Center for Hospice Care
choices to make the most of life

Board of Directors Meeting
501 Comfort Place, Conference Room A, Mishawaka
February 18, 2015
7:30 a.m.

BOARD BRIEFING BOOK

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Center for Hospice Care
choices to make the most of life

CHAPTER ONE

AGENDA

BOARD OF DIRECTORS MEETING
Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
February 18, 2015
7:30 a.m.

A G E N D A

1. Introductions and Welcome New Board members – Amy Kuhar Mauro (5minutes)

2. Approval of December 18, 2014 Minutes *(action)* – Amy Kuhar Mauro (2 minutes)

3. President's Report *(information)* - Mark Murray (5 minutes)

4. Finance Committee *(action)* – Sue Morgan (10 minutes)
   (a) December 2014 Year-End Pre-Audited Financial Statements

5. Policies *(action)* – Donna Tieman (5 minutes)
   (a) Clinical Record Review (new)
   (b) Dress Code (revised)
   (c) Use of CHC Owned Facilities for Staff Personal Events (new)

6. Foundation Update *(information)* – Corey Cressy (10 minutes)

7. Board Education – Year in Review 2014 *(information)* – Mark Murray (20 minutes)

   [All paid staff leave the meeting except for executive office manager taking minutes]

8. Chairman’s Report *(information)* – Amy Mauro (3 minutes)
   (a) Executive Committee Recommendation Regarding Contract Renewal of the President/CEO

Next meeting April 15, 2015 at 7:30 a.m.

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Center for Hospice Care
choices to make the most of life

CHAPTER TWO

MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
December 17, 2014

Members Present:	Amy Kuhar Mauro, Anna Milligan, Becky Asleson, Carol Walker, Corey Cressy, Julie Englert, Sue Morgan, Terry Rodino, Tim Portolese, Tim Yoder, Wendell Walsh
Absent:	Carmi Murphy, Francis Ellert, Mary Newbold, Mike Method
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 10/15/14 meeting as presented. The motion was accepted unanimously.	J. Englert motioned T. Rodino seconded
3. President's Report	• Staff really appreciated the gift of South Bend Chocolate from the board in recognition of the perfect hospice survey. • ADC through October continued to rise throughout the year. November was 382, but we also experienced 170 deaths. The percentage of non-admitted patients that were DBAs in November was 24% and the percentage of DBA referrals from hospitals was 39%. We do get there as quickly as possible. 64% of hospital referrals were admitted the same day or the next day after we got the referral. Hospice House occupancy rates combined through November were 74%, the highest since 2009; however the GIP level of care was 75% compared to 86% in 2012. One of our goals for 2015 is to make sure we are utilizing GIP appropriately. The ADC YTD is up 15% and the number of patients served is up 7%. We are projecting to serve 2,138 patients in 2014—the first time it will be over 2,000 in one year. YTD net gain through November is up 309% from a year ago. Operating revenue is up \$2.5 million. Expenses are up \$1.3 million due to the increase in census. This, during a time of ongoing Medicare rate cuts and the federal Sequester cut. Thank you to the administrative team and their staff for their help and assistance in making 2014 a very good year. • An original water color of the Mishawaka Campus was presented to Mark in-person by Pat Novitski, Jim Seitz and Joe Kuzmitz from 1st Source Bank. It has been placed in room C, because that is where we will host the Crossroads Campaign meetings for potential donors. • CHC's annual memorial service was held on 12/07 at three locations. A total of 630 people attended, compared to over 700 last year. The bereavement department does a	

Topic	Discussion	Action
	great job with this. • We signed an agreement with Merritt Hawkins to hire two more physicians. One CHC physician's last day was 12/12. We are also recruiting for two more nurse practitioners. With the increase in census we are under-staffed in that department. Only 5,500 physicians in the country are board certified in hospice and palliative medicine. • We held "Donuts with Santa" for staff and their families on 12/06. A chamber group from Penn High School performed. There were games, crafts, and a photo with Santa. • The group health insurance premium costs that are the staff responsibility will remain the same in 2015. When announced at the November Staff Meeting, there was spontaneous applause. Thanks to the work Karl H. and the HR Department have done we will also save $30,000 in costs due to rearranging some things. • The third annual Notre Dame "Introduction to Hospice and Palliative Care" course was held on 11/01. A record 125 students signed up for this one credit course. 15 CHC staff and one oncologist were the faculty. This was the third time we have presented the course which is held every third semester. • Thank you to the nominating committee for doing a great job recruiting new board members. They started that process in June or July. We appreciate everyone's suggestions for new board members. New Board Member Orientation will be held on 02/05 at 7:30 a.m. at the Mishawaka office. Current board members are welcome to attend if they would like and we ask that you let Becky K. know if you plan to attend. • Included in the President's Report is a Consumer Reports article of the six things you should look for when choosing a hospice program. CHC is the only one in our service area that meets all six criteria.	
4. Finance Committee	• The finance committee met last week and recommends approval of all three Agenda items. • October – Operating revenue $1.8 million, total revenue $2.3 million, total expenses $1.6 million, net gain $720,000. YTD operating revenue $16.9 million, total revenue $17.4 million, total expenses $15 million, net gain $2.4 million, without beneficial interest in Foundation $1.9 million. • November – Operating revenue $1.6 million, total revenue $1.7 million, total expenses $1.6 million, net gain $97,000. YTD operating revenue $18.6 million, total revenue $19.2 million, total expenses $16.6 million, net gain $2.5 million, without beneficial interest in Foundation $1.9 million.	

Topic	Discussion	Action
	• October was an exceptionally strong month for the organization financially and November less so. We wrote off some A/R and are accruing additional bad debt expenses throughout the year to bring the balance for doubtful accounts up to historical levels by the end of the year. We don't write off bad debts lightly and make a concerted effort to collect them. • A motion was made to accept the October and November financial statements as presented. The motion was accepted unanimously. • Flex Spending Account – Every year staff can set aside up to $2,000 from their paycheck pre-tax to use for medical expenses not covered by their health insurance. $2,000 is the number that has worked out for our organization. About 20-25% staffs participate in this program. • A motion was made to keep the Flex Spending Account limit at $2,000 for 2015. The motion was accepted unanimously. • 2015 Budget – The ADC is a major factor in the income of the organization. Part of the art of putting together the budget is predicting what it will be in the coming year. This year we had significant growth in ADC. The question is whether it is a trend, spike, plateau or peak. For 2014 we are predicting an ADC of 369. Using that number we budgeted a 4.24% increase in ADC of 385 for 2015. Historically we budget an increase in the 3-6% range, so based on that we are budgeting total operating revenue of $21 million, total revenue $22.2 million, total expenses $19.4 million, net gain $2.8 million, and net without beneficial interest in the Foundation of $1.7 million. ADC also drives expenses—direct patient care costs 20% and salary/wages 65% of the overall budget. We budgeted for a number of new positions in 2015, which is more than in the last two to three years—a new full-time medical director, two nurse practitioners, staffing in admissions and billing departments to invest in our internal infrastructure. The ADC includes Hospice House. We look at the Hospice House case mix of level of care and occupancy rates. Those have historically run pretty steady. The GIP level of care will be a point of emphasis in 2015. We will add new staff as census warrants throughout the year. Not all new positions begin on 1/1/15 and are staggered throughout the year. • A motion was made to accept the 2015 budget as presented. The motion was accepted unanimously.	T. Portolese motioned J. Englert seconded T. Yoder motioned C. Walker seconded T. Rodino motioned T. Yoder seconded
5. Foundation Update	• From a fundraising standpoint in comparison to 2013, we are $400,000 ahead. A lot of that has been from some bequests we received. This is the fifth consecutive year of an	

Topic	Discussion	Action
	increase in the amount of money we have raised. The Crossroads Campaign kicked off its quiet phase 07/01. So far between cash, bequests and pledges we have raised over $1.5 million of our $10 million goal. We have had two campaign cabinet meetings. Members of the cabinet are Catherine Hiler as chair, Nafe Alick, Dennis Beville, Tim Portolese, Irv Rosenberg, and Mary Jane Stanley. They are helping us craft our message and identify people to bring in. • Planned giving – We received four estate gifts in October for a total of $341,000. These were unexpected. The Annual Appeal kicked off the week of Thanksgiving and will run through the early part of 2015. • Okuyamba Fest raised money for PCAU. 63 people attended this year. The key note speaker was Brandi Milloy. • Preparations have begun for the 2015 Helping Hands Award Dinner honoring Lou Behre on 05/06 at the Hilton Garden Inn. Honorary chairs are Art Decio and Ernestine Raclin, and event chairs are Chris and Carmi Murphy and Don and Pat Cressy. • A donor survey was sent to 705 members of Circle of Caring. We had a 13.9% response rate compared to 12% last year. 92.86% agreed or strongly agreed their donations are used appropriately. See the President's Report for further details. • Through our payroll deduction program for the Uganda Impact Fund, this year we raised enough money from staff and added money from Okuyamba Fest to help PCAU pay off their office so they are now debt free.	
6. Policies	• Donna T. reviewed one revised and two new policies. The changes were made to meet regulations and the processes of the agency. We educate and assist patients and families in destroying meds. Our processes and policies didn't change. We have never allowed our staff to receive or transport medications. The DEA has just put that into law now. We can assist the family in the home to destroy medications with their witness and signature. That is what we have always done. • A motion was made to accept the policies as presented. The motion was accepted unanimously.	W. Walsh motioned T. Yoder seconded
7. QI Committee Report	• Julie E. reported the committee met 11/18. Welcomed Rebecca Fear as the new Quality Assurance/Medical Records Coordinator. We currently have ten QAPI projects (Quality Assurance and Performance Improvement). During the ISDH survey they asked to see evidence of our QAPI programs and were impressed with the data collection and that we were actually doing something with the results. Great staff and group to be a part of.	

Topic	Discussion	Action
8. Election of Board Members	• Biographical sketches of the four proposed new board members are in the board packet: Ann Firth, Jessie Hsieh, Lori Turner and Suzanne Weirick. The executive committee recommends approval for these nominees. • Mary Newbold is up for re-election to a second three-year term on the board of directors. • The slate of CHC board officers is as follows – Amy Kuhar Mauro, Chair; Wendell Walsh, Chair-Elect; Sue Morgan, Treasurer; Mary Newbold, Secretary; Corey Cressy, Immediate Past Chairman. • A motion was made to accept the four new board members, the re-election of Mary Newbold, and the slate of CHC board officers as presented. The motion was accepted unanimously.	T. Portolese motioned J. Englert seconded
9. Board Education	• Catherine H., chair of the Crossroads Campaign, updated the board on the capital campaign. The cabinet has met a couple times. Corey and Anna M. were happy to assist in some way in the process. Staff did a dry run for the Cabinet of what we have prepared for small groups and individuals to get feedback. The meetings have already enhanced our presentations. We plan to always have an individual participate in the presentations that will represent how they are involved with CHC and why they are committed to the organization. Catherine took that opportunity with her presentation to the CHC board. • We would appreciate being able to say we have 100% board participation in the campaign. It is up to each member to determine what is appropriate for them. The value added to the presentation to say we have 100% board participation is priceless. It has its own impact when we are out asking for pledges that we have already asked internally. Individuals from the Hospice Foundation will follow up with board members in the future. The role you play is very important.	
10. Chairman's Report	• The board self-evaluation survey is in the board packet along with a return envelope. Please return it to Becky K. by the end of the year. • The executive committee does an annual evaluation of the President/CEO every year and a comprehensive evaluation every three years. Please email any comments regarding Mark's performance over the last three years that you want to share directly to Corey. • Recognition of outgoing board members and officers – Carmi Murphy, Julie Englert and Terry Rodino. Corey is leaving as chair and will become immediate past chair of CHC and chair of the Hospice Foundation.	

Topic	Discussion	Action
Adjournment	• The meeting adjourned at 8:30 a.m.	Next meeting 02/18

Prepared by Becky Kizer for approval by the Board of Directors on 02/18/15.

Mary Newbold, Secretary

Becky Kizer, Recording Secretary

Center for Hospice Care
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CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
Hospice Foundation
President / CEO Report
February 18, 2015
(*Report posted to Secure Board Website February 19, 2015)*

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:30 AM. This report includes event information from December 18, 2014 – February 18, 2015. The Hospice Foundation Board meeting follows in the same room.

CENSUS

2014 saw CHC care for more patients than any year in history and marked the first time over 2,000 patients were cared for in a single calendar year. 2,123 patients were on census with 1,818 original admissions during the year. The average daily census (ADC) for the year came in at an all-time high of 370. Our bereavement department was also kept busy with and all-time high average 136 deaths per month totaling 1,631 deaths throughout the year. Per diem days -- the crux of CHC's 2014's financial success -- were up 16% from 2013 at 128,162. The average hospice length of stay (ALOS) dropped to 61 days from 70 in 2013 and the median increased one day to 14 days. Nationally, the 2013 (latest available) hospice ALOS was 73 days and the median was 19. The ALOS for CHC hospice Medicare patients has dropped 20% over the last two years and was down to 65 days in 2014 from 74 in 2013 and 81 in 2012. General Inpatient Levels of Care as a percent of days in our Hospice Houses was down again in 2014. This, along with utilization and occupancy, will be a major focus in 2015. January 2015's overall ADC of 369 was 15% above January 2014.

January 2015	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	527	527	463	64
Original Admissions	159	159	158	1
ADC Hospice	350.00	350.00	304.35	45.65
ADC Home Health	18.55	18.55	16.58	1.97
ADC CHC Total	368.55	368.55	320.93	47.62

December 2014	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	485	2,123	1,993	130
Original Admissions	138	1,818	1,682	136
ADC Hospice	350.87	351.10	303.07	48.03
ADC Home Health	24.94	18.92	19.55	(0.63)
ADC CHC Total	376.81	370.02	322.62	47.40

Monthly Average Daily Census by Office and Hospice Houses

	2015 Jan	**2015** Feb	**2015** Mar	**2014** Apr	**2014** May	**2014** June	**2014** July	**2014** Aug	**2014** Sept	**2014** Oct	**2014** Nov	**2014** Dec
S.B.:	209			211	214	217	213	225	224	224	222	214
Ply:	68			79	76	71	69	67	71	73	67	68
Elk:	84			68	75	77	87	83	89	85	85	86
SBH:	4			6	6	5	6	5	4	6	4	4
EKH:	3			4	5	5	5	5	4	6	4	3
Total:	369			368	376	375	380	385	392	394	382	376

HOSPICE HOUSES

January 2015	Current Month	Year to Date	Prior Year to Date	YTD Change
SB House Pts Served	28	28	33	(5)
SB House ALOS	4.07	4.07	5.03	(0.96)
SB House Occupancy	52.23%	52.53%	76.50%	-23.97%
Elk House Pts Served	25	25	24	1
Elk House ALOS	3.88	3.88	4.79	(0.91)
Elk House Occupancy	44.70%	44.70%	53.00%	-8.30%

December 2014	Current Month	Year to Date	Prior Year to Date	YTD Change
SB House Pts Served	33	321	341	(20)
SB House ALOS	3.76	6.02	5.23	0.79
SB House Occupancy	57.14%	75.69%	69.75%	5.94%
Elk House Pts Served	23	293	223	70
Elk House ALOS	4.13	5.64	5.64	0.00
Elk House Occupancy	43.78%	64.70%	49.20%	15.50%

PATIENTS IN FACILITIES

Of the 527 patients served in January, 159 resided in facilities. Of the 485 patients served in December, 169 resided in facilities. The average daily census of patients in skilled nursing homes, assisted living facilities, and group homes during January 2015 was 122; December 2014 was 135 and YTD through December 2014 ADC was 127.

