Board of Directors Meeting
501 Comfort Place, Conference Room B, Mishawaka
December 17, 2014
7:30 a.m.

BOARD BRIEFING BOOK

Table of Contents

Page

Agenda 2

Minutes of 10/15/14 Board Meeting 4

President's Report 10
- Average Daily Census Charts 28
- Slate of CHC Board Members & Officers 33
- NHPCO Facts and Figures 35
- 2015 Board Meeting Dates 53
- President's Report Attachments 54

QI Committee Meeting Minutes 64

Policies 68

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 17, 2014
7:30 a.m.

A G E N D A

1. Approval of October 15, 2014 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) Flex Spending Limit
   (c) 2015 Budget

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

5. Policies *(action)* – Donna Tieman (5 minutes)
   (a) Medication Disposal (revised)
   (b) Patient Travel Outside of Agency Service Area (new)
   (c) Use of CHC Owned Buildings by Outside Groups and Organizations (new)

6. QI Committee Meeting -- *(information)* – Julie Englert (5 minutes)

7. Election of Board Members and Officers *(action)* – Corey Cressy (3minutes)

8. Board Education – The Crossroads Campaign *(information)* – Catherine Hiler (10 minutes)

9. Chairman's Report *(information)* – Corey Cressy (5 minutes)
   (a) Board Self-Evaluation
   (b) Recognition of Outgoing Board Members and Officers

Next meeting February18, 2015 at 7:30 a.m.

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Center for Hospice Care
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CHAPTER TWO

MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
October 15, 2014

Members Present:	Amy Kuhar Mauro, Anna Milligan, Becky Asleson, Carol Walker, Corey Cressy, Francis Ellert, Julie Englert, Mary Newbold, Sue Morgan, Terry Rodino, Tim Yoder, Wendell Walsh
Absent:	Carmi Murphy, Michael Method, Tim Portolese
CHC Staff:	Mark Murray, Amy Tribbett, Dave Haley, Donna Tieman, Karl Holderman, Mike Wargo, Becky Kizer

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 7:30 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 08/20/14 meeting as presented. The motion was accepted unanimously.	T. Yoder motioned F. Ellert seconded
3. President's Report	• The second Lunch/Dinner & a Movie with a discussion on grief and loss themes in the movie was held last night. 44 people attended with very little promotion. A list of the grief support groups for the fourth quarter of 2014 is in the board packet. • The 3rd Annual Okuyamba Fest is 10/23 at 5:00 p.m. • ADC continues to increase month over month. YTD it is up 14% from last year. September ADC was 392. On 09/17 we hit a new agency record high of 401. The lowest number of patients on a single day during the month of August was higher than the highest day of all of calendar year 2013. Census affects finances. On 9/30 the net gain without counting investment gain/loss is up 168% from the same time last year, operating revenue is up $2 million, and expenses are up $850,000, a more than 2 to 1 ratio of revenue outpacing expenses the first nine months of the year. Expense increases are due to the patient census increase and direct patient care expenses. So far October ADC is running 392. • On 10/12 several Hospice Foundation staff, including Mike Wargo, participated in the Chicago Marathon to raise money for our Road to Hope Fund and the National Hospice Foundation's Global Partners in Care (formerly FHSSA). Our three employees and one staff spouse raised $10,445. The 13 people, including our four, who were running for NHF's Global Partners in Care together raised $23,000, so our four people raised nearly half of the total. • At the last staff meeting Amy Tribbett presented "Creating a Culture of WOW." It is part of our strategic plan to get staff involved to create some type of innovative, remarkable, memorable experience for patients and families that separate us from	

Topic	Discussion	Action
	the competition on the first day of patient care, the first day of patient care with children present, the first day as a CHC volunteer, the first day as a CHC employee, etc. We have WOW boxes at each office for staff to relate an experience with a co-worker that has done something WOW. The cards come to the administrative team to read and initial, and then they go back to the employee's supervisor to share with them and then to the staff person's personnel file. It went over very well with staff. • Mark and Mike W. did a presentation with Jeff Helman at the Indiana and Kentucky annual conference of the American Institutes of Architects in Fort Wayne on "Magical Thinking: Designing End-of-Life Care" • The IMPACT Act was signed by President Obama mandating hospice surveys every three years. Now, in some parts of the country hospices can go for 11 or more years without a survey by the state representing CMS to insure they are meeting the federal rules and regulations for hospice care. The Act also instituted a 100% medical review for programs that have an as yet undecided percentage of patients on census over 180 days. This is a new way CMS is attempting to weed out the unscrupulous hospices who admit ineligible patients and bill Medicare at taxpayers' expense. • CHC received its first hospice survey in just over six years. In 2008 we received 13 deficiencies, and this year none. It was a tremendous effort by all staff. Special thanks to Donna Tieman and her team who were in charge of getting the surveyors what the needed during the week. We had a core of five to six staff instrumental in helping us get through this. We received the official letter yesterday stating we had a clean survey. Mark is often asked if the growth in patient census is negatively affecting the quality of our care and staffing. Despite our growth, the quality of care has not suffered, staff is doing an incredible job, and we have the results of an outside investigation to prove it. Thank you to all staff and administrators. The board asked Mark to commend staff for their efforts. • The City of Mishawaka is working on Central Park renovations. They have and will invest about $8 million total in the various improvements when it's all done. We are continuing with our landscaping improvements. • We are launching a new media campaign with a robust online digital strategy. The themes are, "Now is the right time to call" and "CHC is the right choice." This time we will be showing a map of service area and hit that we have an "expert team" a phrase which resonated within the 300 telephone research public interviews earlier	

Topic	Discussion	Action
	this year. This television campaign was less costly to produce, because we had no live TV interviews and therefore no on location shoots with a film crew. We bought some stock still footage and digitally changed the model's clothes to match our color pallet. WSBT did the animation. Amy and Mark rewrote much of the scripts. Amy is now doing all the media buying, so we are saving additional dollars not going through our agency. • A board member asked about the Enclara shipping missing medication issue. We do have strong processes in place to protect our reputation and identity any anomalies quickly. We noticed a pattern of packages delivered to homes with small or large amounts of tablets missing, some having obvious signs of tampering upon delivery. After the third event, we notified the DEA in Chicago, Federal Express, and Enclara. Initially, Enclara blamed FedEx. After a number of investigations Enclara discovered, indeed, they had a problem and it was a national problem. Enclara serves 475 hospice agencies across the country for 85,000 hospice patients each day. CHC was the only hospice program to report this problem. We appreciate our staff being diligent. Thank you Donna Tieman and Dave Haley for their efforts in this issue. Since the time the President's Report came out, we have not noticed any further problems.	
4. Finance Committee	• The committee met 10/10 and recommends approval of the August and September financial statements. The downturn in the stock market in September affected our investments in the Foundation. Take that out, the numbers are very good. • August total operating income \$1.8 million, beneficial interest in the Foundation of \$324,800, total revenue \$2.1 million, total expenses \$1.5 million, net gain \$622,800, net without beneficial interest in Foundation \$298,000. YTD August total operating income \$13.3 million, beneficial interest in Foundation \$433,800, total revenue \$13.8 million, total expenses \$11.8 million, net gain nearly \$2 million, net without beneficial interest in Foundation \$1.6 million • September total operating income \$1.7 million, beneficial interest in Foundation a loss of \$436,000, total revenue \$1.3 million, total expenses \$1.5 million, net loss of \$256,500, net without beneficial interest in Foundation gain of \$179,600. YTD September total operating income \$15 million, beneficial interest in Foundation loss of \$2,200, total revenue \$15.1 million, total expenses \$13.3 million, net gain \$1.7 million, net without beneficial interest in Foundation \$1.7 million. A year ago we had a net without beneficial interest in Foundation of \$714,000.	

Topic	Discussion	Action
	• The investment committee meets on Friday and we will be asking our management company on whether any changes should be made due to the stock market. • A motion was made to approve the August and September financial statements as presented. The motion was accepted unanimously.	T. Rodino motioned J. Englert seconded
5. Foundation Update	• This is the fifth year we are ahead of the previous year in fundraising. Total fundraising through September is $935,000, and we expect $1.2 million by the end of 2014. • Capital Campaign – Since we started the quiet phase on 7/1, we have raised over $1 million. We received a $500,000 matching pledge from the Leighton Foundation for our palliative care initiative. We have also received some planned giving and estate gifts—one for $165,000. • Annual Friends of Hospice appeal continues through November, at which time the Annual Appeal goes out end of November/first of December. • Bike Michiana for Hospice raised the most we ever had. We are still trying to adjust some money to understand what the split will be, which will probably be about $50,000 net to us when done. We are already planning for next year. • The St. Joseph Valley Street Rods donated $16,000 from the sale of Barnaby coupons. Over four years they have raised $48,000 for us. • We are in the process of updating our annual donor survey that will be sent out next month to donors. We also continue to receive inquiries about the Okuyamba documentary. We continue to have screenings around the world, most recently for an AIDS Foundation in Zambia, a high school in Chicago, and Partners in Health in Boston.	
6. Board Education	• Donna Tieman presented on the Quality Assurance and Performance Improvement (QAPI) projects. This became a part of hospice care in 2008 when CMS mandated through the Conditions of Participation that any hospice that received funding had to have a QAPI program. It is all about data collection. It puts ownership on the governing body to ensure the program reflects the complexity of its organization and services, involves all hospice services, focused on indicators related to improved palliative outcomes, and takes actions to demonstrate improvement in hospice performance. We have ten active projects as of today. • This played out during this year's survey, because the surveyors asked to see evidence of our QAPI program. They were impressed we are collecting data and actually doing something with it. They also looked at the QI Committee minutes that	

Topic	Discussion	Action
	Julie E. attends and that they are reported to the board. The hospice Governing Body is to be notified of what is happening in this area. We have changed processes based on what we've learned in these QAPIs, especially regarding medication errors. • We have been using the Family Evaluation of Hospice Care (FEHC) for almost 20 years. Next year CMS will be requiring all hospices to do a shorter version and hire an outside company to manage the survey process for us at our expense. The survey will be mailed to families, and the company will collect the data and send it to CMS where it will go on a Hospice Compare website so families can compare hospices, not unlike the current Hospital Compare, Nursing Home Compare, etc. We will practice the first quarter of next year and data will officially begin being collected in April 2015, reportable in 2016. It is "voluntary" but if a hospice doesn't participate, its reimbursement would be cut 2% every year. The Indiana State Department of Health (ISDH) is contracted by CMS to do federal hospice and home health surveys.	
7. Nominating Committee Report	• Thank you to those board members that submitted names for consideration as potential nominees. We have met with several of them. Three and a possible fourth person have agreed to be nominated. Elections will be held at the December board meeting. They are: Suzy Weirick, Jesse Hsieh, MD, and Ann Firth. We are still waiting to hear from Lori Turner.	
8. Chairman's Report	• In the board packet is the meeting dates for 2015.	
Adjournment	• The meeting adjourned at 8:30 a.m.	Next meeting 12/17

Prepared by Becky Kizer for approval by the Board of Directors on 12/17/14.

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Julie Englert, Secretary Becky Kizer, Recording Secretary

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CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
Hospice Foundation
President / CEO Report
December 17, 2014
(***Report posted to Secure Board Website December 11, 2014***)

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:30 AM.
This report includes event information from October 16 – December 17, 2014.
The Hospice Foundation Board meeting follows in the same room.

CENSUS

October saw yet another record increase in CHC's average daily census (ADC). November's ADC was down slightly from that number primarily due to a high number of patient expirations. While September had 143 deaths, that number jumped to 165 in October and 170 in November. November also experienced a very high number of DBAs (deaths before admission) due to very late referrals. The percent of non-admitted patients who died prior to being admitted was 24% and the percent of referrals from hospital who were DBA was 39%. October's percentages were 16% and 32% respectively. Occupancy at our two Hospice Houses year-to-date has been the highest of the last six years; however, the percentage of days at the general inpatient level of care has gone down and is at the lowest percentage within the same time frame. We will be addressing this further with staff at the beginning of 2015. Overall, at the end of November we are projecting a 7% increase from 2013 in the number of patients served and an overall increase in ADC of 14 - 15%.

November 2014	Current Month	Year to Date	Prior Year to Date	YTD Change
Patients Served	510	1,985	1,861	124
Original Admissions	159	1,680	1,550	130
ADC Hospice	357.20	351.13	302.83	48.30
ADC Home Health	25.27	18.36	19.68	(1.32)
ADC CHC Total	382.47	369.49	322.51	46.98

October 2014	Current Month	Year to Date	Prior Year to Date	YTD Change
Patients Served	503	1,826	1,721	105
Original Admissions	158	1,521	1,410	111
ADC Hospice	370.16	350.53	302.31	48.22
ADC Home Health	23.42	16.45	19.55	(1.87)
ADC CHC Total	393.58	368.21	321.86	46.35

Monthly Average Daily Census by Office and Hospice Houses

	2014 Jan	**2014** Feb	**2014** Mar	**2014** Apr	**2014** May	**2014** June	**2014** July	**2014** Aug	**2014** Sept	**2014** Oct	**2014** Nov	***2013*** ***Dec***
S.B.:	196	202	212	211	214	217	213	225	224	224	222	*201*
Ply:	62	72	71	79	76	71	69	67	71	73	67	*59*
Elk:	53	51	60	68	75	77	87	83	89	85	85	*58*
SBH:	5	6	5	6	6	5	6	5	4	6	4	*4*
EKH:	4	4	6	4	5	5	5	5	4	6	4	*2*
Total:	321	335	353	368	376	375	380	385	392	394	382	*324*

HOSPICE HOUSES

November 2014	Current Month	Year to Date	Prior Year to Date	YTD Change
SB House Pts Served	32	295	323	(28)
SB House ALOS	4.31	6.14	5.17	0.97
SB House Occupancy	65.71%	77.42%	71.43%	5.99%
Elk House Pts Served	32	274	212	62
Elk House ALOS	3.69	5.69	5.62	0.07
Elk House Occupancy	56.19%	66.64%	50.94%	15.70%

October 2014	Current Month	Year to Date	Prior Year to Date	YTD Change
SB House Pts Served	34	268	297	(29)
SB House ALOS	5.09	6.24	5.22	1.02
SB House Occupancy	79.72%	78.57%	72.89%	5.68%
Elk House Pts Served	35	249	201	48
Elk House ALOS	5.54	5.78	5.50	0.28
Elk House Occupancy	89.40%	67.67%	51.93%	15.74%

PATIENTS IN FACILITIES

Of the 510 patients served in November, 172 resided in facilities. Of the 503 patients served in October, 169 resided in facilities. The average daily census of patients in skilled nursing homes, assisted living facilities, and group homes during November was 131; October was 135 and YTD through November 2014 was 131.

