase in Expenditures

Over the past several years, hospices have incurred increased expenditures related to new requirements for added data submission on claims forms and Face-to-Face encounters for patient recertification. In 2014, hospices will have multiple additional regulatory requirements for even more data collection (additional data items on claims forms and expanded cost report) and quality reporting (2014 implementation of seven new quality measures with a standardized data collection instrument and 2015 implementation of a hospice experience of care survey).

Compliance with these requirements will necessitate increased expenditures related to software and patient record updates, staff training, development of new processes for data collection and oversight, and vendor contracts. In addition, 64% of hospices report having to hire additional staff to comply with the Face-to-Face requirement.

Over 80% of hospices report a moderate to severe budgetary effect for the increased expenditures, representing over 5% of their annual operating budget for close to three quarters of the hospices.

Also, hospices are incurring increased expenses for day-to-day operations because of the current economic and healthcare environments. Hospices report increased expenditures related to overhead costs (70%), medications and supplies (83%), uncompensated care (68%), and benefits and compensation needed to attract and retain staff (85%).

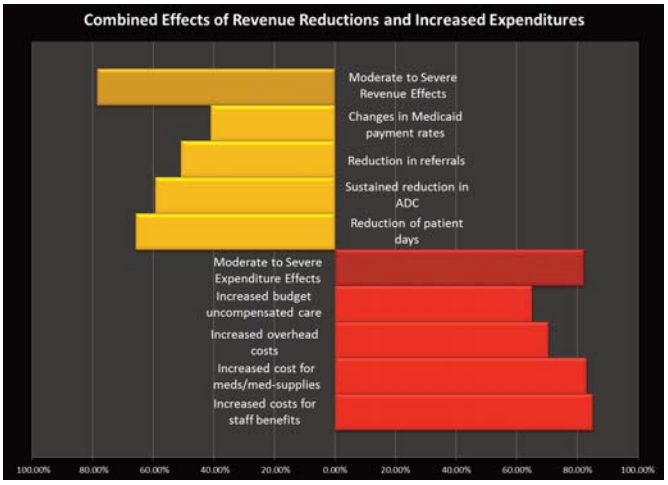
"It takes a massive amount of time trying to keep up with regulatory changes, implementing those changes, and finding resources to help keep us cost effective and compliant."

"We recognize the need for time and effort in compliance. However, like Face-to-Face, the costs already added and those that will be added to insure compliance with reporting, like every RX a patient uses, is not recoverable through changes in practice."

Compound Effects

When considered together, the effect of concomitant reductions in payment and increased expenditures related to new regulatory requirements is significant and presents a substantial economic burden for hospices. While these two budgetary factors represent the greatest financial strain on hospice budgets, hospices are also experiencing multiple additional economic environmental conditions that further decrease revenues and increase expenditures.

Compound Effects



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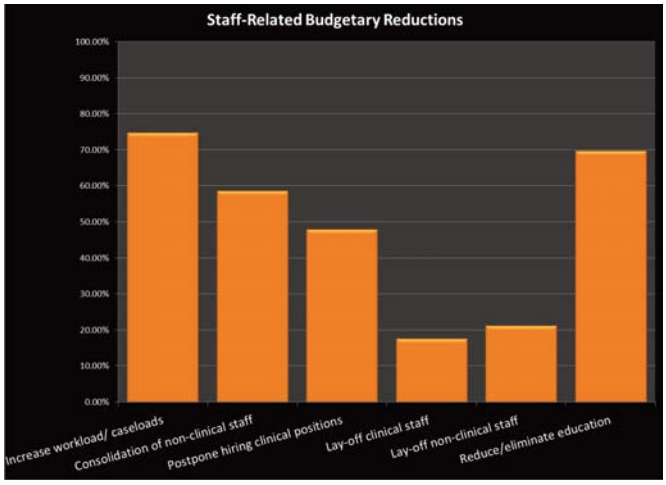
Consequences and Actions



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Consequences and Actions

In response to decreased revenue and increased expenditures, the vast majority of hospices (89.6%) reported that they had implemented measures to reduce spending in 2013 and even more (91.7%) anticipate doing so in 2014. Virtually all of these measures directly or indirectly affect hospice staff.

Three-quarters of hospices have increased workload and/or caseloads (in lieu of hiring additional staff) and just under two-thirds have consolidated non-clinical positions. Just under one-half have consolidated clinical positions (primarily management), almost half have postponed hiring new clinical positions, and a quarter have instituted a hiring freeze. Close to half have modified salary increases and over two-thirds are spending less on staff education. Despite implementing an array of measures to preserve staffing positions, 21% of hospices have laid off non-clinical staff and 18% have laid off clinical staff.

"Clinical staff have had to deal with numerous changes whether resulting from a CR, a MAC interpretation, introduction of Medicaid Managed Care, an EMR upgrade, etc. is just mind numbing and crazy making for them. They are doing work they love, but in an environment that their teammate may be RIF'ed or they may have an assignment they didn't sign on for."