FINANCES

Karl Holderman, CFO, reports the December Year-End Financials will be posted to the Board website on Friday morning, February 13th following Finance Committee approval. For information purposes, the approved November 2014 financials are presented below. Due to year-end closing, we only cover the December Financials at the first board meeting of the year in February. First quarter Finances for 2015 will be covered at the April board meeting.

November 2014 Financial Information

Center for Hospice Care (1)

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

November Overall Revenue	$	1,780,176	Year to Date Overall Revenue	$	19,236,045
November Total Expense	$	1,682,736	Year to Date Total Expense	$	16,682,095
November Net Gain	$	97,440	Year to Date Net Gain	$	2,553,950

Hospice Foundation

Nov. Development Income	$	44,064	Year to Date Development Income	$	1,400,043
Nov. Investment Gains (Loss)	$	235,780	Year to Date Investment Income	$	1,189,838
Nov. Overall revenue	$	280,053	Year to Date Overall Revenue	$	2,643,748
Total November Expenses	$	193,358	Total Year to Date Expenses	$	2,060,716
November Overall Net	$	86,695	Year to Date Overall Net	$	583,032

Combined (2)

November Overall Revenue	$	1,973,534	Year to Date Overall Revenue	$	21,296,761
November Overall Net Gain	$	97,440	Year to Date Overall Net Gain	$	2,553,950

(1) Center for Hospice Care revenue and net gain figures (current month & YTD) reflect net gain posted by Hospice Foundation.
(2) Combined figures (current month & YTD) reflect elimination of net gain posted by Hospice Foundation.

At the end of November 2014, the overall combined net gain for CHC / HF was $2,553,950 representing a 4% increase from November of 2013. CHC's Year to Date Net without the beneficial interest in the HF was $1,970,917 representing a 142% increase from November 2013.

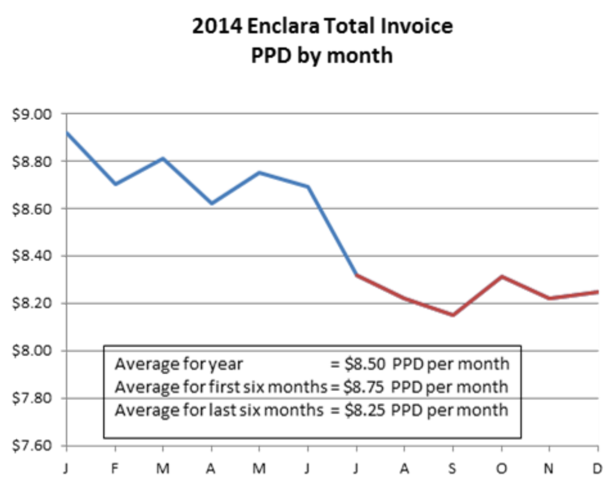
At the end of November 2014, the Foundation's Intermediate Investments totaled $1,386,357. Long Term Investments totaled $16,534,295.

CHC's assets on November 30, 2014, *including* its beneficial interest in the Hospice Foundation, totaled nearly $36.6MM. At November 30, 2014 HF's assets alone totaled just over $31.7MM and debt related to the low interest line of credit associated with the Mishawaka Campus project totaled almost $5.9MM. Both organizations combined have assets now totaling nearly $42.6MM

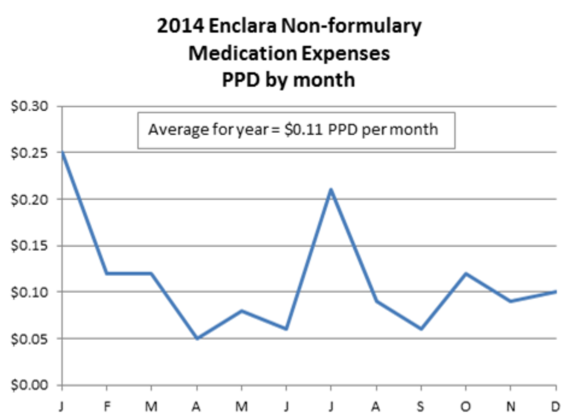
CHC VP/COO UPDATE

Dave Haley, VP/COO, reports…

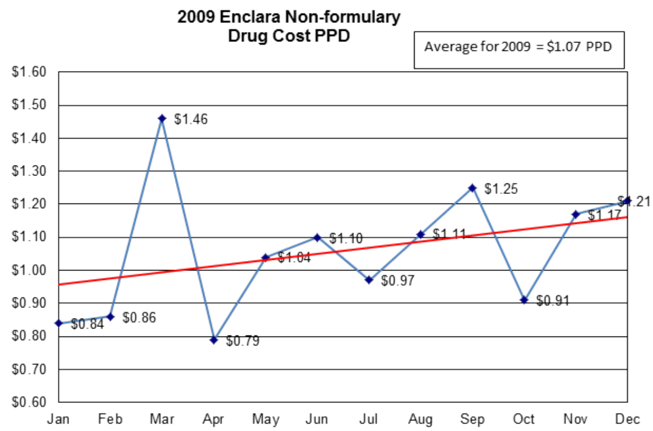
Below are some historic charts regarding our Enclara pharmacy expenses for CHC hospice per diem patients where CHC is responsible for payment of all drugs related to the symptom control of the terminal illness and related conditions. Enclara is our national mail order and PBM pharmacy manager. The first chart is our 2014 total Enclara drug expenses. The average drug expense per patient day (PPD) for 2014 was $8.50. The first half of the year it was $8.75 PPD per month. This dropped 50 cents PPD for the second half of 2014 after Dave expressed to Enclara we were going to shop around for other possible pharmacy vendors. This amounted to a savings of $35,403 in the last six months of 2014. This equates to an annualized savings of just under $71,000.



The second chart is our 2014 non-formulary medication expenses showing an average of 11 cents PPD. This is 75% below Enclara's national hospice customer average rate of 44 cents PPD. It is also represents a 7 cent drop from 2013's average of 18 cents PPD (a 38% drop in a year).



To illustrate just how far we have come, the third chart below shows our calendar year 2009 non-formulary medication expenses. The average that year was $1.07 PPD (with one month hitting a high of $1.46 PPD). The trend line was also rising. The difference between $1.07 PPD and our current 11 cents PPD is $0.96 PPD. This represents a 90% reduction from 2009 to 2014. $0.11 cents per patient day times hundreds of thousands of patient days over five years has produced significant savings. If we were at the 2009 rate of $1.07 PPD during 2014, we would have paid $129,645 more in non-formulary expenses just last year than we actually did.



There have been no further more incidents of Enclara medication packages being opened with missing drugs prior to FedEx delivery to a patient's home. As you will recall, these matters have been turned over to the DEA and Enclara for further investigation and resolution. Out of the 475 hospice programs served by Enclara nationwide, CHC was the first hospice to report the problem -- numerous times -- and eventually convince Enclara that indeed they had a diversion problem, which ultimately turned out to be a national problem for them.

We have initiated phone interviews with physician candidates to fill the vacant position and the new additional position to our medical staffing. We also have had an on-site interview with a nurse practitioner (NP) candidate to fill one of our two new NP positions. Currently, we are not at a point of extending offers for employment, although some prospects appear to have a good potential.

On January 16, Greg Gifford, MD, CHC Chief Medical Officer, and Dave visited Miller's Merry Manor, located inside the IU Health Hospital in LaPorte. We have extended respite and general inpatient (GIP) levels of care contracts to them for their consideration. These contracts are currently under review by their legal department. Miller's is currently operating the rehab unit at that hospital. Such a contract would provide CHC with an option for GIP levels of care in LaPorte County, inside an IU Health Hospital, where there already exists a hospice program. Because they are a competitor, IU Health has refused to meet with us in past years to even discuss such contracts.

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

DIRECTOR OF NURSING UPDATE

Donna Tieman, RN, BA, CHPN reports in December 2014, two additional CHC registered nurses passed the Certified Hospice and Palliative Nursing exam bringing the total number of nurses credentialed as CHPN and experts in the field of hospice and palliative nursing to 13.

Ann Cowe, Patient Care Coordinator of the South Bend Hospice House, retired on January 30, 2015, after 15 years of service. Denise Scroggs, RN, CHPN, assumed the position of the SB Hospice House Coordinator on February 2, 2015. Denise brings 12 years prior experience to the role and we are proud to continue to promote from within when we have the opportunity.

Donna Tieman is working with the CHC Volunteer Coordinators to build a family model of care for the two CHC inpatient units. This model will focus on age specific family interactions and support during the stay of the patient. An additional focus will include volunteer satisfaction based on identified goals of the volunteer in their role.

HOSPICE FOUNDATION VP / COO UPDATE

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

Fund Raising Comparative Summary

Through January 2015, the Development Department recorded the following calendar year gift totals as compared with the same period during the previous five years:

Year to Date Total Revenue (Cumulative)

	2010	2011	2012	2013	2014	2015
January	64,964.45	32,655.69	36,775.87	83,619.96	51,685.37	82,400.05
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**	**1,665,645.96**	

Year to Date Monthly Revenue

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

	2010	2011	2012	2013	2014	2015
January	52,442.49	32,110.69	32,309.58	83,380.18	51,685.37	57,971.60
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	193,065.45
Total	**794,737.19**	**862,777.33**	**928,101.01**	**978,709.19**	**1,033,125.99**

Cornerstones for Living: The Crossroads Campaign

Progress during the quiet phase of the campaign continues. Through the first seven months of this five-year campaign (7/1/14 thru 1/31/15) total cash, pledges and documented bequests stand at $2,301,147. The Campaign Cabinet is in the process of identifying prospective major gift donors. Hospice Foundation staff are reviewing prospective donor information provided by the Cabinet. This information is being integrated into a master list of Tier 1 donor prospects. Campaign related meetings and events are being scheduled for the upcoming months. Event dates are reserved and prospective donors are being contacted.

Follow-up and processing of campaign pledges and payments took place in December and January. We received the first $10,000 installment of a multi-year pledge from Elkhart General Hospital. A campaign pledge of $10,000 from the law firm of May Oberfell Lorber was processed in January. Many thanks to CHC Board Chair-Elect and May Oberfell Lorber partner, Wendell Walsh for his support in securing this campaign gift.

A follow-up meeting and Mishawaka campus tour with the senior program officer of the Elkhart County Community Foundation (ECCF) took place in January. Possible funding opportunities from the ECCF were identified.

Planned Giving

Bequests in 2014 totaled $584,284.78. Estate gifts totaling $96,334.50 were received during the month of December. We did not receive any bequests during the month of January.

Annual Giving

Thru February 9, 2015, funds raised through the 2014-15 Annual Appeal stands at $82,769.50. To date, 438 donors have contributed an average gift amount of $183.12. This compares to the final total of the 2013 Annual Appeal figures of 472 donors who gave an average gift amount of $126.89, for a grand total of $89,074.94 thru May 2014. The 2014 - 2015 Annual Appeal will continue as a mail campaign until May 22, 2015 when our “Friends of Hospice” mail campaign appeal will begin.

Special Events & Projects

The 2015 Helping Hands Award Dinner honoring Lou Behre promises to be a resounding success. Gross revenue in the form of payments and pledges total $218,510.40 (as of 2/9/15) – and sponsorship brochures have yet to be sent. Our deepest thanks go to this year’s Honorary Chairs: Ernie Raclin and Art Decio; event chairs are Carmi and Chris Murphy and Pat and Don Cressy, who are heading up this extraordinary event. The dinner will be held on Wednesday, May 6th at the Hilton Garden Inn.

We will once again be hosting a luncheon for members of the Circle of Caring and other key centers of influence on Thursday, March 19th. Invitations will be mailed in mid-February to approximately 900 individuals and organizations.

Registration for the 7th Annual Bike Michiana for Hospice is already underway and we currently have 142 registered riders. We have also been informed that we have once again been awarded a convention and visitors' bureau grant of $3,000. This money will be used to invest in promoting the event outside the local area. The ride will be held Sunday, September 13th at St. Patrick's County Park. Updates so far include having two restaurants signing on to host the post-ride celebration: Barbici will cater and staff the early shift (from 11 am to 3 pm) while Evil Czech Brewery handles the later portion (from 3 pm to - 6 pm). This year's goal is to have 1,200 participating riders.

Education

The job description for the newly created position, Director of Education & Collaborative Partnerships, has been finalized. Recruiting will begin during the upcoming weeks with the goal of having the position filled early in the 2nd Quarter 2015.

Communications

Final numbers for the annual donor survey that was sent both via mail and email are in. A total of 705 surveys were mailed to Circle of Caring members in November; of those, 103 were returned resulting in a 14.6% return rate as compared with a 12.5% return rate last year. Overall, the survey indicated that donors believe their gifts are being used to *improve the quality of living* for patients in need and that the Hospice Foundation provides the right amount of stewardship and communication for donors.

A brick/memorial donation mailing was sent to approximately 2,800 family members who have had a loved one cared for at our Elkhart Hospice House or who have participated in bereavement counseling services there. The tribute items, selected by those providing memorial gifts for this special appeal, will be installed in May in time for the annual Elkhart Gardens of Remembrance & Renewal event scheduled for Tuesday, June 2nd.

Our Hospice Foundation e-blasts continue to see an excellent open rate, averaging 35% over the past two months. Constant Contact, a leading email provider, examines the result of more than 200 million emails, broken down by industry. In our category, non-profit health and human services, the average open rate is 22.95% (which happens to be one of the highest ranked categories).

Bike Michiana for Hospice emails perform exceedingly well – the emails are opened multiple times by a number of recipients: our e-blast about early registration was sent to 684 addresses and was opened 852 times, with 89 clicks thru to the registration page.

Global Partners in Care (GPIC) / Palliative Care Association of Uganda (PCAU)

Annie Sescliefer, a University of Notre Dame student, spent a week over the Christmas holiday as a job-shadowing intern with our African partner, PCAU. In addition, three other Notre Dame students are currently pursing internship opportunities with PCAU for this summer. Brianna Wanless is a master's student at the Eck Institute for Global Health. Her internship is confirmed;

she will be working on the palliative care benchmark study under the direction of Lacey Haussaman, a faculty member at the Eck Institute. Denis Kidde, HF International Programming Representative, and, Cyndy Searfoss, HF Director of Communications and Annual Giving, have met with Brian Vetter and Nick Rice as well. Both are undergraduates and are working to secure funding through the Kellogg Institute for Global Health and/or the Ford Family Foundation.

Road to Hope Program/Documentary

PCAU has hired a full-time Road to Hope program coordinator and they are scheduled to begin by the end of February. Former CHC staff member, Roberta Spencer has returned to Uganda for her fifth consecutive year as a PCAU volunteer. Among her various assignments for this year's visit are to help with the new coordinator's orientation including providing background information about the partnership, CHC and HF. There are currently 17 children in the program, 15 of whom have sponsors paying for most or all of their school fees.

Editing of the *Road to Hope* documentary film continues. IU South Bend faculty members, Dean Marvin Curtis and Thom Limbert, are currently working on composing an original score while Cyndy Searfoss and Mike Wargo work on the narrative script.