FINANCES

Karl Holderman, CFO, reports the November Financials will be posted to the Board website on Friday morning, December 12th following Finance Committee approval. For information purposes, the non-approved October 2014 financials are below.

October 2014 Financial Information

Center for Hospice Care

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

October Overall Revenue	$	2,354,910	Year to Date Overall Revenue	$	17,455,869
October Total Expense	$	1,634,857	Year to Date Total Expense	$	14,999,360
October Net Gain	$	720,053	Year to Date Net Gain	$	2,456,509

Hospice Foundation

October Development Income	$	396,181	Year to Date Development Income	$	1,355,979
Oct. Investment Gains (Loss)	$	253,547	Year to Date Investment Income	$	954,058
Oct. Overall revenue	$	649,946	Year to Date Overall Revenue	$	2,363,695
Total October Expenses	$	151,341	Total Year to Date Expenses	$	1,867,359
October Overall Net	$	498,605	Year to Date Overall Net	$	496,339

Combined

October Overall Revenue	$	2,506,251	Year to Date Overall Revenue	$	19,323,226
October Overall Net Gain	$	720,053	Year to Date Overall Net Gain	$	2,456,509

At the end of October 2014, the overall combined net gain for CHC / HF was $2,456,509 representing a 9% increase from October of 2013. CHC's Year to Date Net without the beneficial interest in the HF was $1,960,170 representing a 148% increase from October 2013.

At the end of October 2014, the Foundation's Intermediate Investments totaled $883,100. Long Term Investments totaled $16,301,722.

CHC's assets on October 31, 2014, *including* its beneficial interest in the Hospice Foundation, totaled nearly $36.4MM. At October 31, 2014 HF's assets alone totaled just over $31.4MM and

debt related to the low interest line of credit associated with the Mishawaka Campus project totaled nearly $5.9MM. Both organizations combined have assets now totaling nearly $42.5MM

CHC VP/COO UPDATE

Dave Haley, VP/COO, reports on September 28 we had a Pastoral Care Breakfast in our Mishawaka facility for area clergy. 16 community pastors were in attendance. Our guest speaker was Dominic Vachon, PhD, Director of the Ruth M. Hillebrand Center for Compassionate Care at the University of Notre Dame. His presentation was entitled, "Spirituality of Caring and Maintaining Compassion in Ministry."

Dave attended the annual Indiana University at South Bend School of Medicine's "Medicine Ball" on November 8. The medical school program is a partnership with the University of Notre Dame. Dr. Rudolph M. Navari, M.D., former dean and director of Indiana University School of Medicine-South Bend was in attendance. He now is with the World Health Organization and serves as director of the Cancer Care Program in Eastern Europe and is based in Geneva, Switzerland. Dr. Navari received an award that night for his service with the Indiana University School of Medicine-South Bend and his work in developing a community health service which is operated by medical students. They provide free care and also gain patient care experience.

As part of Veterans Day remembrance, employees who are veterans were recognized at our staff meeting held on November 29. They were presented with a certificate, a pin, and they were thanked for their service to our country.

CHC's annual Memorial services for bereaved were held in December 7. We conducted simultaneous services in South Bend at the Kroc Center, in Elkhart at Trinity United Methodist Church and in Plymouth at Christos Banquet Center. 630 people attended this year. South Bend had 236, Elkhart had 229, and Plymouth had 165. Totals include the bereaved, volunteers, musicians and staff.

We have engaged Press Ganey of South Bend to have them perform the new CMS Quality Reporting Requirements for CHC. This will allow us to meet CMS requirements of having an independent third party report results of our patient satisfaction surveys for us. This action is a prelude to when the results of these surveys will be routinely and publicly reported for each hospice in the nation beginning in 2016.

We have had only one more incident (the 9th) of Enclara drugs being diverted prior to FedEx delivery at a patient's home. These matters have been turned over to the DEA and Enclara for further investigation and resolution.

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

DIRECTOR OF NURSING UPDATE

Donna Tieman, RN, BA, CHPN reports the CHC Quality Assurance Department is in the process of reviewing quality data we collect for the QI Committee quarterly reports. Donna Tieman reviewed the Agency QI reports for the past five years. There are quality indicators that are consistently at 100%. We will continue to collect that information monthly, but will focus our quality improvement efforts on those areas we do not consistently score above 95%. Donna is working with the QA Coordinator to redesign the agency's audit tool in an effort to streamline our current audit process, eliminate redundancy and increase productivity among the auditors.

Rebecca Fear, RN, BSN, CPHQ, CHPN began her new role as QA Coordinator recently. Rebecca brings prior Quality Assurance, Quality Improvement, and Infection Control experience to the position. She holds a certification in health care quality assurance.

Three CHC nurses are taking the CHPN exam in December. This will bring our total number of CHPN nurses to 12. CHPN designation means an RN has successfully passed an examination to become certified in hospice and palliative medicine. This exam and certification status is managed through the National Board for Certification of Hospice and Palliative Nurses.

Nineteen CHC nurses were awarded certificates of completion in the Pediatric ELNEC (End of Life Nursing Education Consortium) training in December. 35 CHC nurses are in various stages of completion in the program. CHC Nursing Education is developing an ELNEC program for new hires as part of the orientation process.

TB certification classes were held the last week of October. CHC has three TB class trainers. This allows us to offer certification training to all of our nursing staff on a quarterly basis with minimal downtime in the patient care arena.

Blood draw certification classes were held at The Medical Foundation in November. These classes are a free service from The Medical Foundation.

HOSPICE FOUNDATION VP / COO UPDATE

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

<u>Fund Raising Comparative Summary</u>

Through November 2014, the Development Department recorded the following calendar year gift totals as compared with the same period during the previous four years:

Year to Date Total Revenue (Cumulative)

	2010	2011	2012	2013	2014
January	64,964.45	32,655.69	36,775.87	83,619.96	51,685.37
February	108,025.76	64,530.43	88,893.51	166,563.17	109,724.36
March	231,949.73	165,468.92	194,345.35	264,625.29	176,641,04
April	354,644.69	269,676.53	319,818.81	395,299.97	356,772.11

May	389,785.41	332,141.44	416,792.85	446,125.49	427,057.81
June	477,029.89	427,098.62	513,432.22	534,757.61	592,962.68
July	532,913.52	487,325.01	579,801.36	604,696.88	679,253.96
August	585,168.77	626,466.72	643,819.01	783,993.15	757,627.43
September	671,103.04	724,782.28	736,557.59	864,352.82	935,826.45
October	992,743.37	1,026,728.58	846,979.95	922,261.84	1,332,007.18
November	1,043,750.46	1,091,575.65	895,164.28	969,395.17	1,376,246.01
December	1,178,938.91	1,275,402.38	1,027,116.05	1,185,322.83	

Year to Date Monthly Revenue

(less major campaigns, bequests and significant one-time major gifts)

	2010	**2011**	**2012**	**2013**	**2014**
January	52,442.49	32,110.69	32,309.58	83,380.18	51,685.37
February	41,364.37	30,644.74	43,783.64	82,943.21	43,038.99
March	65,886.51	99,796.42	102,351.84	98,212.12	66,916.68
April	104,544.96	97,332.61	123,998.46	130,674.68	180,156.07
May	33,768.72	51,753.98	90,909.04	40,825.52	100,285.70
June	74,084.48	90,718.18	92,036.89	65,815.51	97,258.66
July	55,278.63	53,536.39	62,069.43	69,939.27	38,243.88
August	51,240.25	83,202.86	64,017.65	92,732.69	79,015.87
September	85,629.27	94,000.56	92,808.58	80,335.67	84,011.71
October	66,061.97	47,779.09	65,904.80	56,439.02	55,208.68
November	49,247.09	48,284.08	46,674.33	47,133.33	44,238.83
December	115,188.45	133,617.73	111,236.77	130,277.99	
Total	**794,737.19**	**862,777.33**	**928,101.01**	**978,709.19**	**840,060.54**

Cornerstones for Living: The Crossroads Campaign

Progress during the quiet phase of the campaign continues. Through November 30th total cash, pledges and documented bequests stand at $1,534,246.

The Campaign Cabinet met for the first time on November 3. Members of the cabinet include: Catherine Hiler (Chair), Nafe Alick, Dennis Beville, Tim Portolese, Irv Rosenberg and Mary Jane Stanley. The first meeting focused on organizational issues. Cabinet duties and responsibilities were reviewed along with the rationale for the campaign and an overview of CHC needs, the value of comprehensive campaigns, and drafts of campaign marketing materials. Cabinet members were asked to provide feedback about marketing materials and a follow up meeting of the Cabinet took place on December 1. A dry run of a presentation being developed for potential campaign donors was the main focus of the December 1 meeting, and the cabinet provided valuable feedback regarding the presentation. A schedule of six 2015 meetings has been approved by the Cabinet. The next Cabinet meeting will focus on prospective major gift donors. Cabinet members are providing names of potential donors for review and evaluation by Hospice Foundation staff.

Major Gifts

Several tours of the Mishawaka campus and meetings with prospective major gift donors took place in October and November. Among them: members of Memorial Hospital's senior leadership team; Pete McCown, President of the Elkhart County Community Foundation; Kay Ball, Executive Director of the Elkhart General Hospital Foundation; and John Foegley, Present/CEO of Foegley Landscaping.

Planned Giving

Four estate gifts totaling $341,042.05 were received during the month of October. One estate gift of $2,670.92 was received in November. In addition, we received documentation in November informing us that we will receive a bequest in the amount of $91,332.90 within a few weeks.

Annual Giving

The 2014 Annual Appeal hit mailboxes the week of Thanksgiving. This year's theme is "The Circle of Caring Begins With You." Although we are still in the quiet phase of the Crossroads comprehensive campaign, we are beginning to work our campaign messages into the annual support pieces. As such, this year's Annual Appeal references the fact that the healthcare landscape in America is changing and that there will be a growing need for hospice care as the Baby Boomer generation ages, while there will be fewer healthcare dollars available to pay for them. As of Friday, December 5th, the 2014 Annual Appeal has raised $10,097.47

Special Events & Projects

Okuyamba Fest, our World Hospice and Palliative Care Day event was held on Thursday, October 23rd at the Mishawaka Campus and attended by 63 people. TV host, producer and philanthropist Brandi Milloy was the event keynote speaker. Brandi spent two weeks in Uganda as a volunteer with PCAU, and was instrumental in helping to establish and implement their social media strategy. She was also a vital part of the Road to Hope Hollywood fundraising event in April. Brandi spoke glowingly of her experiences with PCAU. The event raised $3,451.49 in registration fees and silent auction income as well as generating an additional $1,260 in donations for the Road to Hope Fund.

On October 12th, HF staff members Mike Wargo, Denis Kidde, Cyndy Searfoss and her husband Steve completed the Chicago Marathon as part of National Hospice Foundation's Run to Remember. The team raised a total of $10,415, with half the proceeds going to Global Partners in Care and the other half benefiting our Road to Hope Fund.

Preparations for the 2015 Helping Hands Award Dinner honoring Lou Behre are underway. This year's Honorary Chairs are Ernie Raclin and Art Decio; event chairs are Carmi and Chris Murphy and Pat and Don Cressy. The dinner will be held on Wednesday, May 6th at the Hilton Garden Inn.

Education

Mike Wargo co-presented a session entitled "Crowdfunding to Increase Engagement with your Platform" at NHPCO's 15th Clinical Team Conference and Pediatric Intensive in Nashville, TN on

October 28th. His co-presenter was Sarah Meltzer, MPA, CFRE, Vice President of Philanthropy, National Hospice Foundation.

Communications

The fall/winter issue of Crossroads is in the final phases of development and will be mailed in early January. It features articles on recent events (Bike, Walk and Okuyamba Fest), an announcement of the 2015 Helping Hands recipient as well as articles on the history of hospice and "Two Organizations, One Mission," which provides insight into the working relationship between Center for Hospice Care and the Hospice Foundation.

Our annual donor survey was sent both via mail and email to 705 Circle of Caring members in November. To date, 98 surveys have been returned, a 13.9% return rate. In comparison, we had a 12.5% return rate last year. To summarize the results, the majority of the respondents have been donors at least five years (62.25%); agree or strongly agree that they are informed of the use of CHC's funds (86.73%); agree or strongly agree that they receive the right amount of information regarding the use of their donations (86.73%); agree or strongly agree that they receive the right amount of recognition for being a CHC donor (89.90%); agree or strongly agree that they receive the right amount of benefits for being a CHC donor (74.49%); and agree or strongly agree that their donation is used appropriately to further CHC's mission to "improve the quality of living" (92.86%).

Global Partners in Care/PCAU

In November checks totaling $19,688.89 were sent to our African partner organization, the Palliative Care Association of Uganda (PCAU) via the Global Partners in Care to pay off PCAU's office building. These funds came from CHC/HF staff gifts through voluntary payroll deductions as well as other donations made specifically to support the PCAU Building Fund.

We have a number of Notre Dame students interested in pursuing internship opportunities with PCAU in the coming year. Brianna Wanless is a master's student at the Eck Institute for Global Health and will be working on the palliative care benchmark study. Denis and Cyndy have been meeting with other students, many of whom learned about internship opportunities as a result of completing the one credit hour Introduction to Hospice & Palliative Care class presented by CHC/HF staff on November 1st.

Road to Hope Program/Documentary

Thanks to Torrey DeVitto, actress and hospice ambassador, and Stevie Nicks of Fleetwood Mac, an online contest for a meet-and-greet with Torrey and Stevie as well as (2) sets of tickets to see Fleetwood Mac's December 2nd concert in San Diego, CA raised $13,781 for the Road to Hope fund from a total of 452 donors. The contest was conducted on the crowdfunding platform crowdrise.com and ran from November 21st through November 29th. Texas resident Brian Townley won the largest fundraiser part of the contest with a total of $3,670. Madison Geist, who resides in southern California, was the winner of the drawing, which included a one night stay in a lux Hard Rock Suite that was donated by the Hard Rock Hotel in San Diego, CA. Many of those entering the contest left messages calling Road to Hope a great cause and offering future support.