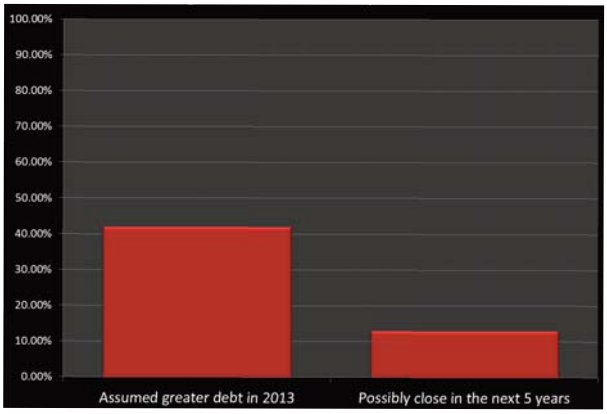
"Our organization cannot keep asking staff to do more and earn less. We are going to lose experienced hospice nurses, nurse practitioners, physicians, social workers, chaplains and hospice aides. With health care worker shortages in the market, we are going to lose the ability to care for more patients at a time when the demand from the community and the aging population is growing."

Hospices are doing their utmost to maintain service provision, but may need to cut back in the near future. For example, most report an increase in the number of requests for uncompensated care over the past two years, with 65% reporting a corresponding increase in budget to accommodate these requests. However, 73% anticipate they will have a great deal of difficulty meeting these requests in 2014.

"Totally out of balance between the expenses associated with increased burden of administrative & regulatory requirements, ongoing operational challenges/ expenses in provision of hospice care and decrease in patient service revenue/fundraising. Later referrals and decrease in LOS are very taxing to the agency from a human and financial resource perspective."

"It is a scary time for us. We are a small community based hospice who just want to serve our community and with all the mandates and budgetary issues, and regulatory burdens, it makes it increasingly difficult to provide quality end of life care."

Large Scale Financial Implications



Looking ahead, hospices report some potential large-scale effects of their current financial situation that may have serious consequences. Forty-two percent report taking on greater debt in 2013 and that same number anticipate assuming greater debt in 2014. Seventeen and a half percent report considering a change in ownership within two to three years and thirteen percent foresee possible closure in the next 5 years.

Implications

The combined financial burden of decreased revenue and increased expenditures, and the budgetary consequences of that burden, has the potential for significant negative effects for hospices. Because most costs are fixed, the one area where hospices can reduce spending is staffing. However, measures such as increased caseloads and decreased benefits frequently lead to burnout, lower staff satisfaction and higher turnover – which in turn may reduce the quality of patient care. In addition, constraints on type or number of patients served, as well as mergers and closures, have negative implications for access to hospice care.

"With potential changes in reimbursement due to decreased number of admissions and lower length of stay our revenue will decrease. We foresee the potential of having to decrease some of our services such as taking all the indigent patients. Generally we have been able to accept all patients [without health coverage] but last week alone we had 5 referrals [of this nature]. We already had our limit at the time these calls came in."

"We are a medium to small hospice. The overall reduced income has only moderately affected our business at this time but we foresee the potential of having to decrease some of our services such as taking all the patients [without health coverage]. We see the increased scrutiny in what we pay for and what we provide and this is causing more "figuring" on whether or not we can take on patients with higher needs. We are seeing less donations to our little [foundation] which we use to assist in paying for funerals and other expenses that families can't absorb. Due to the decreased number of nurses we have to pay a higher and higher wage to get nurses that we can trust to do a good job out in the field. There is an increased work load being applied to all staff to decrease payroll as [much as] possible."

"Our cost going up makes it more challenging to provide the high quality of care that we are known for."

"In 2009 when we first began feeling the economic challenges impacting our nation and our industry, our agency made a concerted effort to be proactive in preparing for the changes in the economic climate. Our efforts have been to no avail. We have continued to operate in the red every month and I am uncertain as to how long this can continue."

"We are experiencing an increase in clinical staff turn-over. These staff persons are reporting to management they feel frustrated with the constant changes and increase in documentation to meet regulations. Staff physicians report increased frustration with…additional documentation requirements that detract from patient care."

"The increasing scope and accelerating pace of regulatory change places a growing burden on senior management, and all levels of staff. This is a significant distraction from our efforts to provide high quality hospice services to a market that has a very low utilization of hospice (18% of Medicare decedents, vs. 40% nationally) within the constraints of Medicare reimbursement."

"Our organization can adapt to change with a reasonable amount of time for preparation and change management. Current changes in reimbursement, regulation and administrative burdens are occurring too fast for any organization to adapt to without severe hardship."