Mishawaka Campus

Work is now complete on the parking lot immediately adjacent to the new Center for Palliative Care with the installation of a fence on the border of our property and that of our neighbor to the south. Fabrication of the wind sculpture, which will be located in the seating area on the southwest corner of campus, is near completion. Installation will take place in the spring.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

An Amy Tribbett, Director of Marketing and Access reports the Marketing, Access, Volunteer Update is as follows for December & January

Outreach and Liaison News in December & January. Our three fulltime Community Liaisons performed:

Number of Pre-Assessments	46
Number of Hospital Visits	57
Number of ECF Visits	49
Number of ALs, IL, CCRC	27
Number of Physician Practices	90
Funeral Homes	31

Lunches/Breakfasts and Speaking Engagements by CHC Community Liaisons:

- Lunch in-service at Dr. Ziebo – Dr. Kamanda in Mishawaka.
- Co-presented with Home Instead owners to a class at Ivy Tech Elkhart on the topic of dementia. They did first half on dementia and CHC did second half on end-of-life care utilizing part of the "Consider the Conversation" programming.

- North Woods Village: “Documenting Patient Decline” nursing staff inservices.
- Heritage Point: Meaningful Moments luncheon presentation.
- Two inservices for the home care staff at Greencroft Communities in Goshen IN.

<u>Community Outreach and Other Referral Source Meetings:</u>

- Emerald Place Grand Re-Opening Celebration.
- Met with Woodland Manor ECF to schedule Veterans Club.
- Nappanee Ministerial Association.
  Elkhart County Council on Aging is coordinating another Aging Gracefully Series for Nappanee. A CHC Community Liaison is the event chair.
- Columba Hall: Introductory visit and patient case review.
- Met with three Woodlawn Hospital Case Managers. Discussed referrals and they have been pleased with what has transpired on the few referrals we do get. Again, Dr. Aldridge is the only physician that utilizes CHC. Case Managers don’t care for Gentiva Hospice but are forced to deal with them due to they have the inpatient contract and a Woodlawn-owned physician is Gentiva’s Medical Director.
- Bowen Center – Working Therapist and Office Manager meeting regarding providing an inservice to their staff.
- Catherine Kasper Home – Met with Administrator and both MSWs.
- Miller’s Merry Manor Culver- Met with MSW and Administrator.
- Met with RNs at Concierge Cardiology (Dr. Rosenblum) in LaPorte to review CHC services.
- Met with SJRMC VNA – dropped off Grief Quarterly Brochures.
- Hubbard Hill met with Activity Director. Confirmed that we could do 12th Vets club and set dates for three others.
- Meeting with Holy Cross House
- Meeting with Holy Cross Village/Dujarie DON.
- Meeting with Holy Cross Village/Andre Place.
- Meeting with Holy Cross Village/Dujarie.
- Meeting with SJRMC Nurse Directors & Managers at South Bend Hospice House.
- Eastlake Nursing and Rehabilitation Center Elkhart. Met with Administrator, Activity Director, Social Services Assistant and nurse for family meeting for PA of a patient.
- Fulton County – Attended and participated in a Senator Joe Donnelly sponsored Veteran’s Event.
- Met with owner of Firefly Home Care, Middlebury.
- Met with Admissions Director Greenleaf Healthcare Elkhart – continues to be one of our best facilities. Their census remains high. Waiting to hear back from assistant to schedule a Consider the Conversation event at one of their senior executive clubs for the community.
- Collaborating with CHC’s spiritual care department to explore possible interaction with faith leaders in St. Joseph County.
- Meeting with Sanctuary @ Holy Cross Amy Fisher, Social Worker.
- Attended the Greenleaf Advisory Board Meeting. Met with Administrator, new Administrator in Training, Marketing Director, and Admissions Director.
- Two meetings with SJRMC Hospitalists.
- Caregiver Homes -- introductory appointment regarding CHC.
- Met with Home Instead Home Care to discuss how our two organizations could work together to provide services for patients in Elkhart County.

- Courtyard Healthcare - Met with the Activity Director to discuss Veterans Club. They are interested in date in March for Genealogy of Flag.
- Met with Mary Activity Director at Woodland Manor ECF to schedule Veterans Club scheduled for 2-18-15 at 2 pm.

<u>Marketing & Access News through February 9, 2015</u>

Admissions:

- A Daily Intake and Revocations Report now being completed for purposes of documenting issues and patterns associated with converting admissions and retaining census. The new tracking mechanism will be beneficial to decreasing problem issues and increasing our conversion rate of referrals to admissions.
- Implemented standard of practice to pre-admit appropriate patients onto service, setting up initial visit within 48 hours or less.

Volunteer Department:

New Volunteer Inquiries	31
Volunteer Interviews	19
Recruiting Efforts	Presentations to two Veterans groups

Marketing:

- CHC Collateral for hospice, dementia, grief services, volunteer and comfort care have been updated with new look and edited content. All include our new ™ designation with our logo, and our new cfhCare.org web address.
- Ongoing work for new website continues.
- CHC's "Fridays on the Front Porch" story was featured February 9 on NHPCO's "Moments of Life made possible by hospice website, www.momentsoflife.org and #moremoments.
- Since October, CHC's digital campaign continues to perform exceptionally well, with a click-through rate of 9%. Benchmark is 2-3%.

NEW POLICIES AND POLICY UPDATES

There are three policies on the agenda for board approval.

1.) The "Clinical Record Review" policy replaces the "Quarterly Clinical Record Review" policy and describes our current practice from a clinical quality chart audit perspective. In the past the majority of charts used to report data at the quarterly Quality Improvement Committee meetings were from those patients on census with us two weeks or less. It is not clear why or who made this determination to have it like this, but we want to change it. If we already audit every chart every month anyway, why were we wasting staff time and resources to perform a separate audit of the same charts just for the quarterly QI Committee meetings? This new policy addresses that. We will start reporting the monthly chart audit data at the quarterly QI Committee meetings.

2.) The revised "Dress Code" policy simply updates our existing policy with some very minor edits and also includes updated Logo Wear information as indicated in the red-lined version distributed.

3.) The "Use of CHC Owned Facilities for Staff Personal Events" simply puts into writing long-standing practices when it comes to "staff for staff" retirement events, going-away events, baby / wedding showers, etc. or other events that should take place outside of normal business hours. All attendees at these events are exclusively CHC employees and using CHC facilities for private functions is not permitted.

WELCOME TO OUR NEW CHC BOARD MEMBERS

Please join me in welcoming our new board members: Ann Firth, Jesse Hsieh, M.D, Lori Turner, and Suzanne Weirick. A new board member orientation was held here at the Mishawaka Campus on February 5 with a two-hour breakfast seminar presented by members of the CHC Administrative Team. A new 2015 Roster of CHC Board Members along with contact information is included as an attachment to this report.

2014 BOARD OF DIRECTORS SELF-EVALUATION

Attached to this report is the summary of scores, responses / comments to the open-ended questions for the 2014 Board of Directors Self-Evaluation along with comparative analysis from prior year surveys. This was distributed at the December meeting. This exercise is performed every other year and distributed at the last board meeting of the year. It is designed for the benefit of the board to raise its own awareness of itself and how members perceive their engagement and effectiveness. Results are reviewed by the Executive Committee who may from time to time make recommendations to the full board based upon the survey results.

2014 BEREAVEMENT STATISTICS

During 2014, the CHC Bereavement Department reports it had average deaths per month totaling 136, the highest in history. It served 2,620 new clients, up 3% from 2,547 in 2012. 15% of the new clients were from the community and without a connection to a loved one as a CHC hospice patient. Additionally, it facilitated 442 group support meetings, performed 1,942 risk assessments, made 4,601 caring phone calls, and mailed 17,795 pieces of materials including letters, magazines and brochures offering condolences and information regarding our comprehensive grief intervention services. They produced one Memorial service at each community where CHC has a care office and they were attended by 630 people. Our Bereavement Department also produced CHC's 21st Camp Evergreen program for children who have experienced the death of a special person in their life. There were 50 campers in attendance along with 67 community volunteers. Phone calls, assessments, mailings, individual / group counseling sessions and presentations totaled 30,989 encounters during 2014, up 21% from 2013.

2014 VOLUNTEER SERVICES STATISTICS

CHC enjoys the services of more than 500 volunteers who provide services such as Patient Care, Community Relations, Bereavement Support, Fundraising, Office Help, Veterans Programming, and on the Board of Directors and Board Committees. Medicare requires participation by volunteers in direct patient care and hospice programming. These CHC volunteers visit patients in their own homes, in nursing homes, assisted living facilities, group homes, and hospitals as well as provide office and other support. Hospice is the only component of the entire Medicare system that requires measurable volunteer participation. Volunteer Hours during 2014 totaled 17,864, up 3% from 2013. 2014 CHC Volunteer hours are equivalent to 8.6 FTEs who never take a vacation day or call in sick. CHC Volunteers drove 46,594 miles, up 9% from 2013. Volunteers provided dollar savings to CHC during 2014 totaling $423,816.

2014 ANNUAL GOALS UPDATE

Included in your packet is a copy of the final status for the 92 individual goals for 2014. Final status is broken down into four categories: "Met" means that the goal was achieved; "In Process" means the goal was started, but not yet completed during calendar year 2014 and likely carried over to 2014; "Not Doing" means after evaluating the goal we decided that for whatever reason we were not going to do the project; and "Not Met" means that we simply didn't get to that goal at all or external factors made the goal no longer realistic or necessary. Results for 2014 are as follows:

Total Number of Published Goals = 92
Met = 49 (53%)
In Process = 32 (35%)
Not Met = 8 (9%)
Not Doing = 3 (3%)

For 2014, 88% of the 92 individual goals were either completed or were in the process of being completed at the end of the year. The percentage of goals met during 2014 is lower than in previous years primarily due to the extraordinary amount of regulatory changes and distractions thrust upon hospice by CMS during the year. Normally, hospice experiences one or two regulatory changes and usually has a year to prepare. During 2014 we had 14 regulatory changes to deal with; many of them significant and one that was so misguided, CMS actually stopped it a few months after implementation. We are delighted to answer specific questions on any of the goals and their status at the end of the year.

2015 GOALS

Included in your packet are the 2015 Goals for Center for Hospice Care and the Hospice Foundation. We have placed individual goals under headings which match the 2011-2015 Strategic Plan. The four overarching goals are: Enhance Patient Care; Position for Future Growth; Maintain Economic Strength; and Continue Building Brand Identification. Annual Goal development begins at the Coordinator level of management and they work their way up through Directors and eventually to the Administrative Team for final approval. We always commence with what staff believes we should accomplish to improve and enhance our organization and the care we deliver.

CHC DIRECTOR OF NURSING RESIGNS

I am sad to report that Donna Tieman has resigned her position as DON in order to retire from her nursing career. Donna began at CHC in March of 2006 and worked as a Primary Nurse seeing CHC patients four days a week under a PRN status. She was promoted to Director of Nursing in January of 2009. She has been a very effective leader for the nursing department and wonderful to work with as member of the CHC Administrative Team for the last six years. Donna has graciously agreed to stay on as DON on a reduced schedule until we find a qualified candidate to take the position. We began advertising and accepted applications and resumes on February 7th. Initial interviews of qualified candidates have already been scheduled.

STRATEGIC PLAN UPDATE

It was mentioned in the board self-evaluation that a member would like to have more information on the Strategic Plan 2010-2015. The plan itself continues to be posted to the board website. An update on the current status of items contained within the plan is attached to this report. If you have any questions regarding the Strategic Plan, please email me at mmurray@centerforhospice.org. The Strategic Plan will be the topic of the education section of the August 2015 board meeting.

NEW CHC URL

We have acquired www.cfhcare.org as our new URL for our website. Eventually our emails will also migrate to this domain. The original domain, www.centerforhospice.org will continue to operate and nothing will be deleted or discontinued. We have long wanted a shorter URL that more accurately reflected our name. The last and fourth word of our name is frequently left off entirely by the media. We believe we are partially to blame for this having spent the last five years directing people to a domain name that doesn’t accurately portray our full name. The length of our URL and the length of subsequent email addresses for all professional staff has also been a concern. The new URL is 43% shorter and much faster to type.

NEW MEDICARE HOSPICE DATA ARRIVES – LATEST EDITION FOR 2013

We have purchased the latest available Medicare Hospice Data for 2013 for the State of Indiana published by two companies who help make the data visually appealing. Selected pages from this colorful and graphics-driven state hospice profile are attached. I’ve included the U.S. data for overall impressions and the Indiana pages which show CHC at the top provider caring for more patients than any program. The provider coming in second – with offices in Indianapolis, South Bend, and Merrillville -- cared for 43% fewer patients than CHC. For CHC in 2013, 96.7% of the Medicare hospice patients came from St. Joseph, Elkhart and Marshall Counties where we have care offices and where the largest population base exists. Therefore, I am only including those county pages in the attachment. The attached report shows demographic information by county for a variety of important metrics and some comparative data for the last thirteen years including market share. Market share is listed below and I have added the number of CHC competitor hospice programs for the three counties based upon the Hospice Directory listing at the Indiana State Department of Health website.

<u>2013 CHC Medicare ONLY Hospice Market Share and Number of Competitors by County</u>

Elkhart County Market Share = 41% with 11 Competitors

Marshall County Market Share = 77% with 13 Competitors

St. Joseph County Market Share = 69% with 12 Competitors

When you examine past growth over time and the potential for future growth of Medicare hospice patients, an important indicator is the "penetration rate." The penetration rate percentage is calculated as the total number of Medicare hospice patients over the total number of Medicare deaths. Comparative penetration rate percentages for 2013 Medicare hospice is listed below:

<u>2013 Medicare Hospice Penetration Rates Comparisons</u>

United States = 67% (Arizona highest at 97%; North Dakota lowest at 39%)

Indiana = 61% (Bartholomew Co. Highest at 79%; Ohio Co. lowest at 25%)

Elkhart County = 61% (up from 24% in 2000)

Marshall County = 65% (up from 30% in 2000)

St. Joseph County = 70% (up from 31% in 2000)

NEW POTENTIAL NAME FOR HOSPICE HOUSE

We are considering changing the name of Hospice House to "Center for Comfort Care" and would like your feedback. We believe many people choose not to want to come to Hospice House because of the name, which to some people, indicates that it is a place where people die. In 2014 31% of the 614 patients who were in Hospice House left alive and either went back to their own homes or back to a nursing facility. The single intent of Hospice House is to provide pain and symptom management that cannot be provided in other settings and short (up to five days) respite stays for families / caregivers under certain Medicare / Medicaid conditions. The new name would also provide an opportunity to continue the use of our branding logo, font, etc. and the theme of "Center" for all of our major product lines.

CHC MEDICARE COMPLIANCE COMMITTEE MINUTES

To insure the board, as the governing body, is aware of our efforts toward an effective internal Medicare Compliance Program, we include the minutes of our most recent Medicare Compliance Committee meeting as an attachment to this President's Report.

CONFLICT OF INTEREST POLICY STATEMENT

You will be asked to sign a conflict of interest policy statement for 2015. This is the same statement we used last year. It is signed each year to meet the requirements of our annual audit and answer specific questions on the IRS Form 990, the nonprofit "tax" return. The document is included as an attachment to this report for you to review prior to Wednesday's meeting. We will have hard copies available for you to sign at the board meeting.

OUT AND ABOUT

I attended the National Hospice Executive Roundtable meeting in Chicago, IL January 11 – 13.

I attended the NHPCO Executive Committee Meeting, Board of Directors Meeting, and Chaired the Hospice Action Network Board Meeting in La Jolla, CA January 20 and 21.

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

Dave Haley's Census Reports

Board Self-evaluation Results and Summary Scores

2010 – 2015 Brief Strategic Plan Update

Hospice Market Data Reports for 2013

Copy of the minutes from the most recent CHC internal Medicare Compliance Committee meeting

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

December 2014 Year-end Financials.

Latest edition of the "H&P" -- the CHC Hospice and Physician Team Newsletter.

CHC Board of Directors "Conflict of Interest" form.