Crowdrise will be providing us with an email list of the entrants; they will be added to our Road to Hope e-blast list. We will also be sending out a thank you blast as soon as we receive the list. PCAU is currently advertising for a full-time Road to Hope program coordinator. This person will be based in Uganda and will be a PCAU employee. He/she will serve as a liaison to each of the schools in which children have been placed, visit the children on a quarterly basis, oversee the budget and payments to schools, develop group activities and work with palliative care organizations to identify students who are appropriate for the program. He/she would also serve as a contact person for sponsored children, providing their sponsors with regular updates. Having this position in place is critical before taking on any additional children in the program due to the incredible amount of time and effort required to ensure the children are properly monitored, particularly given that many of them are located in very remote areas of the country.

Editing of the Road to Hope film continues and is now expected to be completed in the first half of 2015. The first public sneak peak of a segment of the film took place at Okuyamba Fest on October 23rd.

Mishawaka Campus

A complete resurfacing of the parking lot was completed in October. This was necessitated by the appearance of premature cracking in several areas and was completed at no cost to CHC/HF as its presence was reported within the initial warranty period. The final round of exterior improvements, including completing construction of a privacy wall and fence along the south side of the parking lot at the Center for Palliative Care, Comfort Place entrance landscaping and perimeter fencing is expected to be completed by year-end.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

Amy Tribbett, Director of Marketing and Access reports the Marketing, Access, Volunteer Update is as follows:

Outreach Liaison News in and October & November

Lunches/Breakfasts and Speaking Engagements:

- Lunch with Dr. Ronald Powell and two staff members.
- SJRMC University Park Family medicine lunch and learn.
- Dr. Alfred Cox, lunch and learn.
- Dr. Delphond (North Judson) lunch and learn.
- Lunch and learn at Memorial I Street in Michigan City. 40 attended in all, including Drs. Bunton, Edquist, Hahn, Howard, and Kneller.
- Lunch at Dr. Bejes' practice with six employees. Bejes is IU affiliated, but open to CHC.

Community Outreach and Other Referral Source Meetings:

- Permanent contract signed with Wellbrooke of South Bend, a new facility.
- Memorial Hospital – Michael White, RN, committed to partnering with CHC in 2015 – getting us in front of the hospitalists and part of their medical education.

- SJRMC – Carol Walker, Lou Pace and other unit managers will be meeting at the SB Hospice House in January for a tour and conversation regarding ways to enhance communication and design optimal service delivery.
- Tour of Mishawaka campus for reps from Select Health Network. Select Health Network ACO is moving forward in the consideration of selecting CHC as their preferred hospice provider.
- Exhibited at the Siemen's Employee Health and Wellness Fair. 100 employees attended.
- Manned a booth at the Greater Elkhart Chamber of Commerce Women's Lunch – CHC information provided at networking table.
- Exhibited at the Elkhart County Senior Expo.
- Presented Hospice 101 to the 1st Presbyterian Church adult class, Ivy Tech College Med/Sur students, Crest Manor Church of the Brethren and Select Health Network.
- Presented Documenting Patient Decline to West Bend Nursing and Rehabilitation, Crest Manor Church of the Brethren, and Heritage Point.
- Provided hospice information to Rev. Cory Gathright, president of the Interdenominational Ministerial Alliance.
- Completed facility protocols with Northwoods Village, West Bend Nursing and Rehab, Sunset House Group.
- CHC was a Gold sponsor of the MGI Fall Conference. Hosted pre-conference event at CHC's Mishawaka Campus.
- Met with Dr. Orfahl, new pulmonary physician in Marshall County.
- Exhibited at the Marshall County Expo with 1500 seniors in attendance.
- Exhibited at the Lagrange County Council on Aging Senior Expo. 250 attended.
- Chamber dinners – Starke and Knox.

"We Honor Veteran" Ceremonies were held at:

- Pilgrim Manor.
- Holy Cross House – luncheon and pinning.
- Holy Cross Village Dujarie and Quinn.
- Holy Cross Village Andre Place.
- Valley View Health Center in Elkhart.
- Woodlawn Manor Health Care Center in Elkhart.
- Heritage House Assisted Living in Nappanee.
- Courtyard Healthcare in Goshen.
- Millers Merry Manor in Wakarusa.
- Eastlake Terrace AL in Elkhart.
- Greenleaf Health Care and AL.
- Beardsley House in Elkhart.
- Eastlake Nursing and Rehab Center in Elkhart.
- Riverside Village Health and Rehab.
- Goshen and South Bend VA Clinics.

Marketing & Access News through November, 2014

Volunteer Department:

During October, there were 12 interviews for potential new volunteers and 28 overall new inquires pertaining to volunteer opportunities. CHC Volunteer Recruitment Coordinator, Kristiana Donahue, presented to the Marshall County Ministerial Association and the Social Justice in American Medicine club at the University of Notre Dame. Volunteer opportunities were shared with the public at a one-time Informational Session on CHC Volunteer Opportunities, at the MGI fall conference and throughout numerous press release pick-ups in the Elkhart Truth, Goshen Times, Plymouth Pilot and South Bend Tribune to name a few.

The first of two fall trainings took place on Saturday, October 25, from 9 AM – 5 PM, with nearly 30 in attendance. The second phase concluded on Saturday, November 8, from 9 AM – 5 PM with 26 new volunteers present.

On Saturday, November 1, Kristiana presented the volunteer portion of the "Intro to Hospice and Palliative Care" course to students at the University of Notre Dame. Nearly 30 students expressed interest in volunteering with CHC following the class. Applications have been sent to all.

Marketing Department:

In early October, Amy Tribbett and Sarah Lambert, CHC Intake Coordinator, attended a two-day Admissions conference at Nathan Adelson Hospice in Las Vegas, NV. The focus was on intake and assessments. During that trip, they also toured Zappos and had a private, Q&A with two of Zappos' call center managers. It's no secret that Zappos CEO, Tony Hsieh, has literally written the book on delivering world-class customer service. And the stories of just how far they will go to make a customer happy are legendary. We were pleased members of the CHC team had the opportunity to learn from the best.

On October 5, CHC-Mishawaka hosted the St. Joseph Chamber's youth leadership group in the afternoon.

On October 10, CHC was a sponsor of the Teepa Snow (nationally known dementia expert) presentation at the Kroc Center.

On October 13, CHC kicked off a digital marketing campaign – reaching our consumers when they need us. This targeted audience campaign and search engine marketing effort has proven to be very effective in the first six weeks of activity.

On October 15, the Indiana Hospice Veterans Partnership, where Amy Tribbett serves as a board member, presented a day-long workshop in Indianapolis for professionals serving veterans at end of life. Kevin Kelsheimer, St. Joseph County service officer presented to the attendees on accessing VA benefits.

On October 20 & 21, CHC served as the gold sponsor of the Michiana Gerontology Institute's fall conference.

On October 28, the Pastoral Care breakfast and presentation by Dominic Vachon, PhD showcased our Mishawaka Campus in the morning, followed by AARP's After 5 event in the evening.

CHC-Mishawaka hosted the 1st Source Bank's Transitional Bankers meeting on November 11. CHC celebrated National Hospice Month with a big social media push via NHPCO's "Moments of Life: Made Possible by Hospice." At the all-staff meeting on November 19, we honored our own CHC/HF staff that have served our country and celebrated everyone with a wonderful folding chair, donned with our burst logo on the back.

NEW POLICIES AND POLICY UPDATES

On the agenda for this meeting are three policies for your approval. Two are clinical policies, one revised and one new, and one is a new HR policy. Below are the titles of each policy and a brief explanation of what was changed or why the policy is needed.

a.) *Medication Disposal* (revised) – policy was changed to reflect the DEA's Disposal of Controlled Substances Final Rule which became effective October 9, 2014. This rule governs the secure disposal of controlled substances by registrants and ultimate users. These regulations implement the Secure and Responsible Drug Disposal Act of 2010 by expanding the options available to collect controlled substances from ultimate users for the purpose of disposal.

b.) *Patient Travel Outside of Agency Service Area* (new) – policy written to facilitate continuity of care for those hospice patients who travel outside of the CHC service area. This policy was written based upon the NHPCO "Traveling Patient Tool-Kit" to meet CMS regulations.

c.) *Use of CHC Owned Buildings by Outside Groups and Organizations* (new) – this is a proactive HR Manual Policy intended to place parameters around the use of CHC owned buildings by outside groups (particularly the Mishawaka Campus conference center) prior to requests becoming a problem for the agency.

2014 HAPPY HOLIDAYS AND CHC STAFF FAMILY FUN

130 staff and their family members signed up for "Donuts with Santa" held here at the Mishawaka Campus on Saturday morning from 9 – 11 AM. Donuts, juice, a candy cane walk, crafts, surprises, and visits with Santa along with photos were provided by CHC. This event was open to any CHC employee and their families, children and grandchildren from any CHC office. This is the second year we have done this and response was very favorable.

CHC BOARD CONGRATULATORY GIFT TO STAFF FOR "PERFECT SURVEY"

Thanks to an idea generated by board Chair Corey Cressy and Chair-elect, Amy Mauro, on Tuesday, November 11, every CHC staff member in every office received an eight oz. gold box of assorted chocolates from The South Bend Chocolate Company. Boxes included each employee's name, office location and a customized label which read, "Congratulations on the Perfect Hospice Survey, from the Board of Directors, Center for Hospice Care. A photo of the box is included as an attachment to this report along with a thank you note from some staff.

INTRO TO HOSPICE AND PALLIATIVE CARE CLASS AT NOTRE DAME

On November 1, "SC 43350 -- Introduction to Hospice and Palliative Care" was presented for the third time in the Jordan Hall of Science at the University of Notre Dame with a record 125 undergraduate students in attendance. This one-credit pass/fail course held all day on a Saturday is designed to provide pre-professional students with an introductory understanding of palliative and hospice care. It is designed specifically for undergraduates interested in careers in healthcare, but can also be useful to students aspiring to work in other helping professions. This course provides students with an in-depth understanding of palliative and hospice care, focusing on how this care is given in the current healthcare system. CHC administrators, physicians, nurses, social workers, spiritual care staff, and bereavement therapists are the faculty for the course along with one outside oncologist. Students are given an introduction in compassionate interpersonal communication skills, which are needed in caring for people who are in need of palliative care and for people who are dying.

ELECTION OF NEW BOARD MEMBERS FOR 2015 / OUTGOING BOARD MEMBERS

The Nominating Committee consisting of Corey Cressy, Julie Englert, Amy Mauro, Mary Newbold, Terry Rodino, and Wendell Walsh have been meeting since July. 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 2015. The slate for next year consists of four outstanding candidates who have all agreed to serve. The slate has been formally approved by the Executive Committee. The CHC Board needs to ratify / pass the slate of candidates at this upcoming meeting. We also have two new members to the CHC Executive Committee on the slate representing officers.

We would also take this opportunity for our sincere thanks for board service to our outgoing board members, Julie Englert, Carmi Murphy and Terry Rodino. Terry will be leaving the CHC board but continue on the Hospice Foundation board as the Immediate Past Chair. We also thank Catherine Hiler who will be the outgoing Hospice Foundation Chair for her 12+ years of service on both boards. We are pleased that Catherine will continue for the next five years as the Chair of "Cornerstones for Living: The Crossroads Campaign." Corey Cressy will also become Immediate Past Chair for 2015 on the CHC board and Chair the Hospice Foundation board. Chair-elect Amy Mauro will become CHC Board Chair in January and Wendell Walsh will become Chair-elect. Sue Morgan will become Treasurer in January and Mary Newbold will serve as Secretary. Welcome all!

The New Board Member Orientation meeting with the CHC Administrative Team is scheduled for Thursday, February 5 at 7:30 AM here at the Mishawaka Campus. Any board member is welcome to attend to welcome the new board members or for a refresher on the history and current operations of CHC. The first board meeting for our new members will be February 18, 2015.

Again, our thanks to everyone on the CHC Board of Directors!

NATIONAL MEDICARE HOSPICE STATISTIC FOR 2014 RELEASED

Attached to this report is the 2014 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 hospice Medicare data for calendar year 2013 as well as collected information from NHPCO's own National Data Set.

CHC IS THE ONLY AREA PROGRAM THAT MEETS ALL CRITERIA FOR SELECTING A HOSPICE BY CONSUMER REPORTS MAGAZINE

In October, Consumer Reports published an article entitled, "How to Find a Good Hospice Program: Six Features to Look for." Within its service area, CHC is the only hospice program to meet all six of the Consumer Reports conditions. This provides some valuable talking points for CHC board members. The six criteria are listed below along with a few comments regarding CHC's superior status in meeting them.

Consumer Reports writes, *"Most people are referred to hospice by their doctor. Patients, family members, even friends can also make referrals. If you're looking for a program, check with the National Hospice and Palliative Care Organization. But beware: More than half of U.S. hospice programs are for-profit, according to Medicare figures, and several recent news reports have highlighted problems at some of those programs."*

Here's what Consumer Reports thinks Americans should look for in a hospice program:

1.) Not-for-profit status and 20 or more years of experience.

There is no other hospice program in the region as experienced as CHC. In January, CHC will be beginning its 35th year of caring for patients and families as a national recognized, award-winning, not-for-profit hospice agency.

2.) Hospice-certified nurses and doctors on staff and available 24 hours per day.

At CHC, not only does CHC currently have a record number 12 hospice and palliative care certified nurses on staff, but it also has two fulltime board certified hospice and palliative care physicians on staff along with a Doctor of Nursing Practice with an advanced certification in hospice and palliative nursing. Unlike most hospice programs, CHC not only has nurses and physicians on call and available, but adds all core care service disciplines with social workers and spiritual care counselors on call 24 hours a day, seven days a week for patient and family emergencies.

3.) *Palliative-care consultants who can begin care if you're not yet ready for hospice.*

CHC's comprehensive palliative care programming provides consultation services which may include: pain management, goals of care / advance care planning, counseling and support, assistance with coordination of care, referral assistance with available community resources, and education on discontinuation of curative treatment along with information on end-of-life care decision making processes. In 2015, CHC will be opening the region's first free-standing palliative care outpatient clinic where palliative care consultations will take place by appointment.