National Hospice and Palliative Care Organization

Hospice Action Network

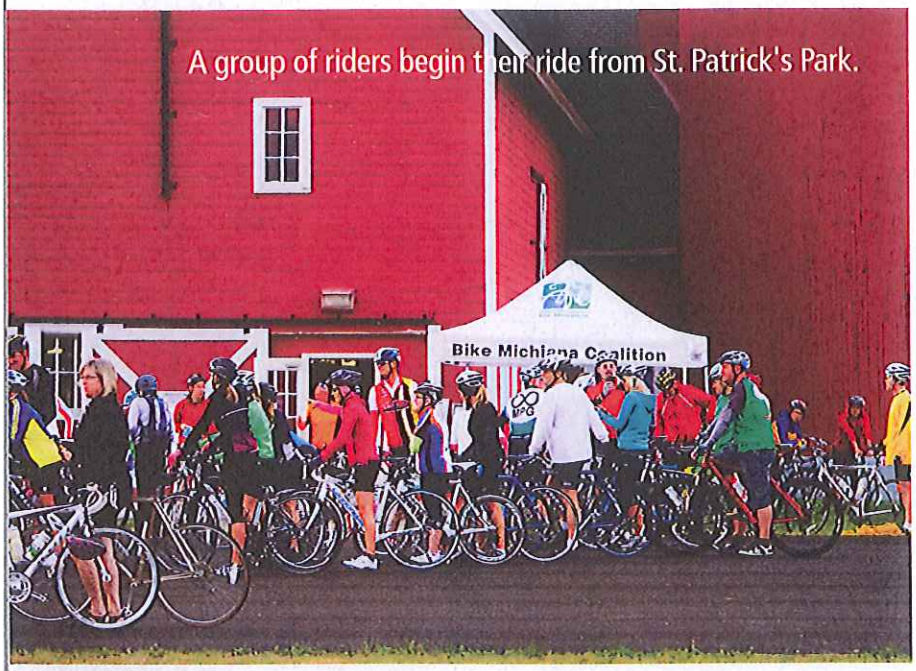
The Scene

BOOM Magazine promotes Michiana's cultural offerings, personalities, attractions and local businesses, with a special emphasis on non-profit organizations' events and activities. We expect this section of BOOM to grow significantly, and we'd like your help to get it rolling!

Please send us some of your favorite photos from your organization's or charity's best events and fundraisers. They just may make the next issue of BOOM Magazine! We prefer snapshots of people that are full of life and enjoying the moment, so please send them our way: Info@MichianaFamilyMagazine.com.

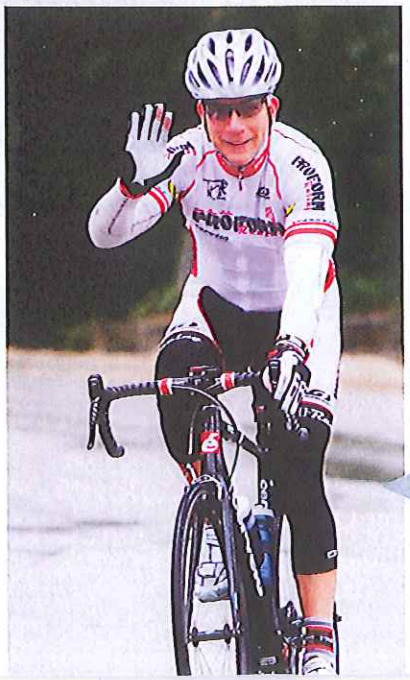
Hospice Foundation

2013 Bike Michiana



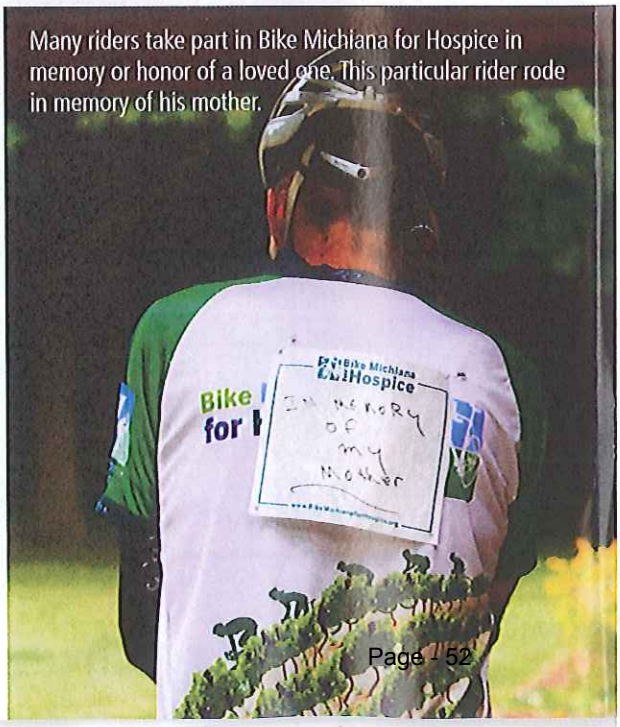
A group of riders begin their ride from St. Patrick's Park.

The German Band Inc., a traditional German "oom pah" band, entertained riders at the Spicer Lake SAG stop.