NEXT REGULAR BOARD MEETING

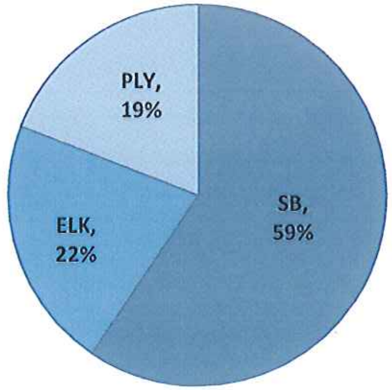
Our next regular Board Meeting will be **Wednesday, April 15, 2015 at 7:30 AM** in Conference Room A, first floor at the Mishawaka Campus, 501 Comfort Place, Mishawaka, IN 46545. In the meantime, if you have any questions, concerns, suggestions or comments, please contact me directly at 574-243-3117 or email mmurray@centerforhospice.org .

# # #

Center for Hospice Care
2014 YTD Average Daily Census (ADC)
(includes Hospice House and Home Health)

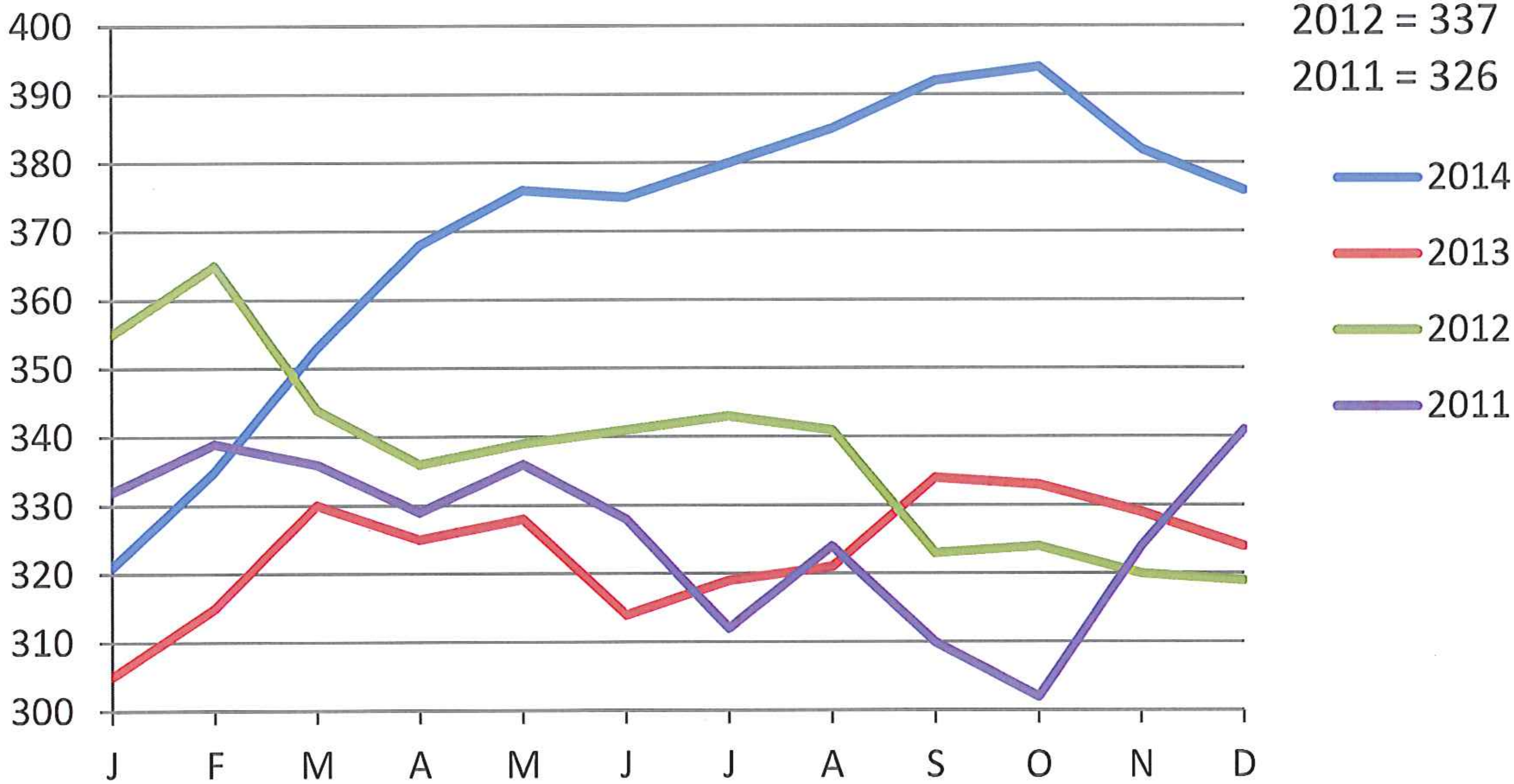
	All	South Bend	Elkhart	Plymouth
J	321	202	57	62
F	335	209	55	72
M	353	217	65	71
A	368	216	73	79
M	376	220	80	76
J	375	222	82	71
J	380	219	92	69
A	385	231	88	67
S	392	229	92	72
O	394	229	92	73
N	382	227	89	67
D	376	218	89	68
2014 YTD Totals	4437	2639	954	847
2014 YTD ADC	**370**	**220**	**80**	**71**
2013 YTD ADC	323	195	69	59
YTD Change 2013 to 2014	47	25	11	12
YTD % Change 2013 to 2014	**14.5%**	**12.8%**	**15.2%**	**19.6%**

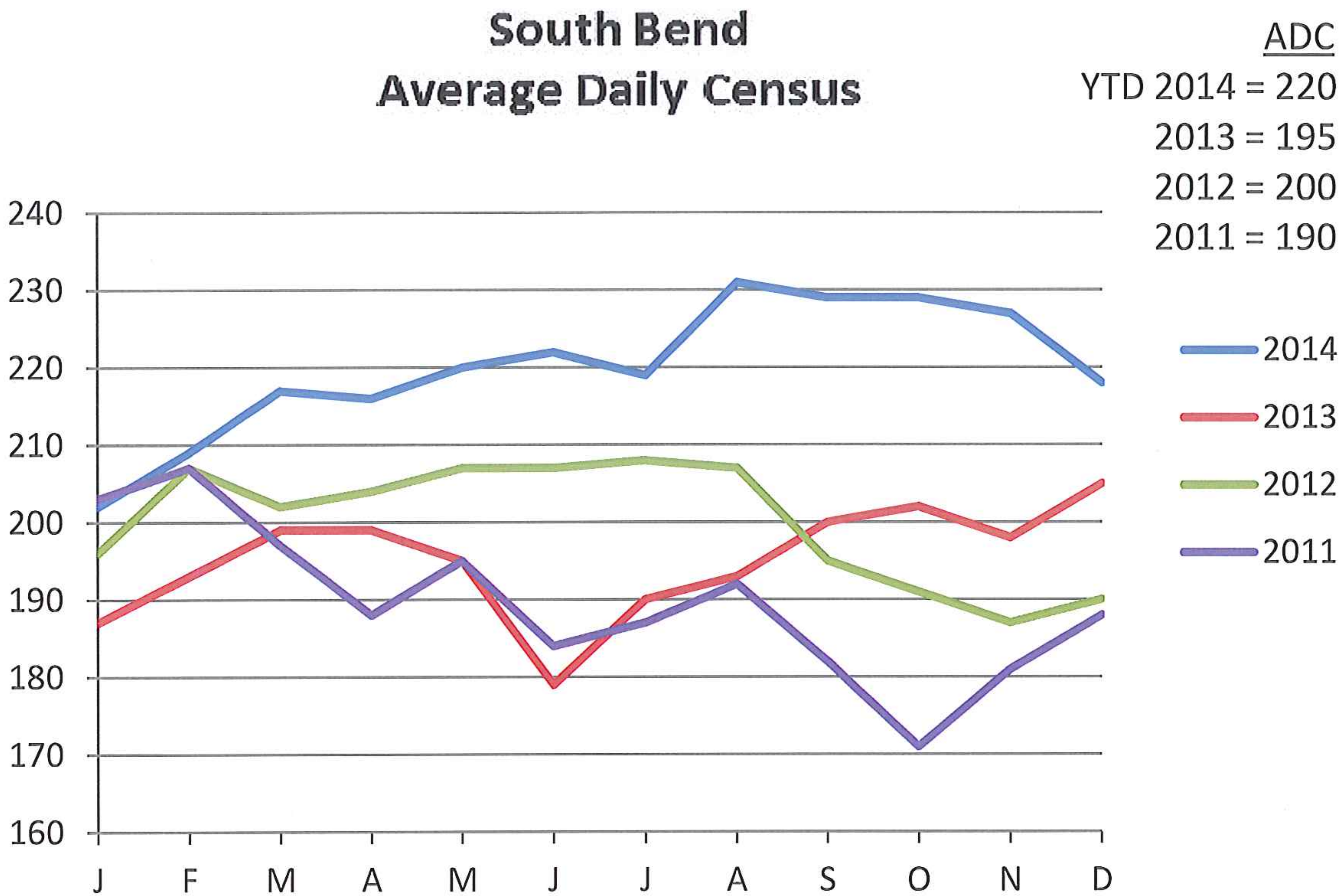
2014 YTD ADC by Branch

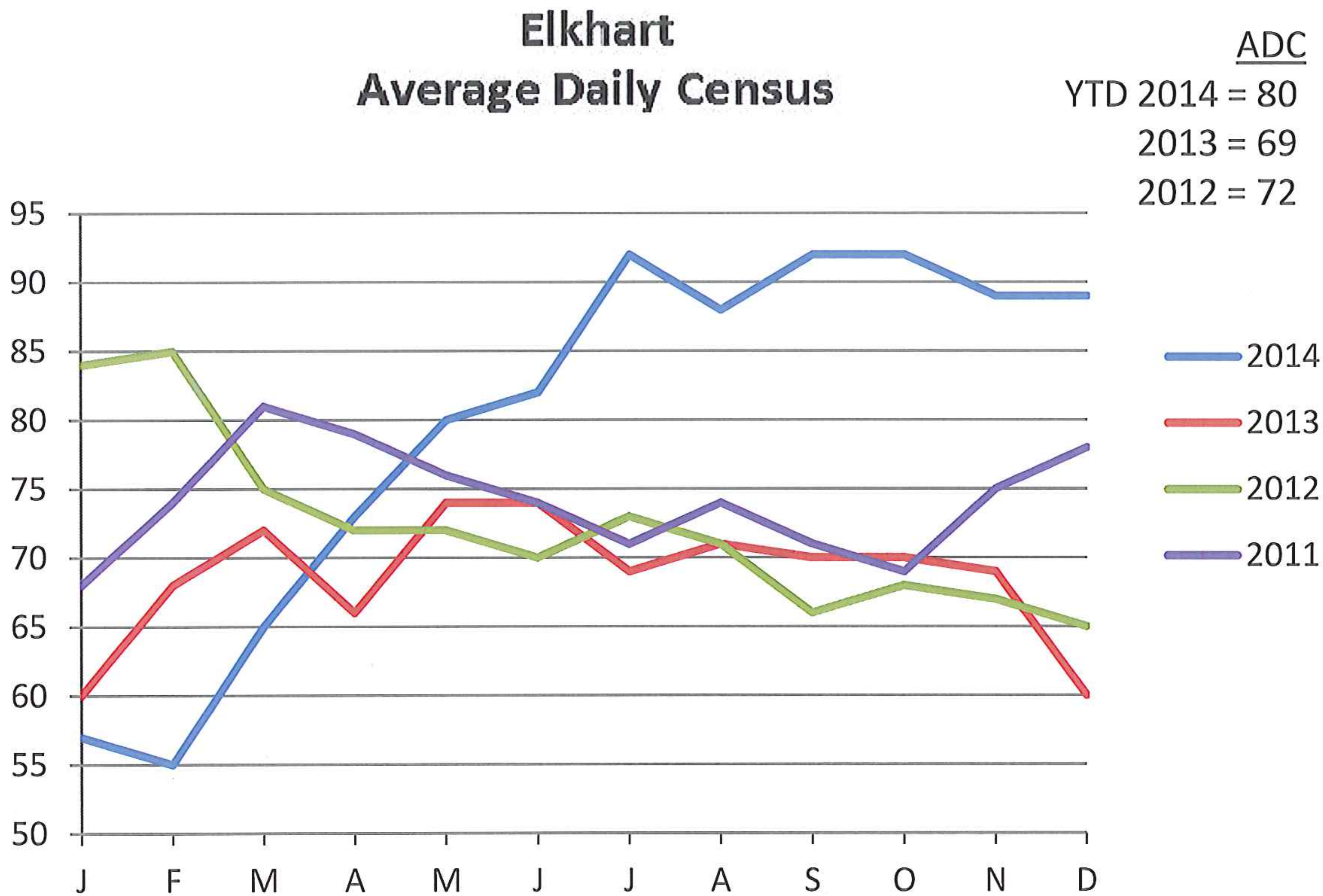


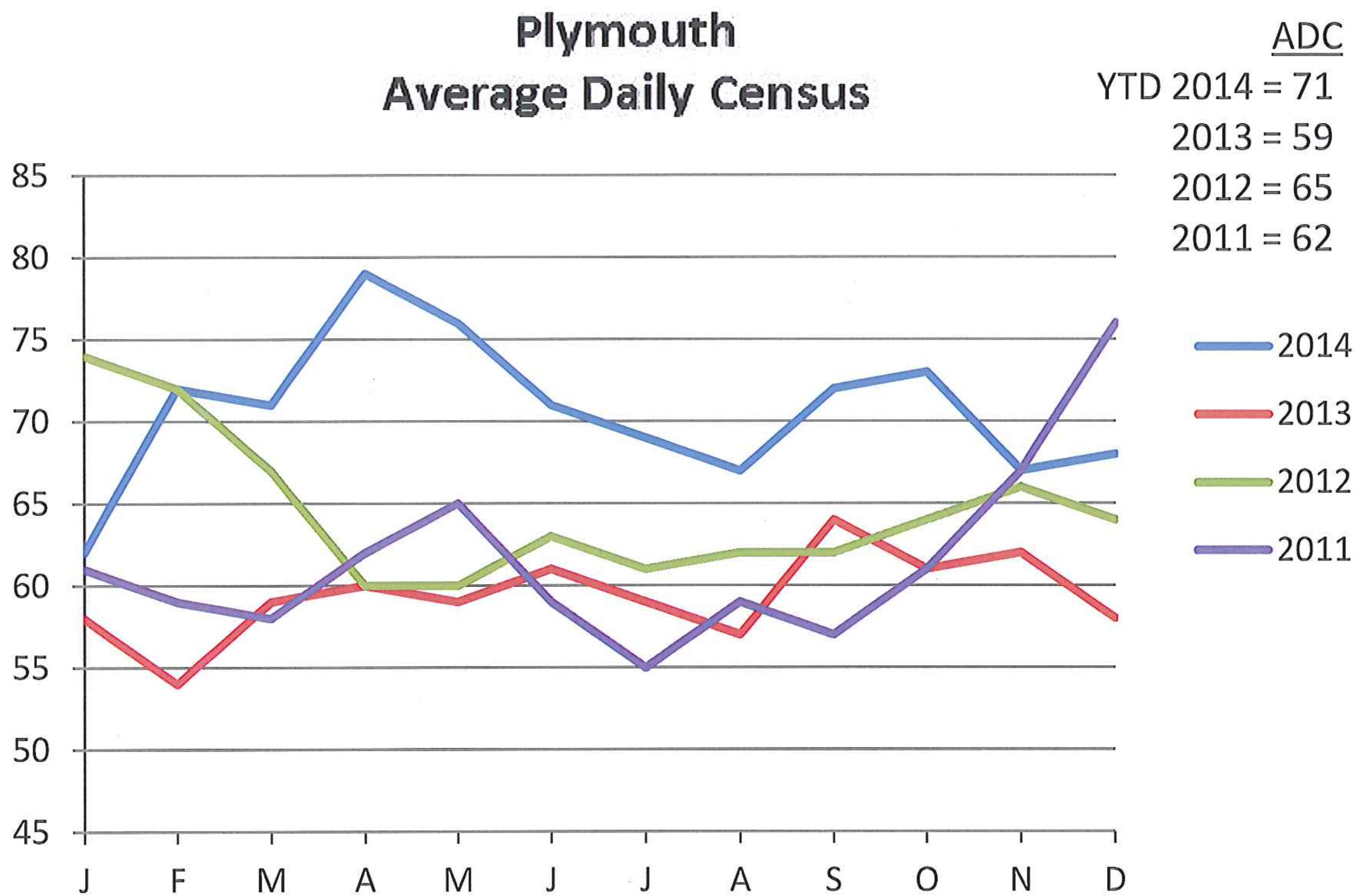
Center for Hospice Care
Total Average Daily Census (ADC)