4.) *An inpatient unit, where patients can go if symptoms can't be managed at home.*

CHC continues to be the only hospice in the region that owns and operates freestanding, dedicated, Medicare certified hospice inpatient units. We have two seven-bed, homelike facilities conveniently located in South Bend and Elkhart.

5.) *Ability to provide care in nursing homes and assisted living residences.*

CHC currently has more than 80 contracts to provide hospice services to the residents of more than 80 nursing homes, assisted living facilities and group homes throughout its eight-county service area.

6.) *Medicare approval. That way, Medicare will cover services, including equipment and home health aides as needed, plus counseling and grief support for the patient and the family.*

CHC is a Medicare and state licensed hospice program. During its most recent inspection by the Indiana State Department of Health, it received a no deficiency finding or a "perfect survey" for its recertification for federal Medicare hospice certification status. Its bereavement counseling programming is one of the most advanced and comprehensive in the nation and is open to anyone in the community who has lost a loved one at no charge whether or not there was an experience with hospice or CHC.

With approximately 7.3 million subscribers, Consumer Reports has been published monthly by Consumers Union since 1936. The magazine issues reviews and comparisons of a wide variety of consumer products and services. As a not-for-profit, Consumers Union has no shareholders and the Consumer Reports magazine accepts no advertising.

2014 BOARD OF DIRECTORS SELF-EVALUATION

At the last meeting prior to the seating of new officers and board members, we take an opportunity to complete a Board of Directors self-evaluation. We do this every other year. At the Board meeting we will be distributing hard copies of the annual Board of Directors Self Evaluation along with a postage page return envelope. We ask that you complete the evaluation and return the form by December 31, 2014. Aggregate results will be included in the February board meeting packet.

CHC CEO TO BECOME NATIONAL CHAIR OF HOSPICE ACTION NETWORK IN JANUARY

The CHC President/CEO will become the national Chair of the Hospice Action Network (HAN) in January. HAN's mission is to advocate for national policies that ensure the best care for patients and families facing the end of life by mobilizing a growing network of Hospice Advocates throughout the nation. HAN implements its agenda through direct lobbying, grassroots advocacy and by working with Hospice Advocates to expand the message through education and by sharing the hospice story with Congress. Because HAN is an affiliate of NHPCO, becoming national Chair of HAN will put the CHC President/CEO back on the full NHPCO Board of Directors and back on the NHPCO nine-member Board Executive Committee for 2015.

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

Dave Haley's Census Reports.

Slate of CHC Officers for 2015 – 2015, Board Members to be Re-Elected to their Second Term, and Slate of New Board Members along with a Brief Biographic Sketch for each new member.

NHPCO's Facts and Figures: Hospice Care in America 2014 Edition

2015 CHC Board of Director Meeting dates.

Press release / story regarding "We Honor Veterans" ceremony and Holy Cross Village

VA / NHPCO / CHC press release regarding "We Honor Veterans"

Consumer Reports report on "How to Find a Good Hospice Program"

Press releases about CHC's perfect Recertification and Relicensure Survey.

Thank you note from CHC staff regarding the South Bend Chocolate Company gift from the board for the "Perfect Survey."

Story from the November issue of "Transcendent" on focusing marking directly on patients and families. The article features the experience of CHC and was written and published by Transcend Hospice Marketing Group who has been assisting CHC for over three years.

QI Committee Meeting minutes from November 18, 2014.

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

Financial information for October and November 2014.

Board Self-evaluation survey and postage-paid return envelope.

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, February 18, 2015 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 .

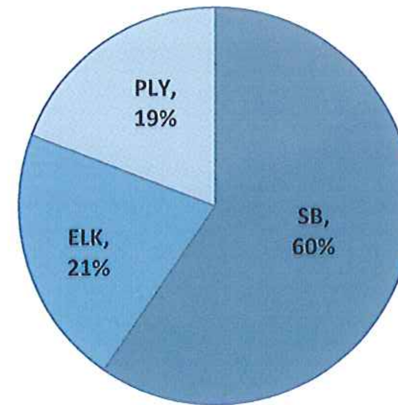
# # #

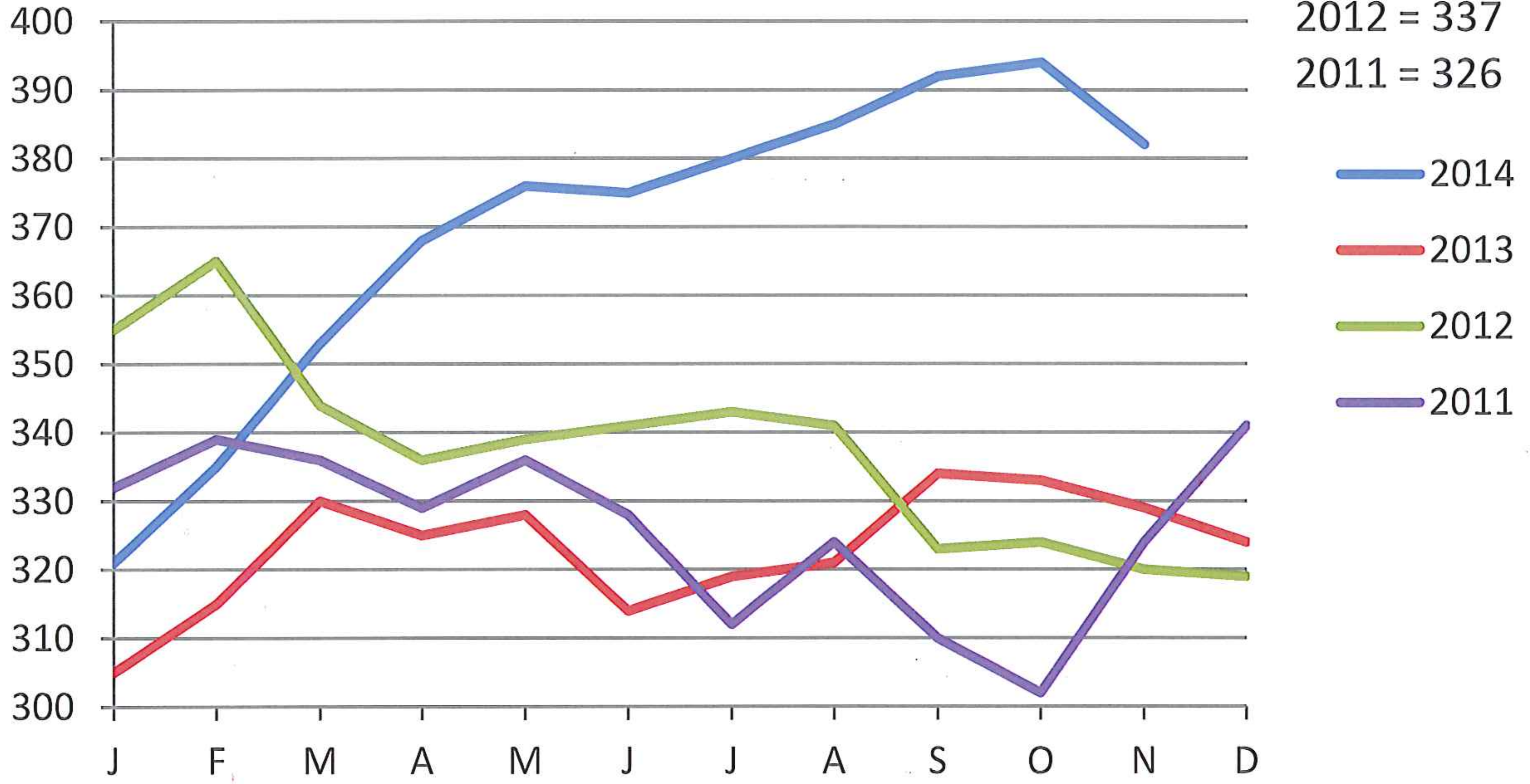
Center for Hospice Care

2014 YTD Average Daily Census (ADC)

(includes Hospice House and Home Health)

	All	South Bend	Elkhart	Plymouth
J	321	202	57	62
F	335	209	55	72
M	353	217	65	71
A	368	216	73	79
M	376	220	80	76
J	375	222	82	71
J	380	219	92	69
A	385	231	88	67
S	392	229	92	72
O	394	229	92	73
N	382	227	89	67
D				
2014 YTD Totals	4061	2421	865	779
2014 YTD ADC	**369**	**220**	**79**	**71**
2013 YTD ADC	323	194	69	59
YTD Change 2013 to 2014	46	26	10	12
YTD % Change 2013 to 2014	**14.3%**	**13.4%**	**14.0%**	**20.0%**