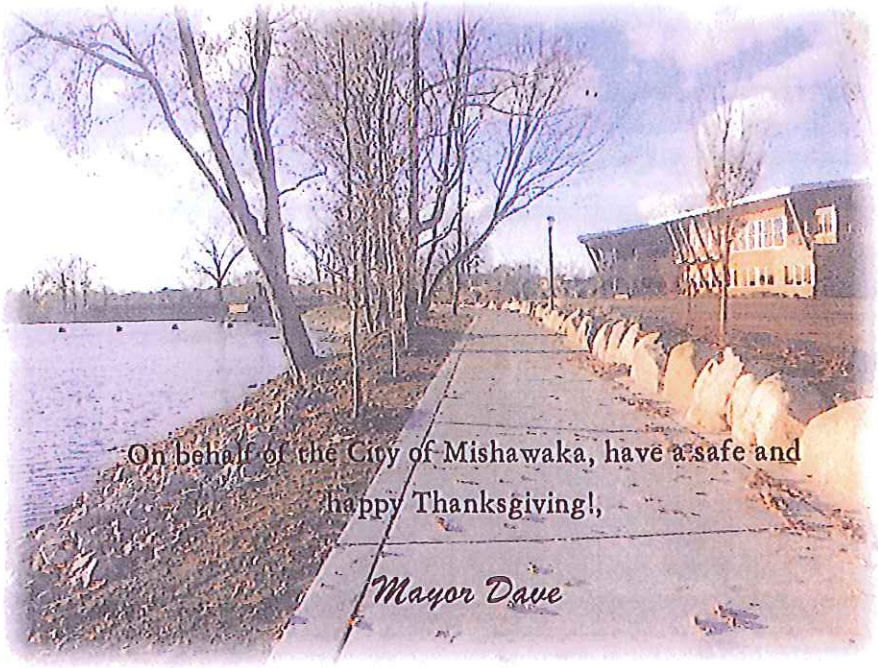


A sampling of some of the great food available at the SAG stops during Bike Michiana for Hospice.

One of many Spin Zone riders pulls into the Weko Beach SAG stop to get some much-needed refueling after riding all the way to the shores of Lake Michigan!



Many riders take part in Bike Michiana for Hospice in memory or honor of a loved one. This particular rider rode in memory of his mother.



Please join us for a special time of thanks and giving!

Come and help us celebrate the official opening of the Mishawaka Riverwalk Central Park to Madison Street Extension Project. This project was done in conjunction with and is adjacent to the Center for Hospice Care Campus. At this time we will dedicate the *"Circle of Life"* Sculpture at the IDNR Fish Ladder.

Where:

The ribbon cutting will be at the fish ladder adjacent to the sculpture.

Please park in Central Park.

When:

Saturday November 23rd, at 9:00am

In the sprit of the season, please bring:

Hats and mittens/gloves to be collected by the Mayor's Youth Council.

Items will be donated to the Mishawaka Food Pantry.

A special thank you to our consultant, sculptor, general contractor, and the IDNR for all your help with the project-

Consulting Engineer

LAWSON-FISHER ASSOCIATES P.C.

General Contractor

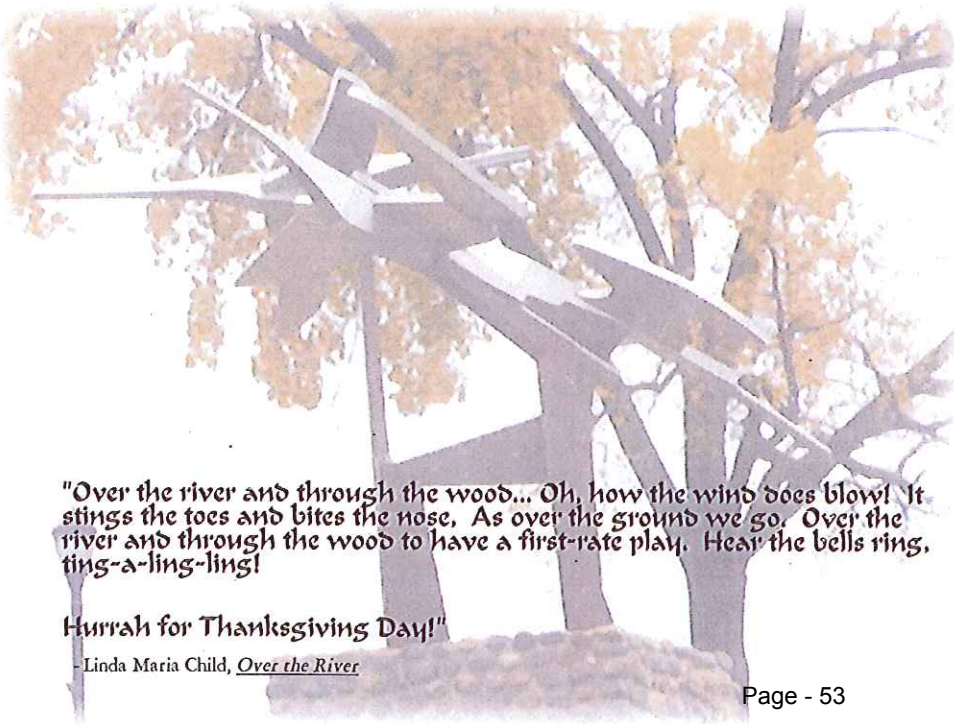
SELGE CONSTRUCTION COMPANY INC.