<u>ADC</u>
YTD 2014 = 370
2013 = 323
2012 = 337
2011 = 326




South Bend
Average Daily Census
ADC
YTD 2014 = 220
2013 = 195
2012 = 200
2011 = 190
240
230
220
210
200
190
180
170
160
J
F
M
A
M
J
J
A
S
O
N
D
2014
2013
2012
2011


Elkhart
Average Daily Census
ADC
YTD 2014 = 80
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
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M
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2014
2013
2012
2011

Center for Hospice Care

BOARD OF DIRECTORS SELF-EVALUATION

2014 Survey Results

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

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

#	Question	Very Good	Good	Average	Fair	Avg. Score 2014	Avg. Score 2013	Avg. Score 2012
1	Board has full and common understanding of the roles and responsibilities of a Board.	4	4	1		**4.3**	**4.4**	**4.7**
2	Board members understand the organization's mission and its products / programs.	8	1			**4.8**	**5.0**	**4.7**
3	Structural pattern is clear (Board, officers, committees, administrative team, staff).	6	3			**4.6**	**4.9**	**4.7**
4	Board has clear goals and actions resulting from relevant and realistic strategic planning.	6	2	1		**4.5**	**4.7**	**4.5**
5	Board attends to policy-related decisions, which effectively guide operational activities of staff.	7	2			**4.7**	**4.3**	**4.7**
6	Board receives regular reports on finances, budgets, products, program performance, and other important matters.	9				**5.0**	**5.0**	**4.9**
7	Board effectively represents the organization to the community.	5	4			**4.5**	**4.3**	**4.6**
8	Board meetings facilitate focus and progress on important organizational matters.	6	3			**4.6**	**4.8**	**4.7**
9	Board regularly monitors and evaluates progress toward strategic goals and products / program performance.	6	2	1		**4.5**	**4.6**	**4.7**

#	Question	Very Good	Good	Average	Fair	Avg. Score 2014	Avg. Score 2013	Avg. Score 2012
10	Each member of the Board feels involved and interested in the Board's work.	3	6			**4.3**	**3.9**	**4.2**
11	All necessary skills, stakeholders, and diversity are represented on the Board.	5	2	2		**4.3**	**3.4**	**4.6**

Ratings by percent of responses:

	2014	2013	2012
Very Good	66%	61%	64%
Good	29%	26%	31%
Average	5%	13%	5%

Participation Rate

2014	60%
2013	60%
2012	57%

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

1. Review 3-5 year strategic plan at each board meeting, reporting progress.
2. Spend more time guiding board members as to how they can be more productive and helpful to the organization.
3. Board meeting should spend equal time focusing on accomplishments and problems.
4. Board members are extremely well informed of the operations of Hospice. Good job!
5. May need to get more male board members.
6. Engage or make effort to involve all board members. Some of the new ones have not acclimated to board & seem bored.
7. Remember to explain what all the initials & abbreviations mean for the new board members.
8. Keep on doing what you are doing.
9. Keep our eyes focused on the patient. Always #1.
10. Continue to have our name advertised. Get the message out that people need hospice tender touch.
11. Make sure the staff knows how important each & every one of them are in the big picture.
12. Encourage attendance at the meetings.
13. Encourage involvement on at least one committee.
14. Encourage involvement in at least one fund-raising event.
15. Continue to be ambassadors of CHC in the community.

16. Attend meetings to stay up to date on all of the activities of CHC and the Hospice Foundation.
17. Be a sounding board for Mark and his team.
18. Continuing to grow market share in region.
19. Continued collaboration with hospitals and other medical professionals in the area.
20. Provide board information as to the effects positive/negative on the ACA.
21. Increasing market share, especially in Elkhart & Kosciusko Counties.
22. I'm not sure of the new building & its debt. How is this being paid for? As a board member should I be aware of this?
23. As a new board member (1 year) I cannot evaluate or determine where the board should focus.

How would you improve the Board's effectiveness?

1. By continuing to encourage members to participate on committees or volunteer at some of the annual fund raising events.
2. Not sure at the moment—communication is excellent.
3. There is so much to process in the hour we have every other month. Is the promise to keep meetings to an hour more important than allowing more time to cover more or to go more in depth? Perhaps we should be meeting monthly or longer when we do meet. I think this feeling could also apply to the question below.
4. The meetings are organized & informational. No changes at this time.

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

1. More clarity on expectations of board members.
2. Forget about diversity. Fill board with qualified people regardless of color, sex, or whatever.
3. Wendell does an excellent job. He asks questions which he already knows the answers in an attempt to educate new board members.
4. Through no fault of our own, we lack minority involvement. The solution is to develop, over the course of years, relationships that lead to additions of people who want to join the board.
5. I am not aware of any gaps.

Center for Hospice Care

Strategic Plan 2011-2015

Updated 02/09/15

Goal A: Enhance Patient Care

Category	Status	Goal
1. Promote confidence of care	Met	Implement 24/7 live telephone answer with a CHC nurse.
2. Expand programming for children	In Process Met	(a) Enhance marketing efforts for pediatric palliative care services. (b) Add perinatal programming.
3. Create a culture of innovation to foster memorable first impressions	In Process	Create innovative, remarkable, memorable, "tell your friends about it" experiences.
4. Avoid ISDH surveys/inspections	Not Doing	Become accredited with a "deemed status" approved accrediting body.
5. Involve caregivers in CHC programming well before it is needed	In Process	Create a Caregiver Training Center
6. Add an underserved niche population	Met	Become a "We Honor Veterans" Partner Hospice.

Goal B: Position for Future Growth

Category	Status	Goal
1. Test new models of caring	Not Doing	Apply for the CMS Concurrent Care Demonstration Project.
2. Achieve a heightened awareness of Merger and Acquisition Opportunities	Met	Explore opportunities with a potentially shrinking number of hospice providers.
3. Enhance succession planning	Met	Create a framework document to assist the Board of Directors in finding the next President/CEO.
4. Perform additional market research	Met	Find out what our customers want and customize our relationship with them to meet their needs and expectations.
5. Become an education destination	Met	Continue exploration of and the intent to become an accredited site for residency education in palliative medicine.

Goal C: Maintain Economic Strength

Category	Status	Goal
1. With Medicare reimbursement cuts of up to 14.3% by 2019, CHC should begin to diversify its revenue stream now	In Process In Process Not Doing	(a) Expand upon chronic care case management experiences from the Enhanced Care model. (b) Investigate the development of a Geriatric Physician Practice. (c) Investigate the development of a Private Duty line of business.
2. Have ongoing philanthropic revenue streams	Met	Increase fundraising, development, investment activities.

Goal D: Continue Building Brand Identification

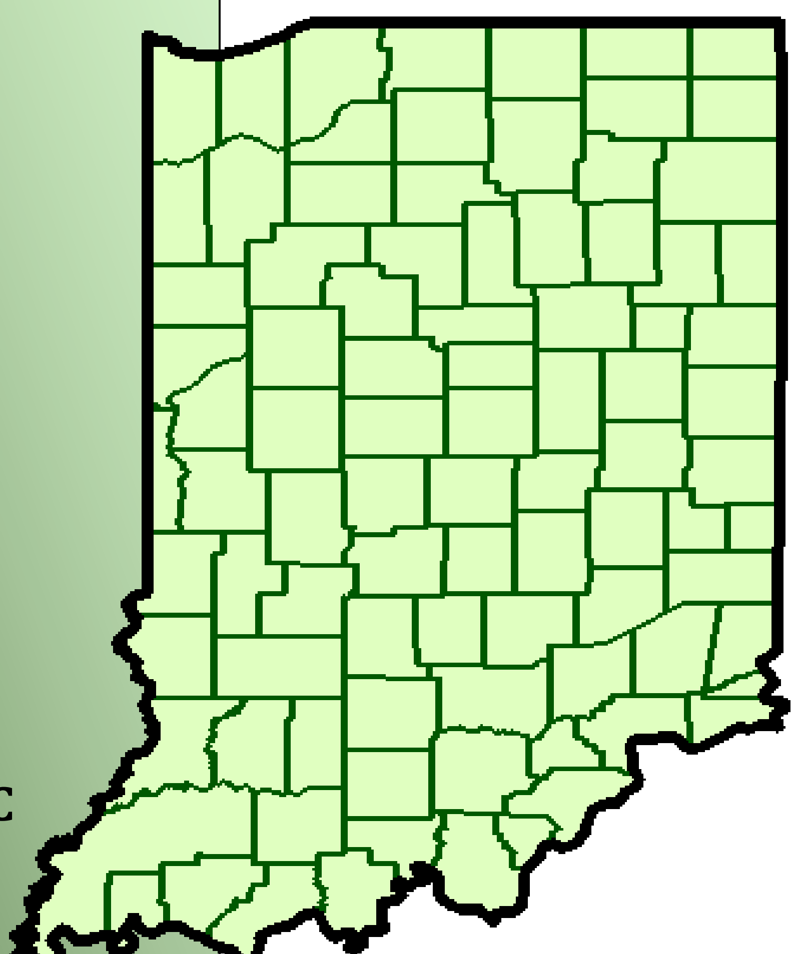
Category	Status	Goal
1. To convey to all target audiences the essence of CHC through consistent branding via graphics, logo, positioning theme, photos, color and fonts.	Met	Continue with Transcend Hospice Marketing's multi-year approach to increase average daily census and increase average length of stay.
2. Gain more national attention as a national leader hospice program.	Not Met	Apply for and win the "Circle of Life Award."
3. Expand what we do well and transform it to new revenue stream	Not Doing	Create an EAP for end-of-life issues in the workplace.
4. Continue to enhance physician relationships	In Process Met	(a) Investigate advisory board opportunities for CHC participation, consultations, speaking opportunities, and regularly scheduled rotated onsite palliative care consultations by CHC NPs and RN hospital liaison positions. (b) Continue to enhance medical school, residency relationships.
5. Continue market differentiation activities and promotion	Met	Create service promises.

Category	Status	Goal
6. Create key long-term initiatives that are uniquely ours to position CHC at THE leading, forward-thinking organization	Met	Use our Hospice Foundation for strategic purposes. (a) Collaborative Partnerships (b) Fundraising (c) Stewardship (d) Education
7. Continue to develop, promote and publicize our international programming	Met	Make our goal of bringing palliative care to all of Uganda well known.

Indiana

State Hospice Profile

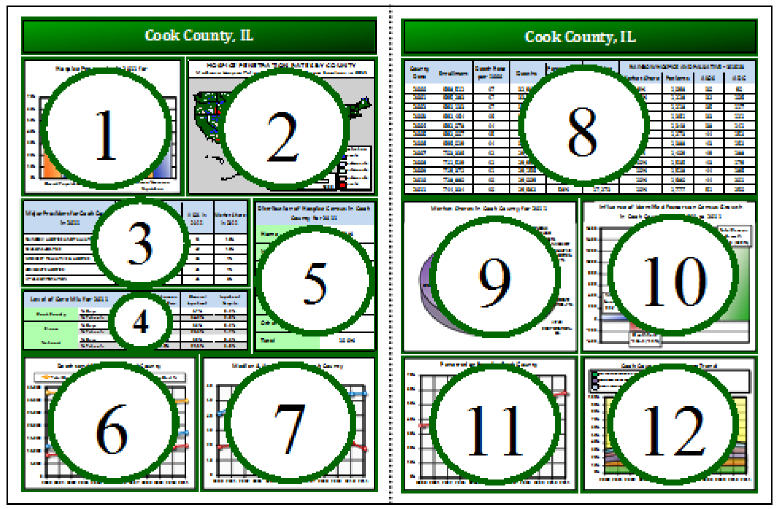
Based on Medicare Data from 2000 to 2013



Produced by
Health Planning &
Development, LLC &
Summit Business Group, LLC

Available through
NHPCO MarketPlace

Definition of Terms—County Profiles



1. Hospice Penetration in 2013

Chart of penetration rate for the total, Hispanic, and African-American populations of the county and state, calculated as:

(Total Hospice Patients) / (Total Medicare Deaths)

2. Hospice Penetration Rate County Map

Map shows the county and surrounding areas. Counties are colored and labeled according to 2013 penetration rate

3. Major Providers Data Table 2013

Providers: Lists of up to five providers in descending order by Medicare market share of patients served

Patients Served: Number of patients served by the provider in that county

Average Daily Census: Average daily census for the provider in that county

ALOS: Average length of stay for the provider's patients in that county:

(Provider's Patient Days in County) / (Provider's Patients Served in County)

Market Share: Market share of the provider in that county, calculated as:

(Provider's Patients Served in County) / (Total Patients Served in County)

4. Level of Care Table 2013

Lists the % of days by level of care and % patients served that use each level of care for the county, the state, and the nation. CHC days calculated as the balance of total days for CHC patients. All other data from the submitted claims

5. Distribution of Hospice Census by Setting

Table shows the % of patient days in 2013 provided in each care setting—Home, Nursing Home, Assisted Living Facility, Hospital, Hospice Facility or Other

6. Deaths and Patients

Chart of total deaths, hospice deaths, and hospice patients for the county by year

7. Average & Median Length of Stay

Chart of average and median LOS for the county. Median LOS is the median number of days patients spent in hospice in that year. Average LOS is:

(Patient Days in County) / (Patients Served in County)

8. County Planning Table

Enrollment: County Medicare enrollment by year

Death Rate per 1,000: Number of deaths per 1,000 Medicare enrollees, calculated as:

(Total Medicare Deaths in County) / (Total Medicare Enrollment in County)

Deaths: Total Medicare deaths in county

Penetration Rate: Hospice penetration rate for the county, calculated as:

(Total Hospice Patients) / (Total Medicare Deaths)

9. Market Shares in 2013

Pie chart shows the percent Medicare market share for the top five or fewer providers in 2013, calculated as:

(Provider's Patients Served in County) / (Total Patients Served in County)

10. Influence of Identified Factors on Census Growth

Chart of total census growth in county (net change in average daily census over the stated period) attributed to four "identified factors"—Medicare enrollment, death rate, penetration, and length of stay

11. Penetration Rate

Chart of penetration rate by year, calculated as:

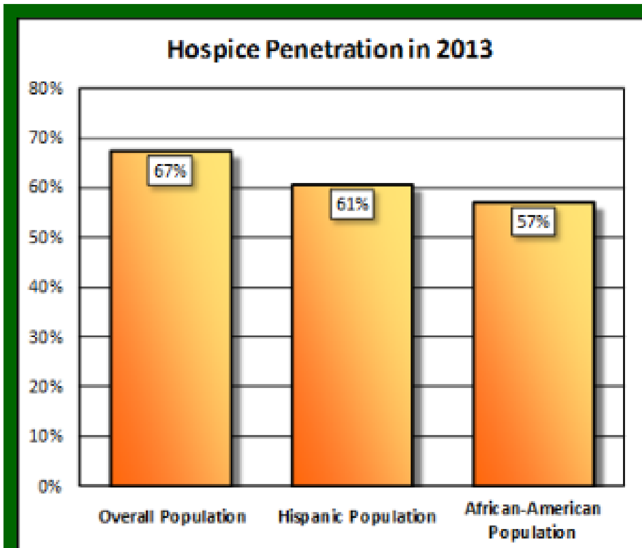
(Total Hospice Patients) / (Total Medicare Deaths)

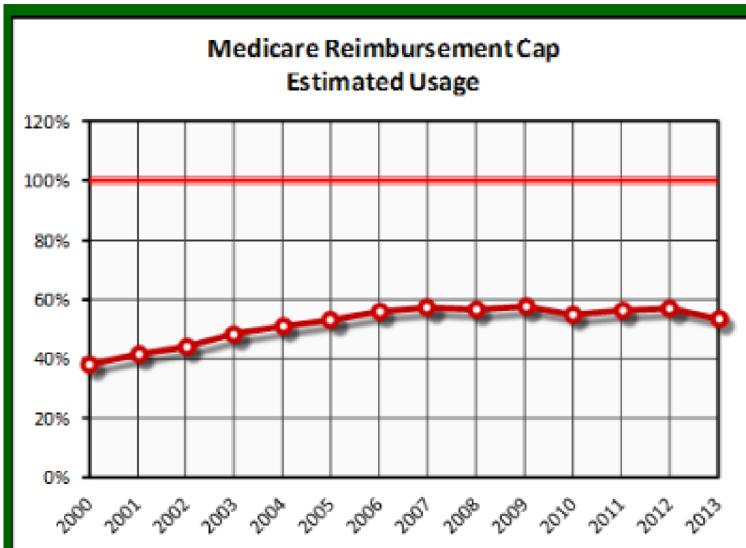
12. County Market Share Trend

Chart shows the trends in Medicare market share by year for the top five or fewer providers and "other" providers in calendar year 2013

*The information in the Hospice Market Atlas™ consists of aggregated data as reported by CMS in the annual Limited Data Sets for calendar years 2000 to 2013. The data within the Hospice Market Atlas™ are **limited to Medicare patients.** In compliance with an executed data use agreement on file with CMS, figures are not listed if they would permit a computation of patient counts less than 11*

United States

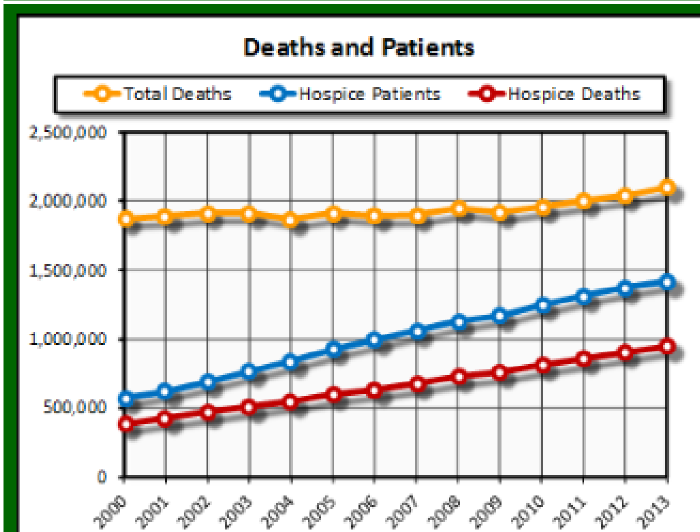


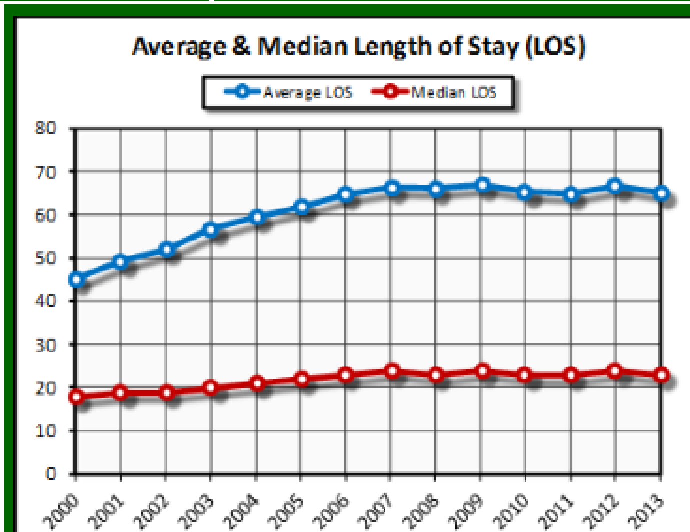


Major Providers in 2013	Patients Served in 2013	Average Census in 2013	ALOS in 2013	% GIP Days in 2013
VITAS HEALTHCARE CORPORATION OF	23,031	5,184	82	2.7%
SUNCOAST HOSPICE	7,417	1,452	71	4.3%
HOSPICE OF PALM BEACH COUNTY,	7,358	1,119	55	4.8%
TIDEWELL HOSPICE INC	7,338	998	50	4.6%
LIFEPATH HOSPICE	6,208	1,213	71	3.6%
COMMUNITY HOSPICE OF NORTHEAST	5,949	998	61	5.7%
HOSPICE OF THE WESTERN RESERVE,	5,889	1,024	63	3.0%
HOPE HOSPICE AND COMMUNITY SERVICES	4,990	938	69	6.4%
CORNERSTONE HOSPICE AND PALLIATIVE	4,976	731	54	3.2%
HOSPICE OF CINCINNATI, INC	4,599	605	48	5.1%

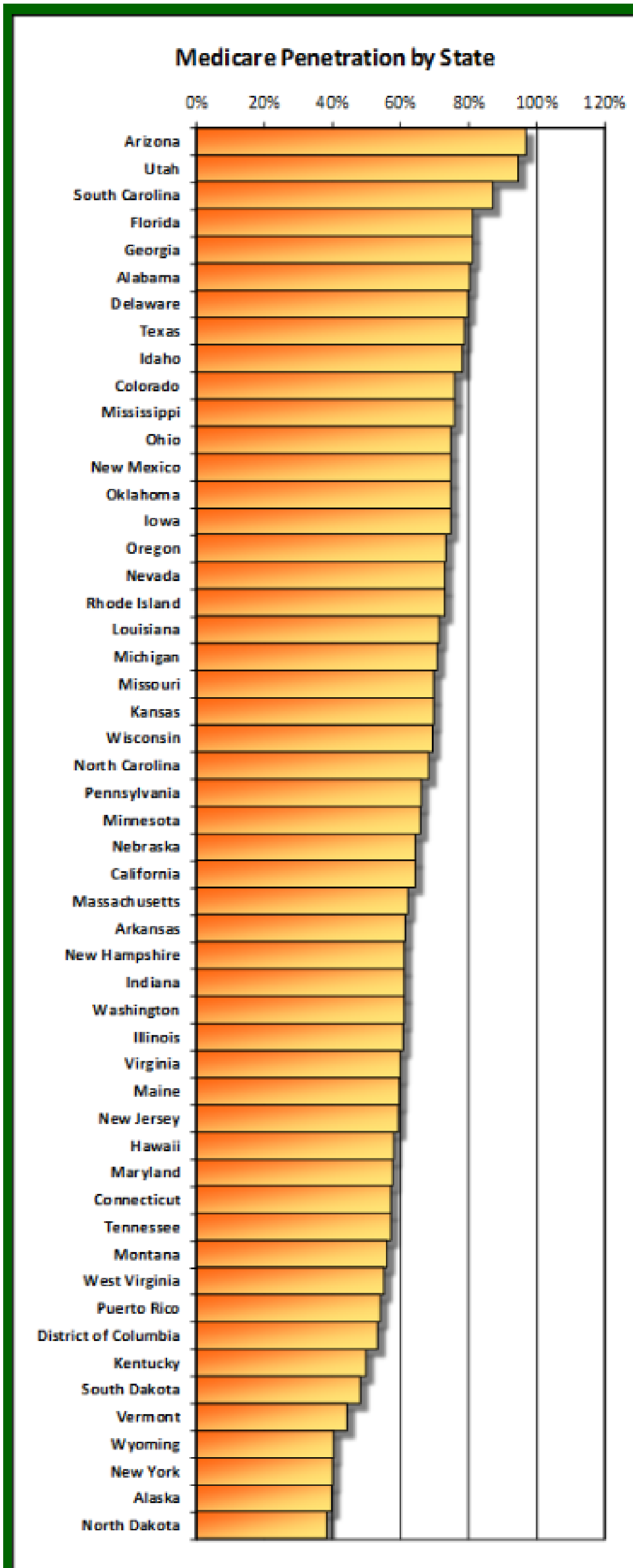
Distribution of Hospice Census in 2013	
Home	56%
Nursing Home	25%
Assisted Living Facility	15%
Hospital	1%
Hospice Facility	2%
Other	1%
Total	100%

Level of Care Mix for 2013		Routine Home Care	Continuous Home Care	General Inpatient	Inpatient Respite
National	% Days	97.6%	0.4%	1.7%	0.3%
	% Patients	87.0%	5.3%	20.7%	3.5%

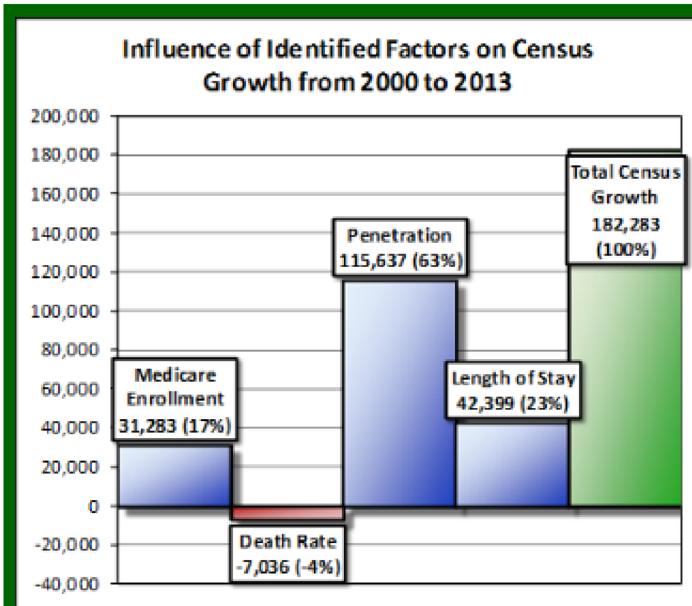


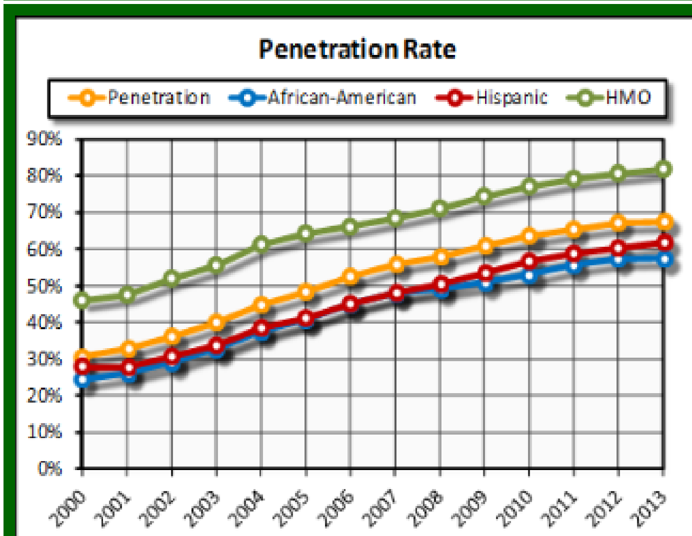


United States

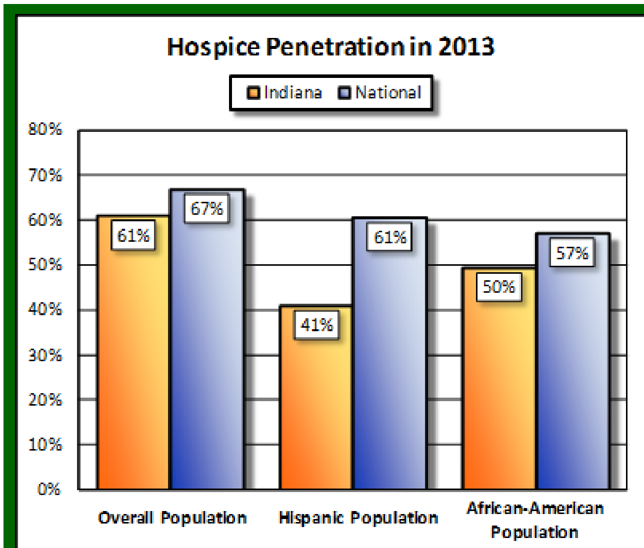


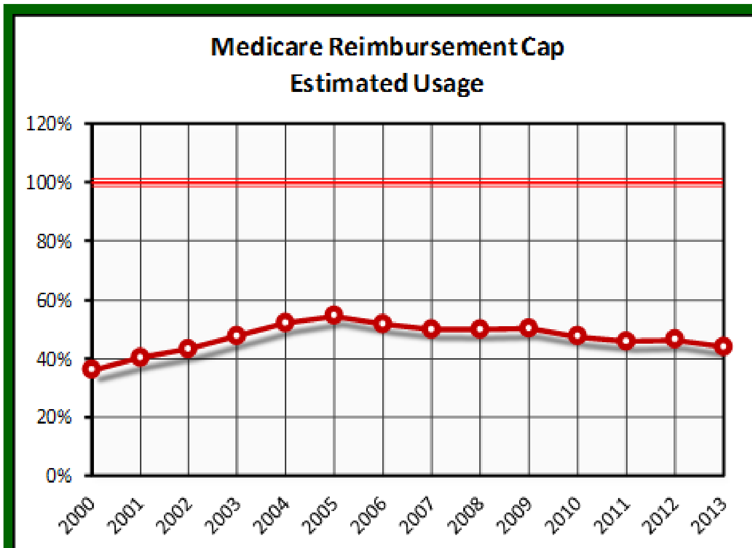
Year	Enrollment	Death Rate per 1000	Deaths	Penetration Rate	Hospice Patients
2000	41,184,926	45	1,873,365	31%	573,537
2001	41,611,566	45	1,887,169	33%	621,012
2002	42,126,898	45	1,911,855	36%	691,870
2003	42,730,211	45	1,912,749	40%	766,413
2004	43,376,811	43	1,869,166	45%	839,239
2005	44,213,663	43	1,913,880	48%	925,963
2006	45,031,940	42	1,892,459	53%	993,698
2007	46,096,318	41	1,896,636	56%	1,061,860
2008	47,238,258	41	1,948,644	58%	1,128,285
2009	48,311,244	40	1,920,266	61%	1,169,921
2010	49,493,327	40	1,960,797	64%	1,246,618
2011	51,093,838	39	2,003,783	66%	1,313,002
2012	52,956,964	39	2,044,448	67%	1,373,084
2013	54,604,850	39	2,103,402	67%	1,419,613