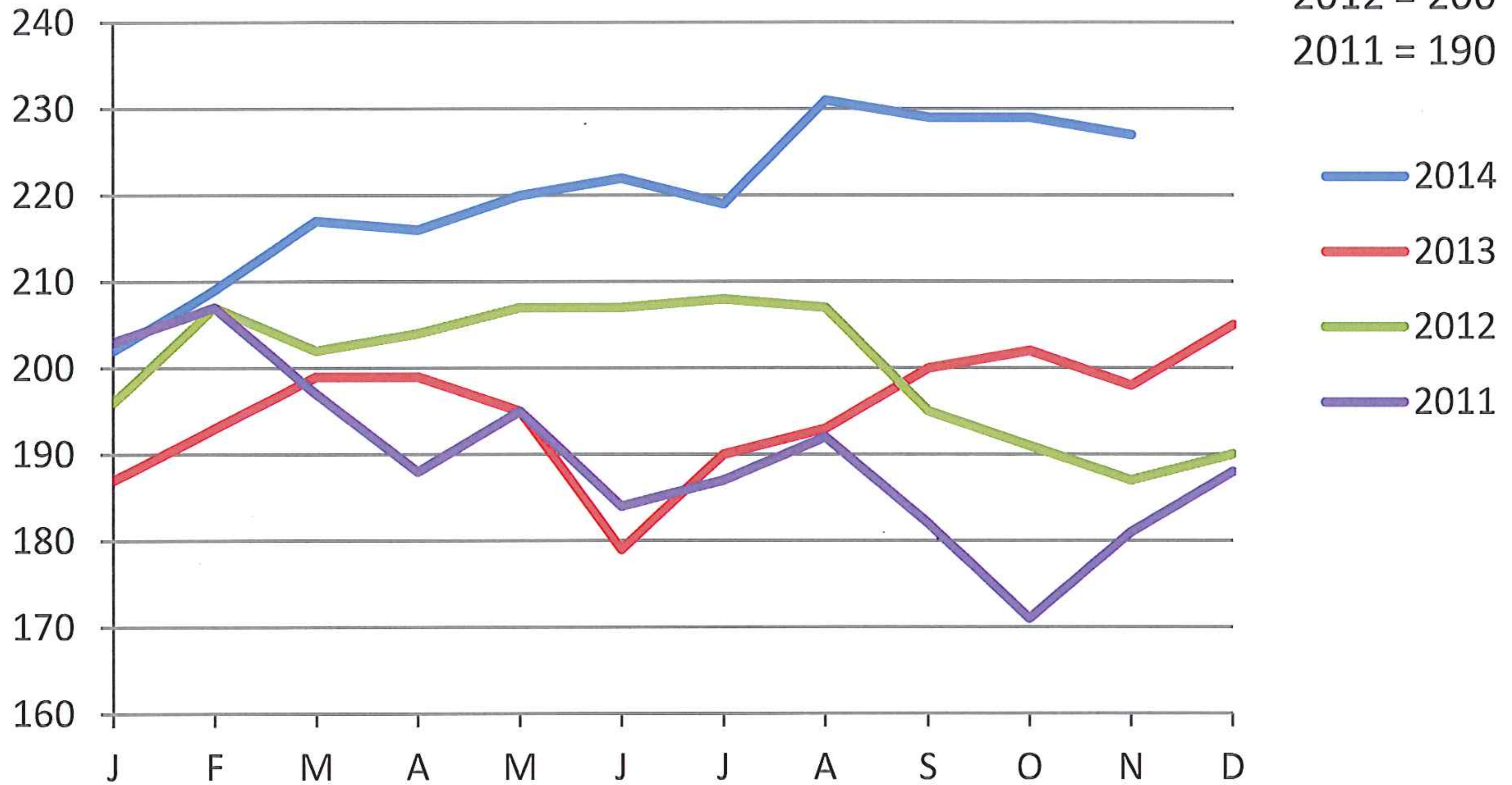


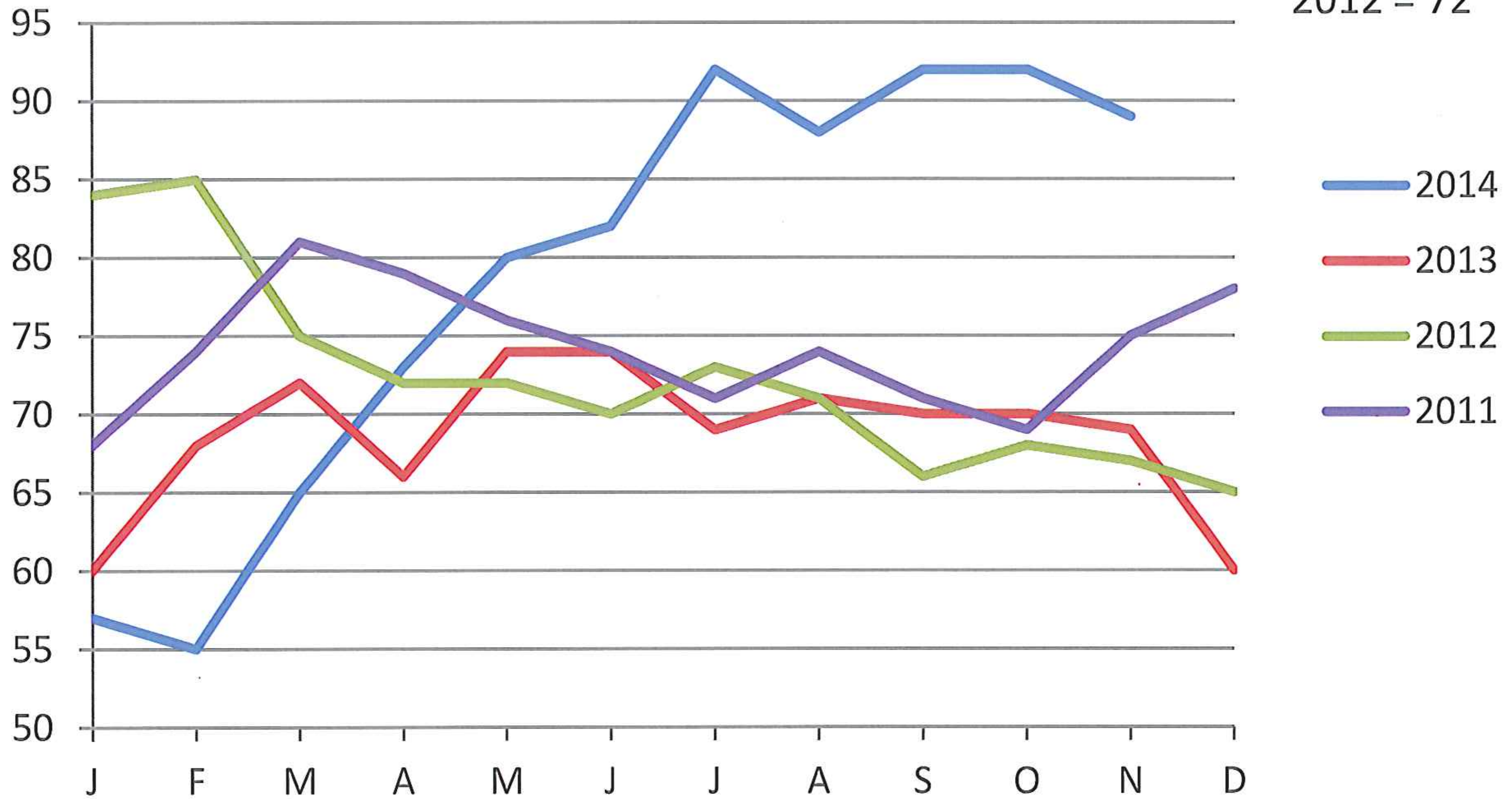


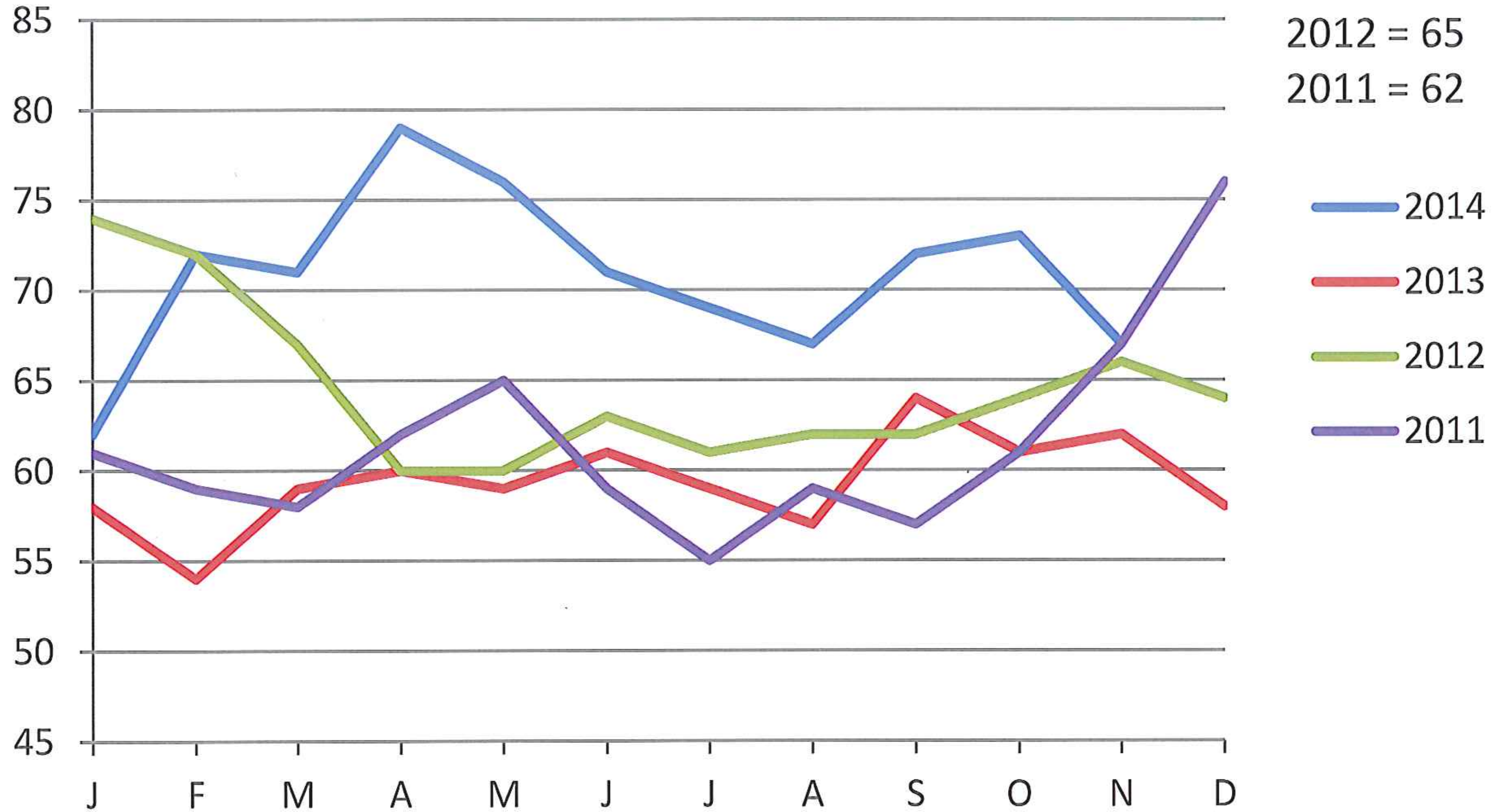
Center for Hospice Care
Total Average Daily Census (ADC)
ADC
YTD 2014 = 369
2013 = 323
2012 = 337
2011 = 326
400
390
380
370
360
350
340
330
320
310
300
J
F
M
A
M
J
J
A
S
O
N
D
2014
2013
2012
2011

South Bend
Average Daily Census

ADC
YTD 2014 = 220
2013 = 195
2012 = 200
2011 = 190




Elkhart
Average Daily Census
ADC
YTD 2014 = 79
2013 = 69
2012 = 72
95
90
85
80
75
70
65
60
55
50
J
F
M
A
M
J
J
A
S
O
N
D
2014
2013
2012
2011


Plymouth
Average Daily Census
ADC
YTD 2014 = 71
2013 = 59
2012 = 65
2011 = 62
85
80
75
70
65
60
55
50
45
J
F
M
A
M
J
J
A
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N
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2014
2013
2012
2011

Center for Hospice Care

choices to make the most of life

2015-2016 Slate of Officers

Amy Kuhar Mauro, Chair

Wendell Walsh, Chair-Elect

Sue Morgan, Treasurer

Mary Newbold, Secretary

Corey Cressy, Immediate Past Chair

Re-Election to Second Three-Year Term

Mary Newbold

Election of New Board Members for 2015, First Three-Year Term

Ann Firth

Jesse Hsieh, MD

Lori Turner

Suzanne Weirick

(Brief Biographical Sketch on new Board Members on next page)

2015 Candidate Slate

Board of Directors

Center for Hospice Care

Ann Firth serves as Chief of Staff to the University of Notre Dame President, Rev. John I. Jenkins, CSC. Her responsibilities include: advising the President; managing the staff and operations of the office; serving as a liaison with the Board of Trustees; working with the Budget Working Group, the Faculty Board on Athletics and the President's Leadership Council. Firth joined the Office of the President in November 2011 as associate vice president and counselor and was appointed to the chief of staff position in March 2012. She received both a Bachelor's degree and a Juris Doctor from the University of Notre Dame.

Jesse Hsieh, M.D has served as the President of The South Bend Clinic, and serves as a Director of Beacon Health System, Inc. He has been a Family Physician with the South Bend Clinic since 2005 practicing at Granger Family Medicine. He is also a Clinical Professor at the IU School of Medicine, performs research at the University of Notre Dame, and is Medical Editor of Michiana Family Magazine. He also plays guitars and vocals in the Vyagra Falls rock band. He is a graduate of the Southern Illinois University School of Medicine.

Lori Turner is Chief Marketing, Innovation & Customer Experience Officer of Beacon Health System. She began this position in August 2013. Previously she served as Vice President Network Marketing and Strategic Communication for Kettering Health System in Southwestern Ohio, which includes seven hospitals, eight emergency centers, and 75 outpatient facilities, where she directed market development and strategized communications. She completed her undergraduate work at the College of Mount St. Joseph and completed her MBA at the University of Dayton.

Suzzane Weirick has a background in Management Consulting and joins the CHC Board from Elkhart. Previously, she has been Senior Budget Analyst in the Office of Budget and Management for the City of Chicago. Suzie is currently a member of the Board of Directors for the Elkhart Youth and Community Center (formerly the YMCA of Elkhart County). She co-chaired (with Tim Portolese) the Elkhart General Hospital Foundation's "Have a Heart" fundraiser this past February to benefit EGH's Center for Cardiac Care which raised $700,000. She is currently the Volleyball Coach at Stanley Clark School. She holds an MBA from Illinois State University.

# # #

NHPCO's Facts and Figures

Hospice Care in America

2014 Edition

2014

National Hospice and Palliative Care Organization

Table of Contents

Introduction . . . 3
About this report . . . 3
What is hospice care? . . . 3
How is hospice care delivered? . . . 3
Who Receives Hospice Care? . . . 4
How many patients receive care each year? . . . 4
What proportion of U.S. deaths is served by hospice? . . . 4
Hospice Use by Medicare Decedents . . . 4
How long do most patients receive care? . . . 5
Short and Long Lengths of Service . . . 5
Where do most patients receive care? . . . 6
Inpatient Facilities and Residences . . . 6
Hospice in the Nursing Home . . . 6
What are characteristics of the hospice patient population? . . . 6
Patient Ethnicity and Race . . . 7
Primary Diagnosis . . . 7
Who Provides Care? . . . 8
How many hospices were in operation in 2013? . . . 8
Agency Type . . . 8
Agency Size . . . 8
Organizational Tax Status . . . 9
Who Pays for Care? . . . 10
Hospice Participation in Medicare . . . 10
How Much Care is Received? . . . 11
What services are provided to patients and families? . . . 11
What level of care do most hospice patients receive? . . . 11
Staffing management and service delivery . . . 11
Volunteer commitment . . . 12
Bereavement support . . . 12
Assessing the Quality of Hospice Care . . . 13
Additional Statistics for NHPCO Members . . . 14
National Summary of Hospice Care . . . 14
NHPCO Performance Measure Reports . . . 14
Appendix 1: Data Sources . . . 16
Appendix 2: How Accurate are the NHPCO Estimates? . . . 17

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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.

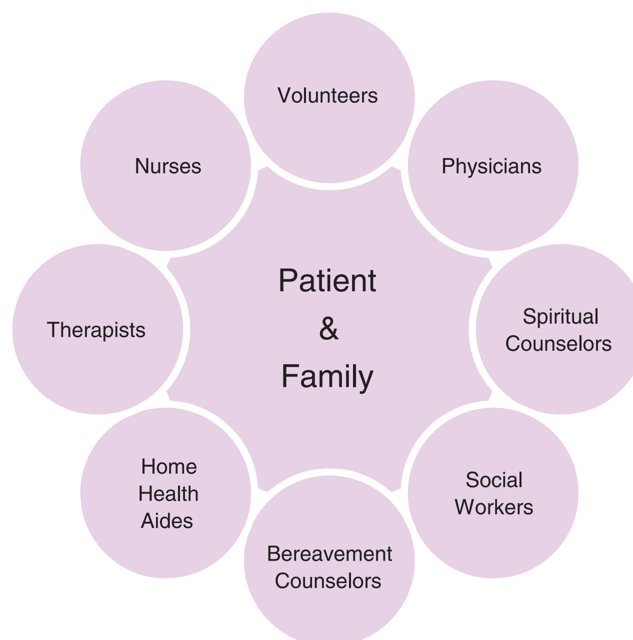

Figure 1. Interdisciplinary team

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Who Receives Hospice Care?

How many patients receive care each year?

In 2013, 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 2012 and who continued to receive care into 2013 (known as "carryovers")
- patients who left hospice care alive in 2013 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.

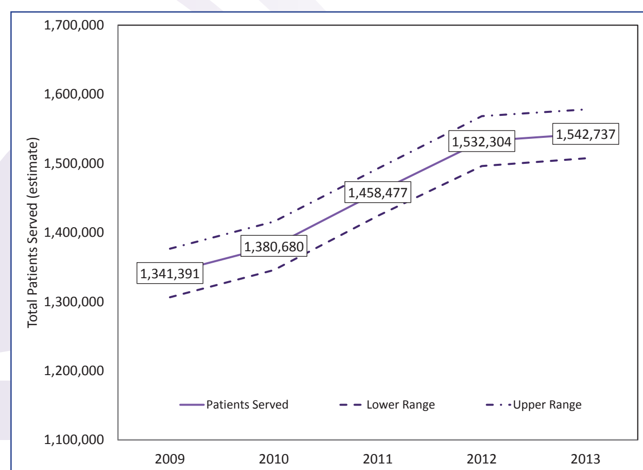

Figure 2. Total Hospice Patients Served by Year [1]

NHPCO continually examines, and when appropriate, revises the methodology employed in its data analysis. In 2013 NHPCO revised the statistical model used to generate the estimate of patients served. The revised model is derived from a combination of NHPCO and CMS data and produces a range of possible values for the patients served estimate rather than a single number. Each year additional data points are added to the model and, as a result, prior year estimates are more refined and may differ slightly from previous estimates.

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, as of the publication date of this document, CDC data on the number of U.S. deaths in 2013 is not available. Therefore, NHPCO is not able to report on the estimated percentage of all deaths while under the care of hospice.

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

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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 3.

How long do most patients receive care?