Sculptor

ROBERT KUNTZ

In cooperation with the

INDIANA DEPARTMENT OF NATURAL RESOURCES



Center for Hospice Care
Compliance Committee Meeting Minutes
October 29, 2013

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

Topic	Discussion	Action
1. Call to Order: 3:00 p.m.		
2. Palmetto LCDs	• The new versions are in use now. Some more changes probably coming.	
3. Follow Up	• Reviewed minutes of the 07/24/13 meeting. Review of documentation for GIP level of care is ongoing. It doesn't only pertain to the nursing department. We have been focusing on it since last the meeting. At the time of the IDT we make sure specific questions get answered that we think the OIG is focusing on, like symptoms that need to be managed, and what has been tried in the home/ECF that has not worked. The PCCs have been asked to review with the IDT how it will be documented in the chart once the decision is made for the patient to go to GIP. The medical directors are doing a good job asking those questions up front. Once a patient is at GIP, we continue to substantiate why they came into Hospice House, what we are doing to manage their symptoms, etc. Danielle and Ann continue to audit for it. Having dedicated social workers assigned to Hospice House has also been very helpful. This will be reviewed as part of the annual compliance in-service at the 11/20 staff meeting.	
4. Home Health Compliance Plan	• The Home Health Compliance Plan was reviewed. • Page 22 – Informed Consent. Our policy says patient or legal representative. An attorney said first the patient or beneficiary should sign forms themselves if they have the capacity. If not, we need to make sure the person signing has the legal authority to do so in Indiana. The decision tree is on the staff website as a tool for staff to help them figure out who can sign for the patient. If there is no one to sign, document that. We need to make sure staff is following the policy and decision tree. They can't get neighbors or whoever is there to sign. This applies to both hospice and home health. There is a difference between a POA and Health Care Representative. We need to re-educate staff on the decision tree, where it is located, and to follow it. We will have Krieg DeVault review it to make sure it is up-to-date and then make it the compliance in-service for 2014. It could be presented earlier in the year. Karl still has the	

Topic	Discussion	Action
	PowerPoint that was used when we first presented the decision tree. • Page 31 – Standards of Care. The first paragraph under Procedure doesn't apply to home health—it is hospice. Will delete it. • Page 40 – Orientation Checklist. It refers to the HR orientation checklist for all employees. • Page 45 – Sanctioned Individuals. We are checking physicians, vendors, staff and volunteers monthly, so we will change "annually" in the first paragraph under Procedure to "monthly."	
5. HIS Survey	• Per CMS the initial one has to be done at the time of admission, but it doesn't say it has to be done at the initial assessment. The second HIS has to be completed at the time of discharge. This is for all payer sources. The form would be completed by the admission nurse and at the discharge visit. The information deals with the continuum of care—where the patient came from and what is going on when we got them. It is probably the beginning of a hospice OASIS. A clerical person can get the information for the HIS. Donna will look up the window of time we have to complete and submit it. It begins 07/01/14, and we will start it April 1st so we'll be ready. We will discuss this further at the next administrative team meeting.	
6. Health Literacy Article	• The committee reviewed an article from the Hospice Compliance Network on "Health Literacy an Unexplored Quality Issue for Hospices." It was suggested that we have our volunteers review the admission packet to see if they understand it. This would allow us to count the time as volunteer hours and also provide us with feedback on our written information. Gail and Amy will look into the free, online health literacy training referenced in the article.	
Adjournment	• The meeting adjourned at 3:45 p.m.	Next meeting 1st quarter 2014

Center for Hospice Care
choices to make the most of life

CHAPTER FOUR

POLICIES

REGULATION: 42 CFR 418.100(c)(2) – Organization and Administration of Services

PURPOSE: To ensure availability of quality, interdisciplinary patient care 24/7.

POLICY: Care and services provided by CHC are available 24/7 to meet the needs of patients and their caregivers.

PROCEDURE:

1. The Agency assures that there is adequate staffing to meet the needs of its patients.
2. On call services are provided to patients and their caregivers after business hours and on weekends and holidays for telephone consultations and visits as needed.
3. The hospice Medical Director or designee provides 24 hour coverage for patient medical needs that arise.
4. The Agency maintains contracts with medical equipment companies to assure that medical equipment (including emergency maintenance, replacement or backup) and supplies are available to all patients 24/7 and in a timely fashion. A medical supply inventory is maintained at the office and may be accessed on an as needed basis.
5. Contractual agreements are maintained with pharmacies in the hospice's service area to assure that medications are readily available.
6. Contracts with acute care facilities throughout the Agency's service area are maintained to provide general inpatient and inpatient respite care when necessary.
7. Other hospice services, including social work and spiritual care, which may provide bereavement support, are available on an on call basis as needed outside of normal business hours.
8. Interdisciplinary team members are available to attend patient deaths 24/7.