Indiana

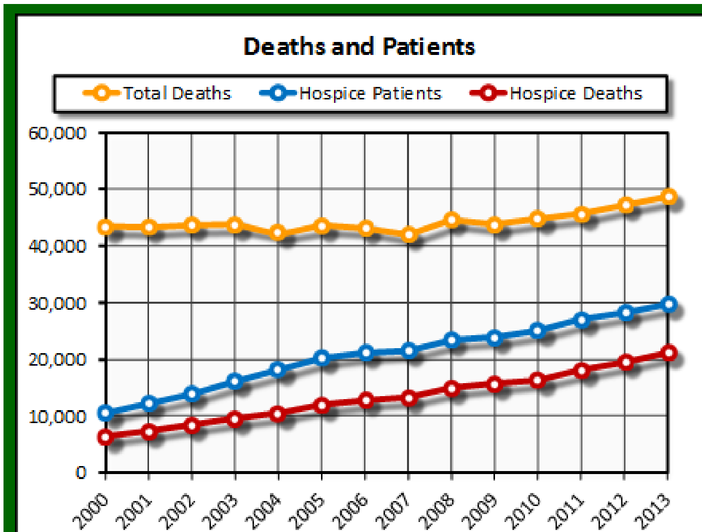


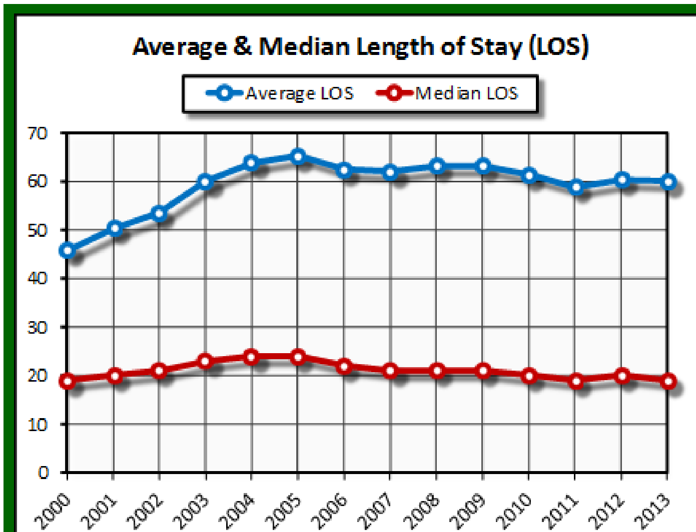


Major Providers in 2013	Patients Served in 2013	Average Census in 2013	ALOS in 2013	% GIP Days in 2013
CENTER FOR HOSPICE AND PALLIATIVE C	1,747	279	58	2.1%
HARBOR LIGHT HOSPICE	1,006	224	81	0.4%
OUR HOSPICE OF SOUTH CENTRAL INDIAN	1,001	188	69	3.1%
ST VINCENT HOSPICE	945	93	36	6.2%
VISITING NURSE & HOSPICE HOME	933	137	53	5.0%
HEARTLAND HOME HEALTH CARE AND HOSP	928	213	84	
PARKVIEW HOME HEALTH AND HOSPICE	928	95	37	4.6%
COMMUNITY HOME HEALTH	887	80	33	5.4%
INDIANA UNIVERSITY HEALTH HOSPICE	855	101	43	2.2%

Level of Care Mix for 2013		Routine Home Care	Continuous Home Care	General Inpatient	Inpatient Respite
Indiana	% Days	98.0%	0.1%	1.6%	0.3%
	% Patients	86.8%	1.9%	18.6%	3.8%
National	% Days	97.5%	0.4%	1.7%	0.3%
	% Patients	87.0%	5.3%	20.7%	3.5%

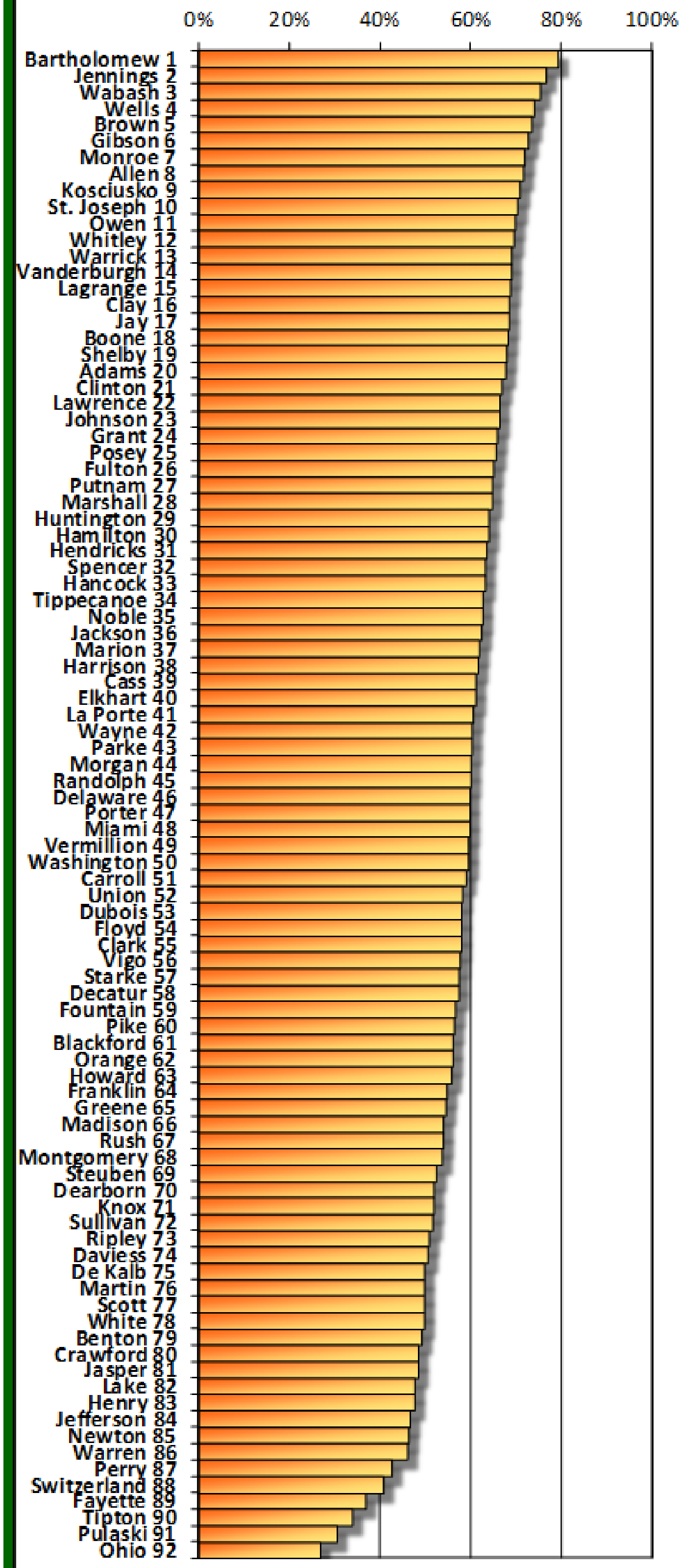
Distribution of Hospice Census in Indiana for 2013	
Home	48%
Nursing Home	40%
Assisted Living Facility	10%
Hospital	1%
Hospice Facility	1%
Other	0%
Total	100%





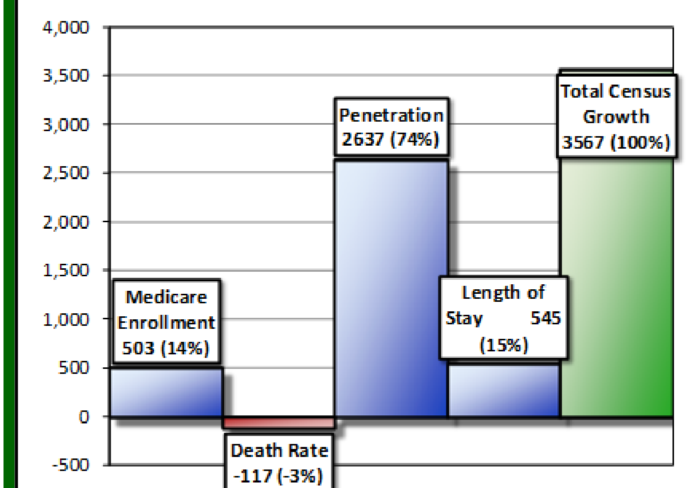
Indiana

Medicare Penetration by Indiana County

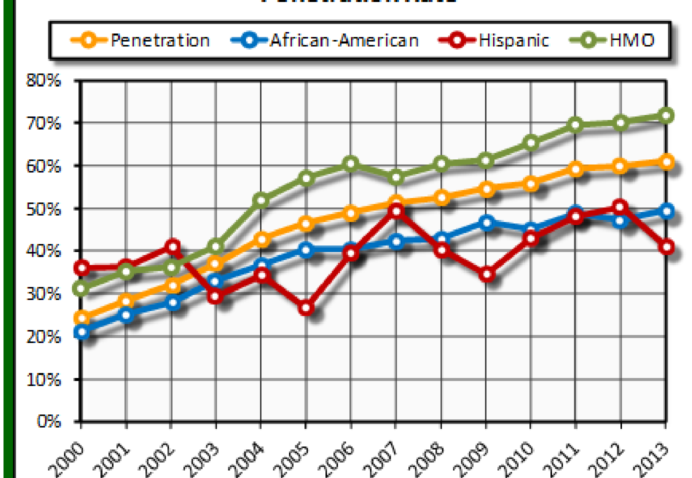


Year	Enrollment	Death Rate per 1000	Deaths	Penetration Rate	Hospice Patients
2000	894,806	49	43,471	24%	10,593
2001	900,665	48	43,305	28%	12,275
2002	910,044	48	43,685	32%	13,963
2003	922,070	48	43,818	37%	16,242
2004	934,464	45	42,472	43%	18,205
2005	951,936	46	43,644	46%	20,276
2006	969,136	45	43,239	49%	21,166
2007	990,013	42	42,059	51%	21,589
2008	1,013,022	44	44,636	53%	23,471
2009	1,034,253	42	43,825	55%	23,928
2010	1,055,007	43	44,852	56%	25,095
2011	1,085,887	42	45,707	59%	27,086
2012	1,121,776	42	47,324	60%	28,358
2013	1,152,054	42	48,743	61%	29,769

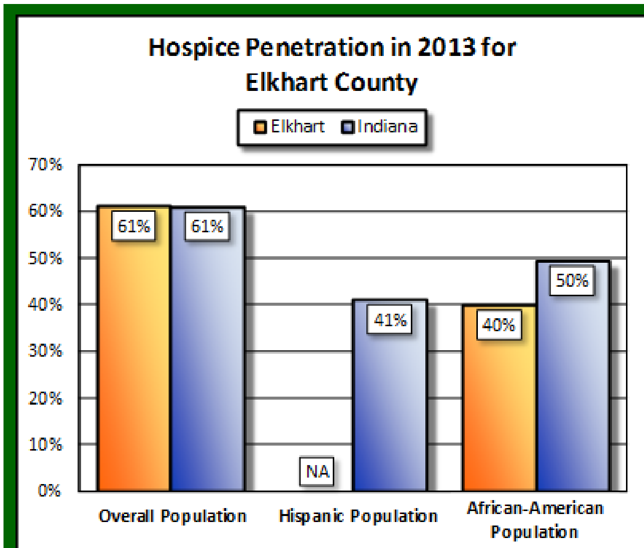
Influence of Identified Factors on Census Growth in Indiana from 2000 to 2013

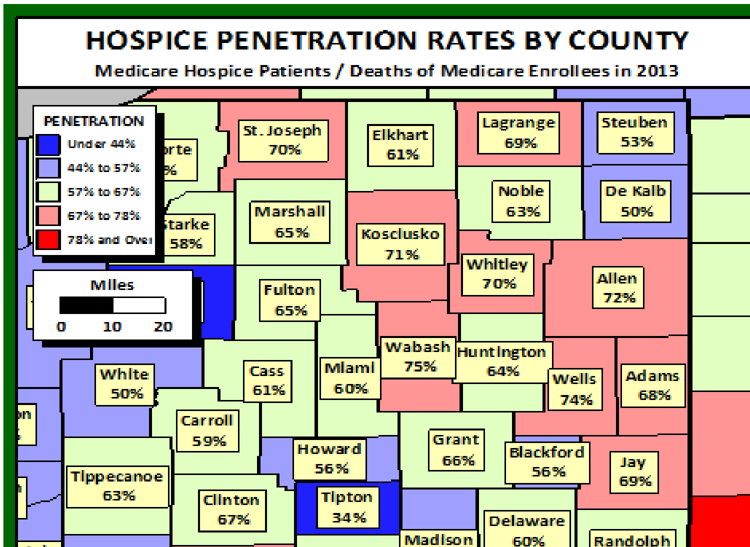


Penetration Rate



Elkhart County, IN

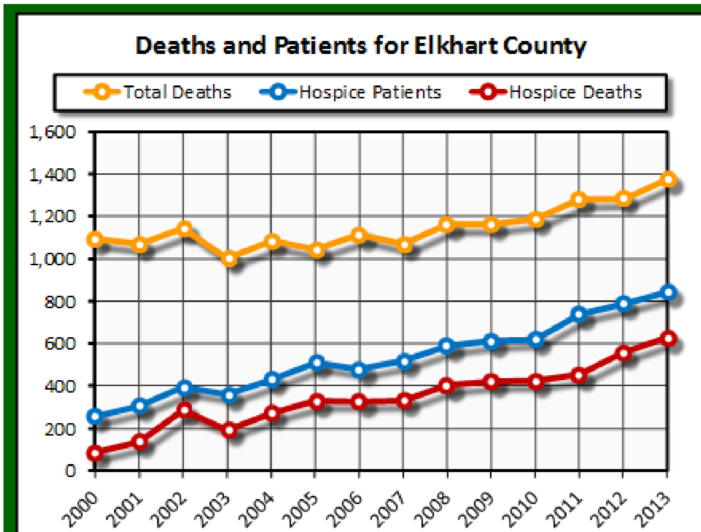


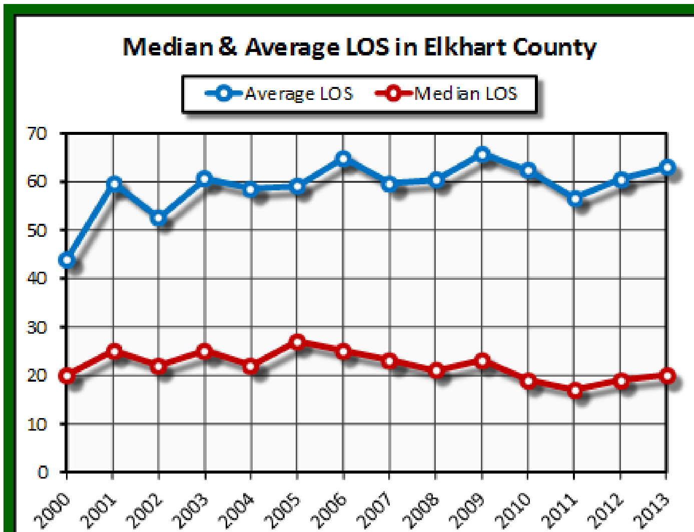


Major Providers for Elkhart County in 2013	Patients Served in 2013	Average Census in 2013	ALOS in 2013	Market Share in 2013
CENTER FOR HOSPICE AND PALLIATIVE	348	52	54	41%
IU HEALTH GOSHEN HOME CARE	231	33	52	27%
HARBOR LIGHT HOSPICE	100	22	82	12%
SOUTHERNCARE SOUTH BEND	51	10	69	6%
ASERACARE HOSPICE	33	12	132	4%