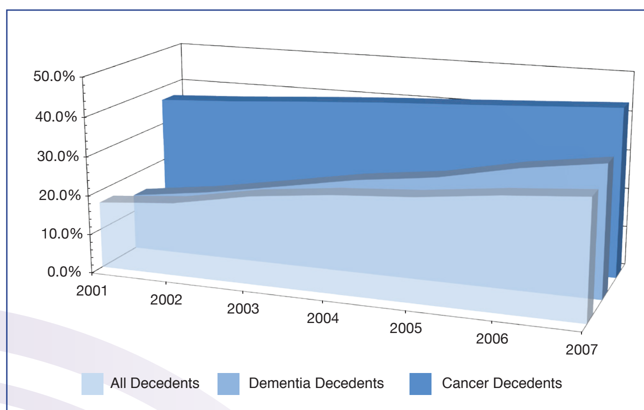

Figure 3. Proportion of Medicare Decedents Accessing Three or More Days of Hospice Care

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 2013 was 18.5 days, a decrease from 18.7 days in 2012[1]. This means that half of hospice patients received care for fewer than 18 days and half received care for more than 18 days. The average length of service increased from 71.8 days in 2012 to 72.6 in 2013 (Figure 4)[1]. Over the past several years the median length of service has declined while the average length of service increased.

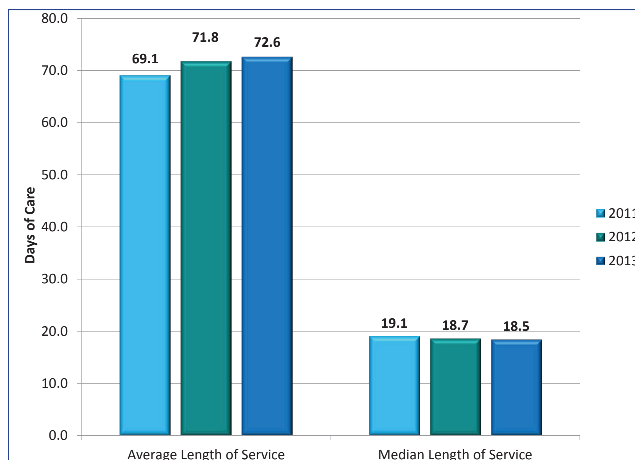

Figure 4. Length of Service by Year [1]

Short and Long Lengths of Service

In 2013, a slightly smaller proportion of hospice patients (approximately 34.5%) died or were discharged within seven days of admission when compared to 2012 (35.5%)[1]. A slightly smaller proportion of patients died or were discharged within 14 days of admission when compared to 2012 (48.8% in 2013 and 49.5% in 2012)[1]. Nearly the same proportion of patients remained under hospice for longer than 180 days (11.5% in 2012 and 2013)[1].

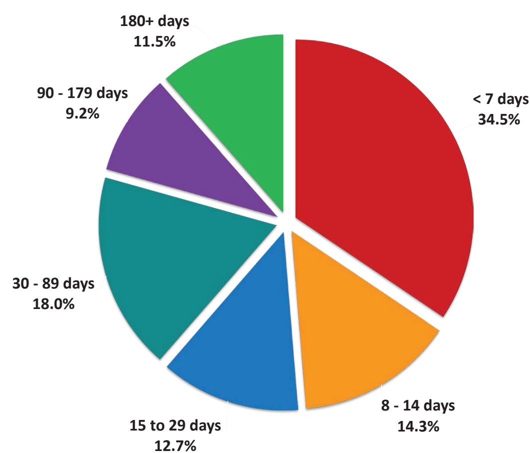

Figure 5. Proportion of Patients by Length of Service in 2013 [1]

* 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 2013, two thirds[1] of patients received care at home. The percentage of hospice patients receiving care in a hospice inpatient facility decreased from 27.4% to 26.4%[1].

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

Location of Death	2013	2012
Patient's Place of Residence	66.6%	66.0%
Private Residence	41.7%	41.5%
Nursing Home	17.9%	17.2%
Residential Facility	7.0%	7.3%
Hospice Inpatient Facility	26.4%	27.4%
Acute Care Hospital	7.0%	6.6%

Inpatient Facilities and Residences

In addition to providing home hospice care, about one in three 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	2013	2012
Female	54.7%	56.4%
Male	45.3%	43.6%

Patient Age

In 2013, approximately 84% of hospice patients were 65 years of age or older—with 41.2% being 85 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	2013	2012
Less than 24 years	0.4%	0.4%
25 - 34 years	0.4%	0.4%
35 - 64 years	15.3%	15.7%
65 - 74 years	16.6%	16.3%
75 - 84 years	26.1%	27.7%
85+ years	41.2%	40.5%

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Patient Ethnicity and Race

Following U.S. Census guidelines, NHPCO reports Hispanic ethnicity as different from race. In 2013, 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	2013	2012
Non-Hispanic or Latino origin	93.2%	93.1%
Hispanic or Latino origin	6.8%	6.9%

Patients of minority (non-Caucasian) race accounted for less than one fifth of hospice patients in 2013 (Table 5)[1].

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

Patient Race	2013	2012
White/Caucasian	80.9%	81.5%
Multiracial or Other Race	7.5%	6.7%
Black/African American	8.4%	8.6%
Asian, Hawaiian, Other Pacific Islander	2.9%	2.8%
American Indian or Alaskan Native	0.3%	0.3%

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 (36.5%)[1] (Table 6). Currently, less than 25% of all 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 2013 were dementia (15.2%), heart disease (13.4%), lung disease (9.9%), and debility unspecified (5.4%).[1]

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

Primary Diagnosis	2013	2012
Cancer	36.5%	36.9%
Non-Cancer Diagnoses	63.5%	63.1%
Dementia	15.2%	12.8%
Heart Disease	13.4%	11.2%
Lung Disease	9.9%	8.2%
Other	6.9%	5.2%
Debility Unspecified	5.4%	14.2%
Stroke or Coma	5.2%	4.3%
Kidney Disease (ESRD)	3.0%	2.7%
Liver Disease	2.1%	2.1%
Non-ALS Motor Neuron	1.8%	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 2013?

The number of hospice programs nationwide continues to increase — from the first program that opened in 1974 to approximately 5,800 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.

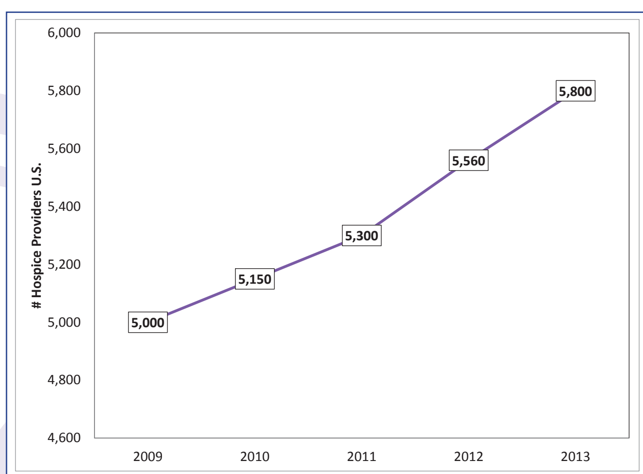

Figure 6. Total Hospice Agencies by Year [1]

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	2013	2012
Free Standing/Independent Hospice	58.3%	57.4%
Part of a Hospital System	19.8%	20.5%
Part of a Home Health Agency	16.7%	16.9%
Part of a Nursing Home	5.1%	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 2013, 78.7%[1] of hospices had 500 or fewer total admissions (Table 8).

Table 8. Total Patient Admissions [1]

Total Patient Admissions	2013	2012
1 to 49	16.1%	15.7%
50 to 150	29.5%	28.7%
151 to 500	33.1%	33.0%
501 to 1,500	16.4%	17.7%
> 1,500	4.9%	4.9%

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 2013, the mean average daily census was 137.7[1] patients and the median (50th percentile) average daily census was 79.5[1] patients. More than one third of providers routinely care for more than 100 patients per day (Figure 7).

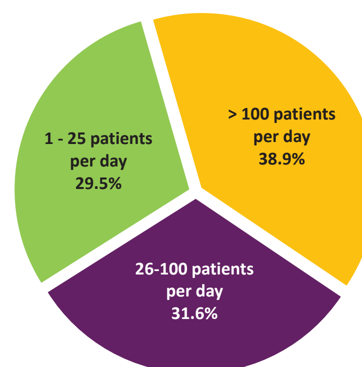

Figure 7. Average Daily Census [1]

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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, 30%[2] of active Medicare Provider Numbers are assigned to providers that held not-for-profit tax status and 66%[2] held for-profit status in 2013. Government-owned programs comprise the smallest percentage of hospice providers (about 5%[2] in 2013).

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 declined over the same period.

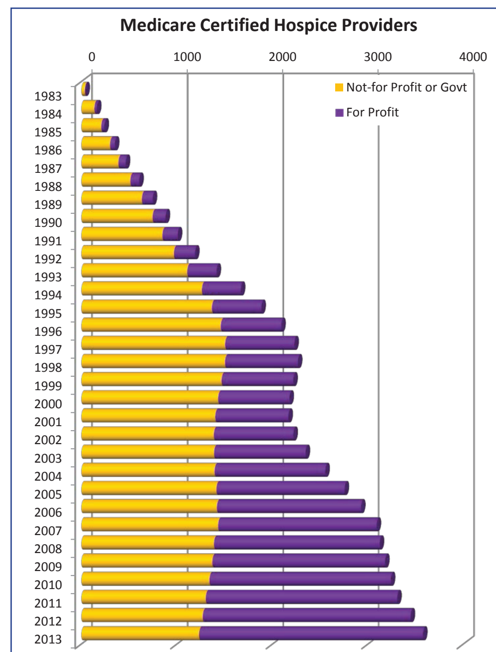

Figure 8. Growth in Medicare-Certified Hospice Providers [2]

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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 87.2%[1] in 2013 (Table 9). The percentage of patient days covered by the Medicare hospice benefit versus other sources was 91.2%[1] (Table 10).

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

Payer	2013	2012
Medicare Hospice Benefit	87.2%	83.7%
Managed Care or Private Insurance	6.2%	7.6%
Medicaid Hospice Benefit	3.8%	5.5%
Uncompensated or Charity Care	0.9%	1.2%
Self Pay	0.8%	0.9%
Other Payment Source	1.2%	1.2%

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

Payer	2013	2012
Medicare Hospice Benefit	91.2%	89.0%
Managed Care or Private Insurance	4.0%	4.4%
Medicaid Hospice Benefit	3.1%	4.3%
Uncompensated or Charity Care	0.6%	0.8%
Self Pay	0.5%	0.6%
Other Payment Source	0.6%	0.9%

Most hospice agencies (92.7%[1]) have been certified by the Centers for Medicare and Medicaid Services (CMS) to provide services under the Medicare hospice benefit. In 2013, there were more than 3,900[2] certified hospice agencies. Figure 9 shows the distribution of Medicare-certified hospice providers by state.

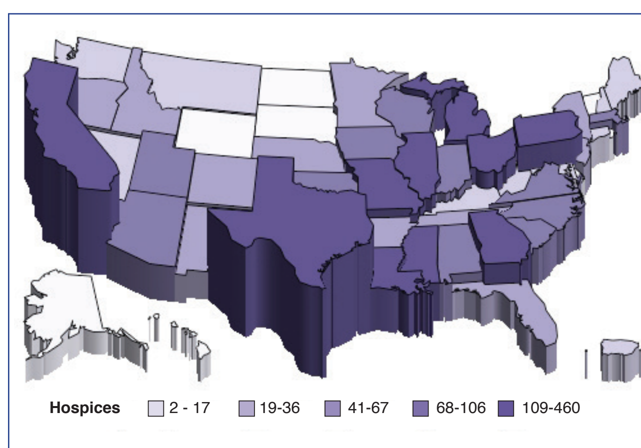

Figure 9. Medicare-Certified Hospices by State [2]

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.

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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 2013, 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	2013	2012
Routine Home Care	94.1%	96.5%
General Inpatient Care	4.8%	2.7%
Continuous Care	0.8%	0.5%
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: 71.8%[1] of home hospice full-time equivalent employees (FTEs) were designated for direct patient care or bereavement support in 2013.

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The number of patients that a clinical staff member is typically responsible for varies by discipline. In 2013, the average patient caseload for a hospice aide was 10.7[1] patients, 11.2[1] patients for a nurse case manager, and 25.2[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. In fact, 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.

NHPCO estimates that in 2013, 355,000[1] hospice volunteers provided 16 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 2013, most volunteers were assisting with direct support (60.9%[1]), 20.4%[1] provided clinical care support, and 18.7%[1] provided general support.

In 2013, 4.5%[1] of all clinical staff hours were provided by volunteers. The typical hospice volunteer devoted 46.5[1] hours of service over the course of the year and patient care volunteers made an average of 20[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 2013, for each patient death, an average of 1.9[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 (92.1%[1]) also offer some level of bereavement services to the community; community members account for about 11.4%[1] of those served by hospice bereavement programs.

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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	2013
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*	85.9%
Family Evaluation of Bereavement Services (FEBS)	
How well services met the needs of the bereavement client (% "Very Well")	76.5%
Comfortable Dying Measure	
Patient's pain brought to a comfortable level within 48 hours of initial assessment	64.0%
Patients still uncomfortable due to pain 48 hours after initial assessment	12.8%

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.

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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. 2013, NHPCO National Data Set and/or NHPCO Member Database.
2. 1st Quarter 2014, 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.

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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

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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.

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2015 BOARD OF DIRECTORS MEETINGS
Administrative and Foundation offices
501 Comfort Place, Mishawaka IN 46545
Wednesdays, 7:30 a.m.

Date	Topic of Focus
February 18	Year in Review New members' first meeting
April 15	Review of Audit
June 17	Annual Professional Advisory Group report Review of Personnel Policies Manual (every other year) Review of Bylaws (as needed; at least every three years)
August 19	Foundation Update Strategic Plan update
October 21	Quality Assurance Performance Improvement updates
December 16	Budget for 2016 Election of new members and officers Board Self-Evaluation (every other year)

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Thursday, November 13, 2014
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Holy Cross Village Hosts We Honor Veterans Pinning Ceremony

Carole Moats, volunteer with the Center for Hospice Care, recognizes Holy Cross Village independent living resident George Hickner for his military service in World War II during a We Honor Veterans pinning ceremony held at the Indiana continuing care retirement community.