Effective Date: 07/13	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

Signature: President/CEO

Center for Hospice Care

DATING OF MEDICAL RECORDS

Section: Compliance, Patient Care Category: Hospice, Compliance Page: 1 of 1

REGULATION: 42 CFR 418.104(b) – Clinical Records

PURPOSE: To sign and date medical records in compliance with federal and state regulations.

POLICY: Under the 410 Indiana Administrative Code (IAC) 17.1-9.1, medical record must include clinical notes that document all services provided and that are signed by the individual providing the services. Under 405 IAC 1-5-1, all providers participating in the Indiana Medicaid program must maintain clinical records that identify the person rendering services to the patient, his/her position, and the date services are rendered.

PROCEDURE: ~~Documentation of clinical notes includes entering the required information into the computer and is inclusive of the individual entering and dates of service.~~ All services provided to Agency patients by CHC staff and contracted staff are documented in the clinical record by the individual providing the service. Each original entry into the medical record will have an electronic date and time stamp, and include the electronic signature of the person providing the services.

Each employee is assigned a unique electronic name and password as their login ~~n~~ to the patient's medical record. This electronic login constitutes as the employee's electronic signature (see "Securing Patient Information in the Electronic Record.")

In the event the electronic medical record is not functional, manual documentation will be corrected by a strike through and the initials of the individual making the correction. If a manual addendum to the record is necessary, the person making the addendum will identify the new entry beginning with the word "Addendum" and will complete the entry with a signature and date.

~~When adding to a medical record, identify it as an addendum, list the date of when the activity occurred, document and sign name along with credentials.~~ If a medical record requires an addendum or correction, the individual staff person making the correction or addendum will identify the new information as an addendum, and type their name and date below the final new entry.

RISK AREA: False dating of amendments to medical records.

Effective Date: 08/00	Revised Date: 08/13~~05/11~~	Board Approved: 08/17/11
Reviewed Date: 12/09		Signature Date: 08/17/11

Signature: President/CEO

REGULATION: 42 CFR 418.112 – Hospices that provide hospice care to residents of a SNF/NF or ICF/MR.

PURPOSE: To ensure that the terminally ill resident who elects palliative care services in an Extended Care Facility (ECF) will receive the same services as if they were residing in their own home.

POLICY: Center for Hospice Care will provide hospice services in an ECF only after a written agreement has been finalized, if required, and does not unlawfully influence the referral of patients from said contracted facilities.

Core services are routinely provided directly by Agency employees. ~~Contracted staff may be used to provide core services only when necessary during periods of peak patient loads or under extraordinary circumstances.~~ When contract staff is used, the Agency maintains professional, financial, and administrative responsibility for the services. Hospice care will be provided to nursing facility residents in accordance with accepted standards of practice and is carefully coordinated with the nursing facility staff.

PROCEDURE: Before a patient residing in a nursing facility is admitted to a hospice program, an agreed upon contract is signed by both parties spelling out the responsibilities of each.

The centralized admission team handles hospice referrals from all referral sources in the same manner.

Hospice core services including nursing, medical social work, and counseling, are provided directly by Agency staff and are not delegated to nursing facility staff or privately paid professionals.

Non-core services may be provided at fair market value in accordance with contracts with other providers.

The Agency maintains professional management responsibility for all contracted services and ECF staff.

~~The nursing facility staff is expected to provide care for the hospice patient resident equal to that provided by family and other caregivers for hospice patients that do not reside in a facility.~~

Signature:  President/CEO

Hospice patients who reside in nursing facilities receive care according to the hospice plan of care that is established and reviewed by the hospice IDT and coordinated with care provided in the nursing facility.

Hospice patients who reside in nursing facilities receive care and services that are reasonable and necessary for the management of the terminal illness.

RISK AREAS:

Providing hospice services in a Long-Term Care facility (LTC) before a written agreement has been finalized.

Providing hospice services to actual or potential referral sources that may violate the anti-kickback statute, federal or state statute or regulation, including improper arrangements with the nursing homes.

Hospice overlapping the services that a nursing home provides, which results in insufficient care provided by a hospice to a nursing home resident.

Hospice improperly relinquishing core services and professional management responsibilities to nursing home staff, volunteers, and privately paid professionals.

Center for Hospice Care

ELDER JUSTICE ACT REPORTING

Section: Patient Care, Compliance Category: Hospice, Hospice Compliance Page: 1 of 1

REGULATION: Patient Protection and Affordable Care Act – Section 1150B

PURPOSE: To identify Agency staff reporting responsibility under the Elder Justice Act.

POLICY: Center for Hospice Care staff will report known or reasonable suspicions of crimes against residents of Skilled Nursing Facilities (SNF) that the Agency is contracted with to provide hospice services. These crimes may include, but are not limited to, abuse, neglect, theft, and/or fraud.

PROCEDURE:

1. Reasonable suspicion ~~Upon learning~~ of a crime against a resident of a contracted SNF, will be reported ~~the crime~~ to the Indiana State Department of Health (ISDH) by email, fax, or telephone, and to the County Sheriff's office of the county the SNF is located in. The contact numbers are posted at each Agency location in the employee break room and on the Agency staff website.

2. Reasonable suspicion of a crime ~~Those crimes~~ resulting in serious bodily injury will ~~are to~~ be reported immediately to the above agencies. The reporting will occur no later than ~~within~~ two hours after forming the suspicion. ~~of becoming aware of the witnessed or suspected crime.~~

3. Reasonable suspicion of a ~~All other~~ crime~~s~~ not related to serious bodily injury will be ~~are to be~~ reported to the above agencies within 24 hours after forming the suspicion. ~~of knowledge of the crime.~~

4. Report all reasonable suspicion of ~~such witnessed or suspected~~ crimes to your supervisor immediately.

Effective Date: 10/11	Revised Date: 07/13	Board Approved: 10/19/11
Reviewed Date:		Signature Date: 10/19/11

Signature: President/CEO

Center for Hospice Care **DRAFT** New

INFECTION CONTROL PROGRAM

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

REGULATION: 42 CFR 418.60 – Infection control

PURPOSE: To monitor, track and prevent the transmission of communicable disease and infection.

POLICY: The Agency maintains and documents an effective, organization-wide infection control program that includes active monitoring, surveillance, identification, prevention and control of known or suspected infections among the hospice's patients and employees.

PROCEDURE:

1. The hospice's infection control program includes, but is not limited to, the following components:
   (a) Education and training for staff, volunteers and patients/caregivers on the principles of infection identification, prevention and control;
   (b) Education for staff and volunteers on the use of standard precautions;
   (c) Designation of the Director of Nursing as the focal point of accountability for the infection control program in collaboration with the hospice's QA Coordinator and Infection Control committee;
   (d) Collection and analysis of surveillance data related to infections among staff, volunteers and hospice patients;
   (e) A written bloodborne pathogens exposure control plan; and,
   (f) A written plan for dealing with epidemics as a component of the hospice's emergency/disaster management plan.

2. As an integral component of the hospice's quality assessment and performance improvement program, infection control data is collected and analyzed to determine trends and areas in need of improvement to minimize risk of infections. Data collected may include, but not be limited to:
   (a) Identification of targeted infections;
   (b) Identification of unusual/undesirable trends and factors contributing to those trends;
   (c) Monitoring staff compliance with infection control policies and procedures; and,
   (d) Reportable employee or patient illnesses and infections.

3. A summary of all infection control activities performed, as well as results of aggregated surveillance data analysis is provided by the Infection Control QAPI and included in reports to the hospice's leaders at the quarterly QI meeting.

4. The hospice's written infection control plan and its infection control practices are monitored, reviewed, evaluated and updated on an annual basis and as needed.

Effective Date: 07/13	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

Signature: President/CEO

Center for Hospice Care

PLAN OF CARE COORDINATION

Section: Patient Care, Compliance Category: Hospice, Compliance Page: 1of 1

REGULATION: 42 CFR 418.112 – Hospices that provide hospice care to residents of a SNF/NF or ICF/MR.

PURPOSE: To facilitate the coordination of the plan of care between Agency and the long-term care (LTC) facility.

POLICY: The Agency interdisciplinary staff and the LTC interdisciplinary staff will meet ~~on a regular basis to~~ facilitate the coordination of the plan of care for the Agency patient residing in the LTC facility.

PROCEDURE:

1. On admission, the nurse will initiate the plan of care, leaving a written copy in the facility chart and starting the plan of care in the computer.

2. The first visit for the primary nurse will be two-fold: one to assess the patient, and second to coordinate the plan of care with the facility staff
3. The coordinated plan of care will be reviewed at each visit and any changes in the plan of care will be communicated to the LTC staff when they occur and documented in both charts.

4. Monthly the Patient Care Coordinator will fax to the appropriate facility contact a the list of current Agency patients in their facility, with the request to fax Agency when the patient's care conference will be held, so that we may be in attendance.

5. Upon receiving notice of a conference time, the Patient Care Coordinator will notify the Agency staff in writing.

6. The Agency team will attend the care conference and document their attendance.

Effective Date: 01/02 Revised Date: 07/13~~05/11~~ Board Approved: 08/17/11
Reviewed Date: 12/09 Signature Date: 08/17/11

Signature: President/CEO

PURPOSE: To ensure physicians are not sanctioned by the government

POLICY: The Agency will routinely verify that affiliated and referring physicians are not sanctioned by the state or federal government.

PROCEDURE:

List of Excluded Individuals/Entities (LEIE)

Monthly~~Annually~~ the LEIE will be searched by the QA Coordinator to ensure no active physicians affiliated with Agency are on it. A search will also be conducted upon referral from a new physician.

Licensure Verification

Human Resources will verify current physician licensure for each referring physician every two years.

Out of State Physicians

Out of state physicians will be reviewed through the process above. In addition, the Medical Director will review their care to assure that it is in compliance with Indiana practice standards.

PURPOSE: Declare standards of care to be utilized by Center for Hospice Care (Agency).

POLICY: The standards of care and practice utilized by the Agency shall be those standards required under all applicable federal and state regulations. The only exception to this shall be where the Agency has adopted policies representing a higher standard(s) than those defined in the applicable federal and state regulations.