Contact

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Email

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(PRWEB) November 13, 2014

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On Monday, November 10, 2014, Holy Cross Village at Notre Dame hosted the Center for Hospice Care's We Honor Veterans pinning ceremony.

The ceremony honored veterans who live at Holy Cross Village, a continuing care retirement community in Indiana. The pinning ceremony not only publicly acknowledged the military service and sacrifices made by veterans and their families, it also allowed each to share his or her story. More than 30 of the community's 45 independent living veterans participated.

"We have residents from four wars—World War II, the Korean War, Vietnam War and Bosnian Conflict—living at Holy Cross Village," said Susan Griffin, the senior living community's marketing director. "This was our way of thanking them for their dedication to our country."

"On Veterans' Day, the nation honors American heroes for their military service," said Amy Tribbett, director of marketing and access for the Center for Hospice Care. "But it's important to remember that veterans also deserve recognition and compassionate care when dealing with a serious illness."

Holy Cross Village at Notre Dame hosted the Center for Hospice Care's We Honor Veterans pinning ceremony.

> "We have residents from four wars—World War II, the Korean War, Vietnam War and Bosnian Conflict—living at Holy Cross Village," said Susan Griffin, the senior living community's marketing director.

Serving northwest Indiana, the Center for Hospice Care is an independent, community-based, not-for-profit organization dedicated to improving the quality of life through hospice, home health, grief counseling, and education. As a We Honor Veterans partner, the organization delivers specialized care to veterans who are facing a life-limiting illness.

We Honor Veterans was created by the National Hospice and Palliative Care Organization in collaboration with the Department of Veterans Affairs to empower hospice and other healthcare providers across America to meet the needs of seriously ill veterans and their families. Center for Hospice Care has achieved a Level 4 partner status, the highest attainable level in the We Honor Veterans program.

The We Honor Veterans pinning ceremony is just one of the many activities that occur at Holy Cross Village on a regular basis. The senior living community sponsors events all year long to help enrich the lives of residents.

A continuing care retirement community in Notre Dame, Indiana, Holy Cross Village offers a full range of assisted living care, including 24-hour skilled nursing services and compassionate memory care. The senior living community's comprehensive selection of living options include independent living villas and apartments, assisted living apartments, a skilled nursing center, and memory care suites—all supported by a full continuum of on-site health care.

Nestled among the landscaped campuses of Holy Cross College, the University of Notre Dame and Saint Mary's College, Holy Cross Village offers a rare combination of campus activities, inviting common areas, and abundant amenities and activities. In fact, U.S. News & World Report recognized Holy Cross Village as one of the Best Nursing Homes in 2014. This notable honor signifies earning five stars in overall performance from the Federal Centers for Medicare and Medicaid Services.

Holy Cross Village is conveniently located just south of the Indiana Toll Road (Interstate 80/90). The community's office is located in Andre Place off Holy Cross Parkway at 54515 State Road 933 North. For more information or to schedule a visit, call (574) 251-2235 or visit online at http://www.HolyCrossVillage.com.

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Veterans Administration and National Hospice and Palliative Care Association create "We Honor Veterans" program

Posted: Nov 05, 2014 12:26 PM EST

By Jacob Burbrink, Internet Director CONNECT

As the nation honors veterans of the armed forces on Veterans Day next week the Center for Hospice Care is urging people to remember those dealing with a serious illness.

A press release by the Center for Hospice care said the Veterans Administration and National Hospice and Palliative Care Association has been working together to provide specialized care to Veterans facing a life-limiting illness. As a part of the partnership, the organizations created a "We Honor Veterans" program to empower hospice and other healthcare providers across America to meet the unique needs of seriously ill Veterans and their families.

The Center for Hospice Care has recently achieved the highest attainable level in the program. President and CEO of the organization Mark Murray said the staff and volunteers worked hard to make the achievement possible.

"Many steps were taken, including increasing the integration of Veteran-specific education for staff and volunteers, evaluating and growing our Veteran-to-Veteran Volunteer Program, developing resources to help our Veterans and their families' access benefits, along with continually evaluating and implementing better ways to improve care and service to Veterans and their families throughout our organization," Murray said.

To learn more about the "We Honor Veterans" program you can visit www.WeHonorVeterans.org.

ConsumerReports.org

How to find a good hospice program

6 features to look for

Published: October 2014

Hospice doctor Bethany Calkins visits Paul Scheier. Click on photo to see related story.

Most people are referred to hospice by their doctor. Patients, family members, even friends can also make referrals. If you're looking for a program, check with the National Hospice and Palliative Care Organization. But beware: More than half of U.S. hospice programs are for-profit, according to Medicare figures, and several recent news reports have highlighted problems at some of those programs.

Here's what to look for in a hospice.

- Not-for-profit status and 20 or more years of experience.
- Hospice-certified nurses and doctors on staff and available 24 hours per day.
- Palliative-care consultants who can begin care if you're not yet ready for hospice.
- An inpatient unit, where patients can go if symptoms can't be managed at home.
- Ability to provide care in nursing homes and assisted living residences.
- Medicare approval. That way, Medicare will cover services, including equipment and home health aides as needed, plus counseling and grief support for the patient and the family.

See our complete end-of-life coverage

Click on the photo at right to read "A Beautiful Death" and watch our video, which follow the end-of-life journey of Paul Scheier, a retired dentist from Buffalo, N.Y. It contains more information on how to prepare for this final passage.

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Wednesday, November 5, 2014

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Center for Hospice Care Earns Perfect Recertification and Relicensure Survey: Indiana State Department of Health Finds No Deficiencies or Non-compliance Issues

On Monday, October 6, 2014, surveyors from the Indiana State Department of Health began a survey for continued Indiana hospice state licensure, and, federal certification for continued participation in the Medicare Hospice Benefit program at Center for Hospice Care. The agency received a "perfect survey" and a finding of no deficiencies.

Contact

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South Bend, Indiana (PRWEB) November 05, 2014

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On Monday, October 6, 2014, surveyors from the Indiana State Department of Health began a survey for continued Indiana hospice state licensure, and, federal certification for continued participation in the Medicare Hospice Benefit program at Center for Hospice Care. The agency received a "perfect survey" and a finding of no deficiencies.

Elkhart Office

> "The surveyors commented that, 'The patient care is outstanding. Everything was perfect,' and, 'It was so evident how educated the entire staff is.'"

The Indiana State Department of Health surveyors began their investigation by looking for anything out of compliance or patient care issues. They did this by:

- Visiting all three care offices in South Bend, Plymouth and Elkhart.
- Making in-person visits to Center for Hospice Care patients in residential homes, nursing homes, and both Hospice Houses.
- Carefully Reviewing randomly selected patient charts from all of the above settings searching for errors or missing documentation from all disciplines, including Bereavement client charts, programming, and outcome measurements.
- Reviewing Human Resource/personnel files for both staff and volunteers.
- Reviewing patient care policies with a specific eye toward infection control and Quality Assurance Performance Improvement (QAPI) projects.
- Interviewing various care staff regarding their personal knowledge of the Hospice Medicare Conditions of Participation, the numerous recent changes to those regulations, as well as their personal familiarity with internal Center for Hospice Care patient care policies and procedures.

Since Center for Hospice Care's last survey six years ago, the federal regulations for Medicare hospice have gone through some major changes. In the past, there may have two changes a year along with a year's notice to get ready for them. In 2009, that began to change, and increasingly more regulatory initiatives went into effect each year. In 2014 alone, the hospice industry is dealing with 14 different regulatory changes.

At the conclusion of the four-day survey, there were no deficiencies or non-compliance issues found. The surveyors commented that, "The patient care is outstanding. Everything was perfect," and, "It was so evident how educated the entire staff is."

"For hospice licensure and federal certification, this time around, against far greater challenges than we've ever faced before, I couldn't be more proud of the staff at Center for Hospice Care," expressed Mark Murray, President and CEO. "Like every success we experience, it is always a team effort, and our Center for Hospice Care team members are superior across the board in every way.

"Center for Hospice Care provides remarkable care to its patients, follows all of the rules and regulations while doing so, and makes a profound, positive difference in our community. Because we know and believe that no matter what, it all comes down to a quality day of care at the patient bedside."

Center for Hospice Care is a premier not-for-profit, community-based agency improving the quality of living through hospice, home health, grief counseling, and community education. With offices in South Bend, Plymouth, and Elkhart, Center for Hospice Care serves St. Joseph, Marshall, Elkhart, Fulton, Kosciusko, LaGrange, LaPorte and Starke Counties. For more information, log on to http://www.centerforhospice.org.

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Fox 28

Center for Hospice Care receives "perfect survey"

Posted: Nov 04, 2014 4:13 PM EST

By Katie Lathrop, Producer | CONNECT |

November is National Hospice Month, and the Center for Hospice Care, based right here in Northern Indiana, has good reason to celebrate.

They received a "perfect survey" from the Indiana State Department of Health, after surveyors found no deficiencies or non-compliance issues for continued Indiana hospice state licensure and federal certification for continued participation in the Medicare Hospice Benefit program.

Surveyors began their investigation back on October 6th. They visited all three Centers for Hospice Care offices, which are located in South Bend, Plymouth and Elkhart. The surveyors also:

- Made in-person visits to Center for Hospice Care patients in residential homes, nursing homes, and both Hospice Houses.
- Carefully reviewed randomly selected patient charts from all of the above settings searching for errors or missing documentation from all disciplines, including Bereavement client charts, programming, and outcome measurements.
- Reviewed Human Resource/personnel files for both staff and volunteers.
- Reviewed patient care policies with a specific eye toward infection control and Quality Assurance Performance Improvement (QAPI) projects.
- Interviewed various care staff regarding their personal knowledge of the Hospice Medicare Conditions of Participation, the numerous recent changes to those regulations, as well as their personal familiarity with internal Center for Hospice Care patient care policies and procedures.

Center for Hospice Care serves St. Joseph, Marshall, Elkhart, Fulton, Kosciusko, LaGrange, LaPorte, and Starke Counties. According to their website, they are a "premier not-for-profit, community-based agency improving the quality of living through hospice, home health, grief counseling, and community education." You can visit their website here.

Thank you for your thoughtfulness!
Becky

Thank you so much for your kindness!
Lynne

Mary Lou Foley

MMM - THANKS SO VERY MUCH!
EVELYN

Love the chocolates! Thank!
Terri Ely

Thank you so very much!
Darlene

WOW! Thanks!
Amy
Tribbett

Thanks so much! Your acknowlegment mean a lot!
Rita Chisos

Thank you for your Thank you
Judy

Chocolate makes everything better!
Thank you, Barb King

Center for
Hospice Care
choices to make the most of life
Congratulations on the
Perfect Hospice Survey
From the Board of Directors
Center for Hospice Care
THE SOUTH BEND CHOCOLATE COMPANY

Transcendent

Marketing insights for taking hospices to the next level

GROWTH – November '14

3rd November 2014

To increase census and length of stay, it makes sense to focus on growing census in segments that tend to have longer lengths of stay – exactly what data on the family/self referral segment indicates.

Choose an article to learn more.

Why Focus on Marketing to Patients and Their Families?

Without a doubt, doctors continue to be major gatekeepers and influencers in guiding patients and their families to hospice care.

Many families won't consider hospice until the doctor says it's time. Unfortunately, that "time" often is called much later than it should be – frequently granting patients mere days or even hours to receive only partial benefits of what hospice can provide.

But among Transcend's clients, when admissions come from a family or self referral, the patient length of stay can be substantially greater compared to referrals from healthcare professionals. So if you can grow referrals from the family/self segment, and those patients receive your services for a longer period of time, you can increase the quality of care as well as your revenue.

Patients/families who called us directly had an ALOS nine days longer and a median that was seven days longer when compared to all other referral sources.

- Mark Murray, president and CEO of Center for Hospice Care

"We just started our fourth year comprehensive media campaign directed toward the public," said Mark Murray, president and CEO of Center for Hospice Care (north central Indiana). "Referrals from the family/self category – the public directly calling us – have continued to increase year over year. Last year, they were up 50 percent from 2011. Patients/families who called us directly last year, met eligibility requirements and were admitted to our hospice, had an average length of stay that was nine days longer and a median that was seven days longer when compared to all other referral sources. Since the most frequent complaint we receive is, 'Why didn't somebody tell me about hospice sooner?' presumably these consumers also have a better experience than if they had waited for their trusted healthcare professional to suggest hospice."

This trend makes sense to other hospice administrators we've talked with as well. When patients or families recognize the need for help at end of life, they often raise their hands sooner – even before a doctor may be willing to admit the depleted or greatly diminished effects of curative treatment.

Sometimes, it's the doctors, not the families, who can't let go.

- Theresa Brown, oncology nurse

Recently, an oncology nurse, Theresa Brown, addressed this situation in a *New York Times* article titled "When It's the Doctor Who Can't Let Go." In part, the article said, "Sometimes, it's the doctors, not the families, who can't let go. Because doctors are supposed to cure, efforts directed elsewhere, even palliative care, can feel like a failure."

In addition, as Baby Boomers continue to age and face end-of-life decisions for their parents, their partners or themselves, the preference for autonomy in making such crucial choices is likely to increase. Baby Boomers often prefer to research their

options and make their own choices regardless of what “authorities” say. By educating family healthcare decision makers on why your organization is the preferred source of hospice care, and empowering them to contact you directly, you may avoid the obstacles of physician hesitancy for timely referrals.

Are you currently monitoring admissions from the family/self referral segment? Have you compared LOS from this segment to patients referred by doctors and other healthcare professionals? You just might see an opportunity for meaningful growth.