PROCEDURE: ~~Agency affirms life and neither hastens nor postpones death. It is the mission of the Agency "to comfort and support all people facing the end of life," while upholding the values of compassion, dignity, innovation, integrity, quality, service, and stewardship.~~

The Agency offers all of its services to individuals and their families without regard to age, gender, nationality, race, creed, sexual orientation, disability, diagnosis, availability of a primary caregiver, or ability to pay.

The Agency provides a coordinated program of palliative care and supportive services, which are available on an intermittent basis, 24 hours per day, seven days a week, in both home and certain facility-based settings. Physical, social, spiritual, and emotional care is provided by a clinically directed interdisciplinary team consisting of patients and their families, and professionals. This interdisciplinary approach to care focuses on the individual's physical symptoms, and the emotional and spiritual concerns of the patient and/or family. The team works together to develop a plan of care, and to provide services that will enhance the quality of life and provide support for the individual and family, while respecting their wishes during the various phases of the illness and the bereavement period. Patient/family needs will be assessed on a continual basis, with all treatment options explored and evaluated in the context of the patient/family's values and symptoms.

RISK AREAS: Discriminatory admission and discharge of patients.

CHAPTER FIVE

ELECTIONS

Center for Hospice Care
2014 Board of Director Candidates
Brief Biographical Sketch

Anna Milligan, RN -- A retired registered nurse, she was at one time the Coordinator of the School City of Mishawaka nursing program. Her interest in education continues today as a longtime volunteer at McKinley Primary Center. She is currently a member of the board of directors for the South Bend Education Foundation which promotes and funds initiatives to enrich learning for students and staff of the South Bend Community School Corporation. For the past two years, Anna and her husband, Sam Milligan, MD, have co-chaired the "Greatest Chefs of Michiana" event which teams local restaurants with local celebrities in a donor vote contest for best creation a new menu dish to benefit the YMCA of Michiana. She has also been a Dinner Committee member for the "Down the Avenue" annual fundraising event for St. Mary's College as well as the CHC "Helping Hands Award" dinner committee. The Milligans have attended and supported the CHC HHD dinner event for many years.

Suzanne Morgan RN, BS, MS -- She was promoted this year to Chief Clinical Officer for Kindred Hospital Northern Indiana (formally Our Lady of Peace Hospital), Mishawaka following nine years as Director of Quality Management. As CCO, she is responsible for all day-to-day operations, budget expense, labor and capital, the development of long and short term goals and participating in strategic planning. Prior to joining the LTACH (long term acute care hospital), she was Director of Clinical Education at Saint Joseph Regional Medical Center (SJRMC) for four years and before that she was Coordinator of Quality Improvement at Elkhart General Hospital. She has been a guest lecturer at Bethel College School of Nursing and a board member of the IVT Respiratory School. She received her Diploma in Nursing from Bronson Methodist Hospital School of Nursing, Kalamazoo, MI a Bachelor of Science Health Arts from the College of Saint Francis, Joliet, IL, and a Master's Degree in Healthcare Management from Finch University/Chicago Medical School, Chicago, IL.

Tim Portolese – With a background in business and marketing, he has spent much of the past decade in volunteer service and fundraising / development for mostly Elkhart area non-profit organizations, particularly Child and Parent Services (CAPS). A volunteer since 2004 and a member of the CAPS board of directors since 2009, he has worked on fundraising events that have raised $3 million dollars for preventing and addressing child abuse in Elkhart County. He was involved with the "ElkART on Parade" event where 30 large painted elk statues were displayed throughout the county and sold to benefit CAPS and which raising over $500,000. He is the recipient of the 2013 "Volunteer Fundraiser of the Year" award from the Michiana Chapter of the Association of Fundraising Professionals. He is currently co-chair for the "Have a Heart" community art project where five-foot fiberglass hearts designed and created by local artists have been placed throughout the Elkhart community to be auctioned at the Lerner Theater on 2/14/14 to benefit the Elkhart General Center for Cardiac Care. He is a graduate of Indiana University with a degree in Public Affairs Management.

Carol Walker, RN, MSN -- For the last two years, she has been Administrative Service Line Director at SJRMC. Responsibilities include: Medical-Surgical Service Line--Oncology Unit, Cancer Genetics, Cancer Research, Tumor Registry, Pt. Navigators, Medical-Renal Unit; Renal Dialysis, WOCN program, Diabetes Education, and the Pain & Palliative Care programs. Prior to this position she was Director of Professional Development / Magnet, Maternal-Child Clinical Nurse Specialist, and Division Director--MCH, Education, Infection Control, WOCN, & Nursing Documentation at SJRMC. Prior to joining SJRMC 11 years ago**,** she was Unit Director--NICU and Pediatrics at Porter Hospital in Valparaiso, IN. Since 1988 she has served on the Program Committee for the Northwest Indiana Chapter of the March of Dimes and on their Board of Directors for the last nine years including three years as Board President. She received her BS and AAS in Nursing from Purdue University and a Masters in Nursing from IUPUI.

# # #