For more information on strategies to increase family/self referrals:
Contact Stan Massey

Center for Hospice Care
QI Committee Meeting Minutes
November 18, 2014

Members Present:	Alice Wolff, Amy Knapp, Amy Tribbett, Ann Cowe, Dave Haley, Donna Tieman, Gail Wind, Holly Farmer, Julie Englert, Larry Rice, Marjie Lolmaugh, Rebecca Fear, Sue Morgan, Becky Kizer
Absent:	Greg Gifford, Mark Murray, Vicki Gnoth

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m.	
2. Committee Members	• Welcomed Rebecca Fear, the new QA Coordinator.	
3. Home Health Report	• Page 2, Nursing – Documentation of homebound status was 100%. We have tracked the problem to nurses not loading the correct form in Cerner. • Page 4, Medications – Still struggle with reconciliation of med profiles. Frequently we see patients convert to the hospice program within the first 7-10 days of admission, and that process gets lost because now we are focusing on hospice. We will track this to see if that is what is going on.	
4. Hospice Report	• Page 5, Medications - Have started a new QAPI project to look at the medication order process and why Cerner and Enclara profiles don't match and insure nurses know how to write med order correctly.	
5. Revocations & Live Discharges	• We continue to review all live discharges and revocations. The number of revocations was down to the single digits for the third quarter. The percentage of revocations to acute care was 74% compared to 57% last quarter. Revocations within 25 days of admission were 8 this quarter compared to 17 last quarter. September had zero. Reason for revocation – September had 8 go to acute care, which were all the revocations that month. Some go to an ECF to access Medicare A, some seek curative treatment not in our plan of care, and some no longer want hospice services. The number of live discharges was nearly the same as last quarter. Percentage of live discharges with IDT input – most occurred in May—71%. We did some staff education and now it is in the 90's. Our goal is 100%. Patients that moved out of service area went to a hospital out of service area or that we don't have contract with, or personal travel was 9 this quarter. We continue to monitor this and deliver education as needed.	

Topic	Discussion	Action
6. Clinical Quality Measures	• We are looking at pain assessed at each skilled nurse visit and at gastrointestinal bowel function. Pain has been assessed 100% this year. Bowel function – We look at the last bowel movement, bowel sounds, and bowel regimen if on an opioid. We have done much education this year and have seen improvement. Part of this is the way the electronic records looks to the nurse. Bowel sounds and opioids are somewhat hidden in record and the nurse has to scroll down to find it. This quarter ranged from 92% to 98.9% compliance.	
7. Hospice House Volunteers	• Don't have any data to share today. The QAPI is meeting tomorrow. We surveyed current Hospice House volunteers, and have also decided to survey volunteers that stopped to see if we could glean information from the reasons they left. We will share the data at the next QI Committee meeting. The group is revising the Hospice House volunteer job descriptions and creating levels of volunteers. Some just want to give patients or families support, some just answer the phone, let in visitors, and some want to do patient care.	
8. HIPAA	• Staff competency in HIPAA is assessed on a routine basis. Staff receives routine updates on HIPAA. The annual HIPAA in-service was presented at the September staff meeting. Going forward we will have level two training which is done at the time of hire that is job specific to that employee. Annually the agency will set up auditing and monitoring of how the agency will be doing that and what it will look like.	
9. Caregiver Confidence	• So far we have caused awareness across disciplines about the fact our caregivers are not feeling confident during the dying process. We also discovered some of our staff doesn't feel confident. In the nursing department we conducted a survey to measure their level of confidence in actually dealing with families during this crisis situation. The QAPI meets this week to review the statistics. We have done education in other disciplines too.	
10. Spiritual Care Contact	• The counselors are following up with phone calls to caregivers to ask why they were not satisfied with the amount of spiritual care contact they received. Often it is not as many visits as they wanted, so we are trying to work with their local clergy to get them more involved. Also we continue to remind spiritual care counselors at the initial assessment and time of recert to inquire if the frequency of contacts is enough.	
11. Emotional Support to Family	• B10 and E3, Feelings of anxiety or sadness; Emotional support before death – We have seen improvement. We are getting back to where we were in the first quarter when we	

Topic	Discussion	Action
	were below the Indiana average. Social workers are working on written information they can give to families when they start services, including pictures so it is more meaningful. Amy K. attended an NHPCO webinar on mental health which focused on anxiety and depression. We don't have great attendance at those webinars, because of the time of day, so we will assign staff to watch the archived webinar. • E4, Emotional support after death – The QAPI is gathering information from the FEHC surveys for anyone that didn't check "right amount" to see if they left information so we could follow up with them. One thing we are doing is encouraging nurses to do Secure Message after 24 hours of death if they do a phone call to the family, attend visitation or funeral, etc., so bereavement knows that contact has happened. Holly will be reviewing that at the December nurses meeting. Nick D. created an email distribution list so staff can choose bereavement contacts. We also talked about social workers using the language from the survey, so hopefully families use that. Bereavement staff is also attending IDTs now, so if families have increased needs for emotional support we can talk about it as a team and whether bereavement needs to do an early contact.	
12. Adverse Events	• We are tracking medication errors through Enclara reports. We are focusing on med errors because that is the greatest area of exposure because of the high risk of patient safety. It was higher this quarter. We discovered meds were disappearing at the time of delivery to door with either missing pills or whole bottles from the package. We are working with FedEx, Enclara and the DEA. This has been elevated to an investigation by the DEA in New Jersey and Indiana, and they are also working with Enclara and FedEx. There was an increase in med errors in July in Hospice House which was attributed to Omnicare and some processes involving two new nurses. We did see improvement in August and September.	
13. Infection Control	• A copy of the COPs regarding infection control and CHC's Infection Control Program policy were shared with the committee. We are looking at best practices in the industry so we can align ours with those. We are also undergoing data collection regarding infection control surveillance reporting. Our current indicator is if there is documentation when a patient is on an antibiotic and its efficacy. In addition, we do an annual car trunk check to make sure the supplies nurses are carrying are adequate and haven't expired. We posted a flyer in October during infection control week on PPE donning and removal. Every year we do an in-service with the aides on infection control practices. Other disciplines also receive training in their orientation. An annual	

Topic	Discussion	Action
	in-service on bloodborne pathogens is presented at an all staff meeting. We have a program that follows the COPs guidelines. We also make sure our policies and procedures line up with best practices and the COPs. We had no needle sticks this quarter to report. • Our infection control efforts will now be reported to the QI committee every quarter. One thing we heard during the ISDH hospice survey was while our overall efforts for QI Committee reports meet regulations, the surveyors would like to see the agency infection control efforts reported on quarterly instead of annually, as we have previously been reporting.	
14. ECF Professional Management	• We have been tracking daily visits at ECFs when a patient is at the end of life. We are looking at patients with us more than two weeks where the team was made aware the patient was actively dying or near the end of life. We did some education. June and July we met 100%, so in August we started looking at all patients, not just ECF. August was 74% and September in the 70's. We reminded staff to use Secure Message in Cerner to let staff know when a patient is actively dying. We do use Secure Message to notify the team of any changes in a patient's condition. We don't use Secure Message as much as we could. We still see a lot going through email. So we will continue to look at increasing that number and provide better support for ECF staff, the patient and family at the end of life. • Goal – We have not decided what the goal should be. Sometimes we don't know a patient has died or is actively dying. We may see a patient on Monday and there is no indication the patient was going to die two days later. Ideally it should 100%, but there will always be a small margin that just happens. There is also a lot of staff turnover in ECFs. We need to do ongoing education of ECF staff to notify us when there is a change in a patient's condition.	
15. Other	• This is Julie Englert's last meeting. Thank you for what you have contributed to this group over eight years. It has been very meaningful. Sue M. is the new board member on this committee.	
Adjournment	• The meeting adjourned at 8:50 a.m.	Next meeting 02/17

Center for Hospice Care
choices to make the most of life

CHAPTER FOUR

POLICIES

REGULATION: 42 CFR 418.106 – Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment
Office of National Drug Control policy
Indiana Dept. of Environmental Management

PURPOSE: To provide education and guidance for the safe disposal of prescription medications in the patient's home.

POLICY: Prescription medications no longer needed by the patient **may** be disposed of.

Medications are the property of the patient and are not the property of the Agency. No medication will be disposed of without the written consent of the patient or the patient's representative.

Medications disposal will be documented in the clinical record by Agency staff, utilizing the Agency Medication Disposal form, in compliance with state and federal requirements. All medication disposal will be done in the presence of the patient or patient's representative.

Medications remaining in the patient's home after the death/discharge of the patient will be documented in the patient's medical record.

PROCEDURE:

1. Upon a change of medication or death/discharge, the Agency staff will educate and offer guidance to the family members on the appropriate disposal methods of remaining medications~~offer to dispose of any unused medications~~. The patient/family have the right to refuse. The refusal will be reflected in the patient's medical record, along with the name, strength of the medication, and the amount remaining. Included in the documentation is the patient/caregiver's name attesting to the refusal, and the date the patient's attending physician was notified of the refusal.

2. No medications, scheduled, unscheduled or over the counter will be removed from the home under any circumstance by the Agency staff.

3. The name of the medication, the amount and how it was disposed of, and the name of the witness will be documented on the Medication Disposal form.

4. The U.S. Food and Drug Administration (FDA) and the White House Office of National Drug Control Policy issued the following guidelines in 2007 for the proper disposal of prescription medications:

a. Follow any specific disposal instructions on the drug label or patient information that accompanies the medication. Do not flush prescription drugs down the toilet unless this information specifically instructs you to do so.

b. If no instructions are given, throw the drugs in the household trash, but first: Remove the drugs from their original containers and mix them with water and with an undesirable substance, such as used coffee grounds or kitty litter. The medication will be less appealing to children and pets, and unrecognizable to people who intentionally may go through your trash.

c. Put the drugs (or the mixture of drugs with an undesirable substance) in a sealable bag, empty can, or other container to prevent the medication from leaking or breaking out of a garbage bag.

d. Remove any patient identification labels, or completely mark through patient identification information.

e. Take advantage of community drug take-back programs that allow the public to bring unused drugs to a central location for proper disposal. Call your city or county government's household trash and recycling service (see the blue pages in a phone book) to determine if a take-back program is available in your community.

5. As part of the aforementioned policy, the government recommends the following drugs be flushed down the toilet instead of thrown in the trash. The goal is to reduce the danger of unintentional use or overdose and illegal abuse.
   - Actig (fentanyl citrate)
   - Avinza Capsules (morphine sulfate)
   - Baraclude Tablets (entecavir)
   - Daytrana Transdermal Patch (methlyphenidate)
   - Duragesic Transdermal System (fentanyl)
   - Fentora (fentanyl buccal tablet)
   - Meperidine HCI Tablets
   - OxyContin Tablets (oxycodone)
   - Percocet (Oxycodone and Acetaminophen)
   - Reyataz Capsules (atazanavir sulfate)
   - Tequin Tablets (gatifloxacin)
   - Xyrem (Sodium Oxybate)
   - Zerit for Oral Solution (stavudine)

6. HOSPICE HOUSE: When any medications are disposed of in Hospice House, it will be disposed of with the witness of two staff members~~nurses~~. The Medication/Disposal form will be completed and filed in the patient's chart.

7. LONG TERM CARE / HOSPITAL SETTING: When the patient resides in long term care, or in the in-patient hospital setting, Agency staff will follow the policies
   of the facility for disposing of patient medications.

8. The Agency will comply with the Drug Enforcement Administration and adjust the policy as required to ensure total compliance with state and federal regulations. Failure to comply with this policy may result in disciplinary action.

9. Patients and families may locate an authorized collection receptacle by calling the DEA Office of Diversion Control's Registration Call Center at 1-800-882-9539.

New

Center for Hospice Care

PATIENT TRAVEL OUTSIDE OF AGENCY SERVICE AREA

Section: Patient Care Policies Category: Hospice

REGULATION: Section 946 Medicare Modernization Act of 2003.

PURPOSE: To facilitate continuity of care for those hospice patients who travel outside the Agency service area.

POLICY: The Agency makes every effort to facilitate travel for hospice patients who wish to go outside the Agency's service area, regardless of the destination.

PROCEDURE:

1. When a hospice patient indicates he/she would like to travel outside the Agency's service area, the Interdisciplinary Team (IDT) receives permission form the patient to contact a hospice program near the proposed Travel Destination (TDH) in order to initiate a contractual agreement and provide needed patient health information.

2. The IDT social worker works in conjunction with the Agency COO to secure a Temporary Service Agreement with the identified receiving hospice.

3. Once a contractual agreement is in place with the TDH, the RN Case Manager:
   (a) Reviews the patient's travel plans with the patient's attending physician.
   (b) Ensures the patient has an adequate supply of medications for 14 days.
   (c) Arranges for DME, oxygen or other supplies as needed.
   (d) Updates the patient's plan of care to reflect the impending travel.
   (e) Forwards a copy of the patient's plan of care, current medication profile, DNR status, advance directives, hospice election form, travel arrangements, and other information as requested by the TDH.

4. If the patient's condition worsens or warrants intervention while enroute to or from the TDH, he/she is advised to seek treatment at the nearest medical facility.

5. When the patient returns from travel, the IDT reviews and revises the patient's plan of care and files the TDH's transfer summary in the patient's clinical record.

6. The Agency will discharge and/or transfer the patient to the TDH if:
   (a) The patient chooses to extend the vacation/travel beyond 14 days;
   (b) The patient dies while at the travel destination; or
   (c) The patient's condition worsens or requires change to a different level of care and needs to be transferred to the TDH in order to access necessary care.

Effective Date: 11/14	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

Signature: President/CEO

USE OF CHC OWNED BUILDINGS BY OUTSIDE GROUPS AND ORGANIZATIONS

CHC does not seek outside organizations to use our facilities. CHC will occasionally grant permission to outside organizations to hold meetings or events at one of our owned facilities. Organizations requesting this approval must have a connection to CHC, which may include associations like a similar mission, a partnership with CHC in the community, a like-minded educational interest, or being a supporter of CHC/HF in some manner. CHC staff may request approval for use on behalf of outside organizations, and if approved, may be required to take on responsibility and accountability for the meeting and the facility use, including being personally present before, during and after the meeting/event.

All requests for use by outside groups and organizations require approval by a member of the CHC Administrative Team. It is the general intent that outside groups would only hold meetings or events during CHC's regular weekday business hours of 8 AM to 5 PM. Requests outside of these times are generally denied and require prior approval by the CHC President/CEO, and CHC staff must be present on a volunteer basis in numbers necessary to ensure the security of the CHC properties. CHC facilities are not available for rent or for use for personal functions and events by outside individuals or groups.

The CHC office in Plymouth is not owned by CHC and is not available for any meetings of any kind by any outside individuals or groups.