Level of Care Mix for 2013		Routine Home Care	Continuous Home Care	General Inpatient	Inpatient Respite
Elkhart County	% Days	98.3%	0.0%	1.2%	0.4%
	% Patients	89.3%	1.0%	18.3%	5.2%
Indiana	% Days	98.0%	0.1%	1.6%	0.3%
	% Patients	86.8%	1.9%	18.6%	3.8%
National	% Days	97.6%	0.4%	1.7%	0.3%
	% Patients	87.0%	5.3%	20.7%	3.5%

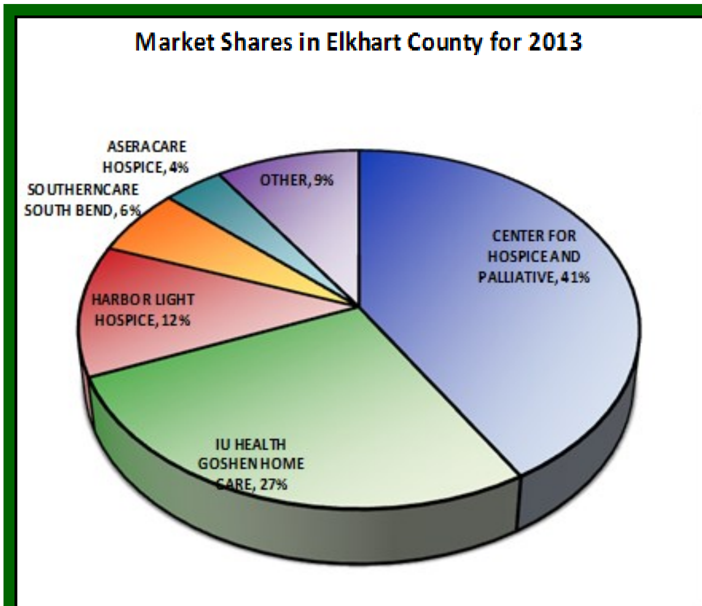
Distribution of Hospice Census in Elkhart County for 2013	
Home	47%
Nursing Home	38%
Assisted Living Facility	13%
Hospital	1%
Hospice Facility	1%
Other	0%
Total	100%

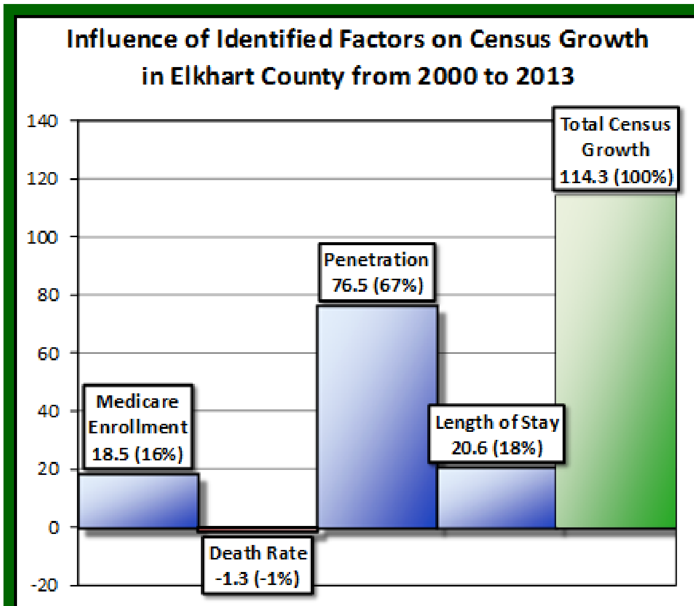


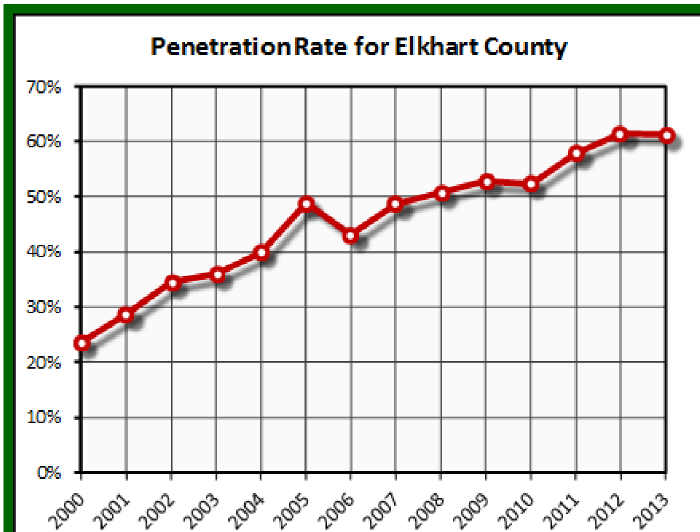


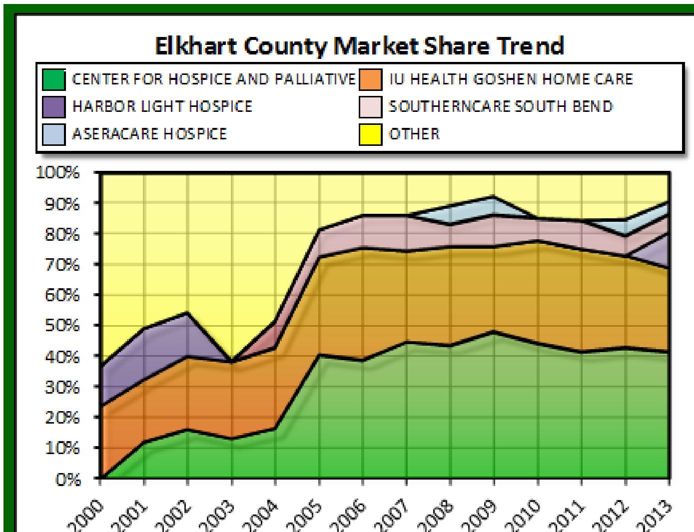
Elkhart County, IN

Year	Enrollment	Death Rate per 1000	Deaths	Penetration Rate	Hospice Patients	CENTER FOR HOSPICE AND PALLIATIVE - 151501			
						Market Share	Patients	ALOS	ADC
2000	23,275	47	1,092	24%	257	5%	12	12	
2001	23,441	46	1,067	29%	306	12%	36	45	4
2002	23,857	48	1,142	34%	393	16%	63	41	7
2003	24,297	41	1,001	36%	360	13%	47	64	8
2004	24,896	43	1,081	40%	431	16%	70	57	11
2005	25,266	41	1,045	49%	510	40%	206	55	31
2006	25,939	43	1,113	43%	479	39%	185	71	36
2007	26,629	40	1,067	49%	519	45%	232	61	39
2008	27,408	42	1,162	51%	589	44%	257	65	46
2009	28,184	41	1,162	53%	613	48%	295	59	48
2010	29,177	41	1,188	52%	621	44%	275	60	45
2011	30,336	42	1,280	58%	740	41%	306	53	45
2012	31,388	41	1,284	61%	788	43%	338	54	50
2013	32,265	43	1,376	61%	842	41%	348	54	52



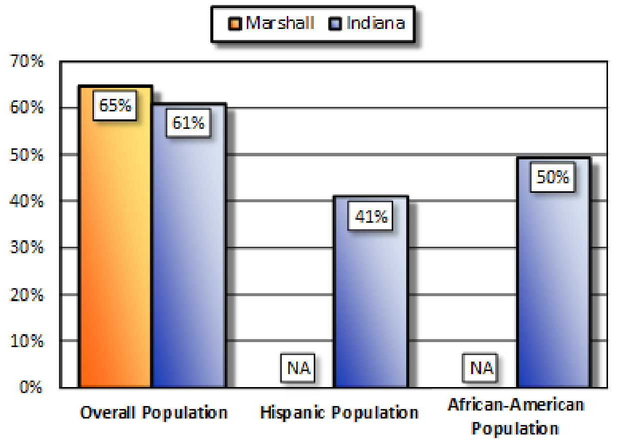






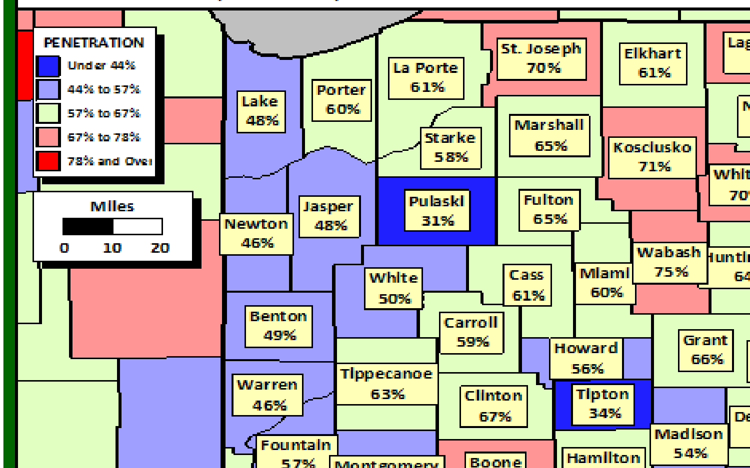
Marshall County, IN

Hospice Penetration in 2013 for Marshall County



HOSPICE PENETRATION RATES BY COUNTY

Medicare Hospice Patients / Deaths of Medicare Enrollees in 2013

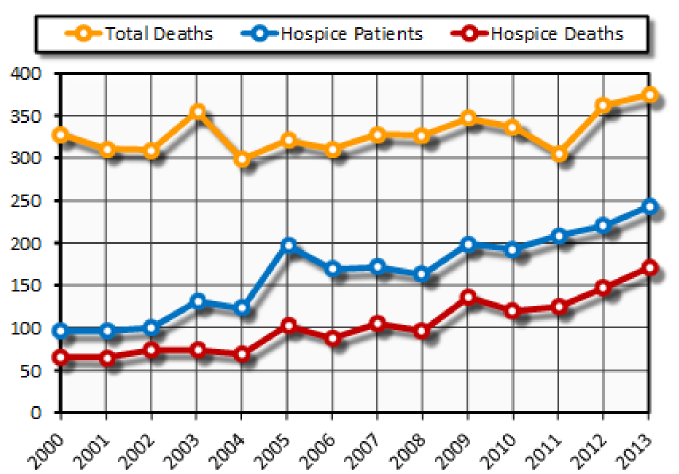


Major Providers for Marshall County in 2013	Patients Served in 2013	Average Census in 2013	ALOS in 2013	Market Share in 2013
CENTER FOR HOSPICE AND PALLIATIVE	188	34	66	77%

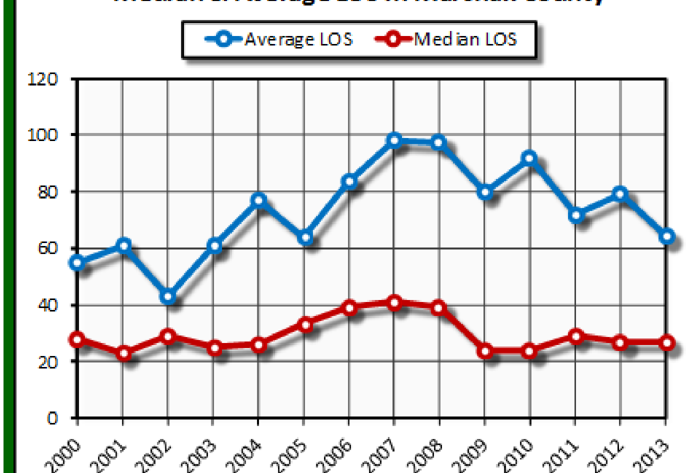
Distribution of Hospice Census in Marshall County for 2013	
Home	57%
Nursing Home	38%
Assisted Living Facility	4%
Hospital	0%
Hospice Facility	1%
Other	0%
Total	100%

Level of Care Mix for 2013		Routine Home Care	Continuous Home Care	General Inpatient	Inpatient Respite
Marshall County	% Days	98.6%	0.0%	1.2%	0.2%
	% Patients	92.2%	0.4%	15.6%	2.5%
Indiana	% Days	98.0%	0.1%	1.6%	0.3%
	% Patients	86.8%	1.9%	18.6%	3.8%
National	% Days	97.6%	0.4%	1.7%	0.3%
	% Patients	87.0%	5.3%	20.7%	3.5%

Deaths and Patients for Marshall County



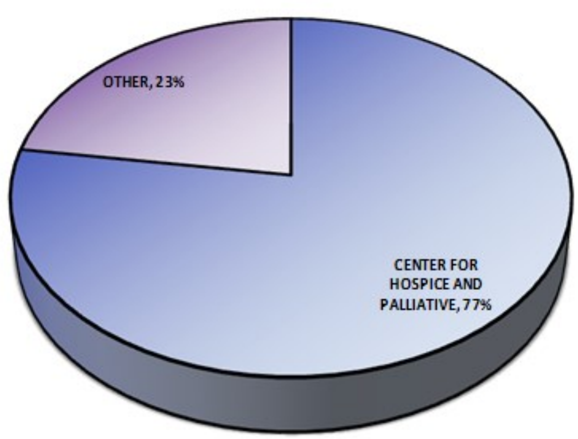
Median & Average LOS in Marshall County



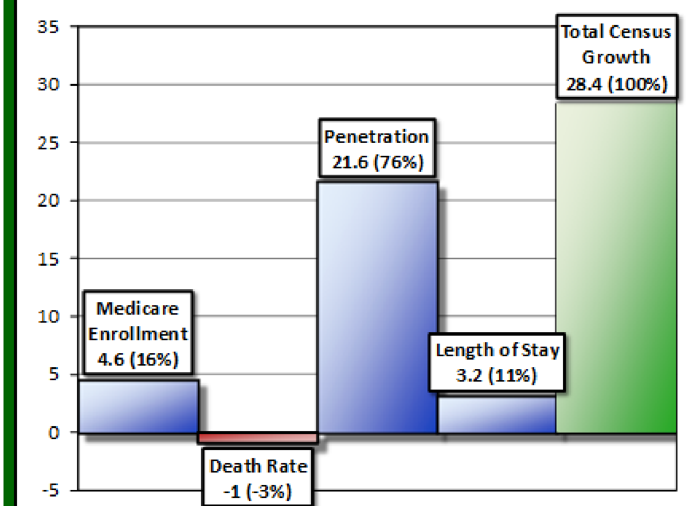
Marshall County, IN

Year	Enrollment	Death Rate per 1000	Deaths	Penetration Rate	Hospice Patients	CENTER FOR HOSPICE AND PALLIATIVE - 151501			
						Market Share	Patients	ALOS	ADC
2000	6,856	48	328	30%	97	89%	86	58	14
2001	6,894	45	310	31%	97	85%	82	58	13
2002	7,005	44	309	33%	101	87%	88	43	10
2003	7,096	50	355	37%	132	76%	100	68	19
2004	7,110	42	299	41%	124	76%	94	78	20
2005	7,217	44	321	62%	198	78%	154	64	27
2006	7,343	42	310	55%	170	78%	133	90	33
2007	7,504	44	328	52%	172	78%	134	107	39
2008	7,674	42	326	50%	164	79%	129	107	38
2009	7,817	44	347	57%	199	83%	166	86	39
2010	7,923	43	337	57%	193	81%	157	93	40
2011	8,130	38	306	68%	209	77%	161	76	33
2012	8,435	43	363	61%	221	80%	177	79	38
2013	8,575	44	375	65%	243	77%	188	66	34

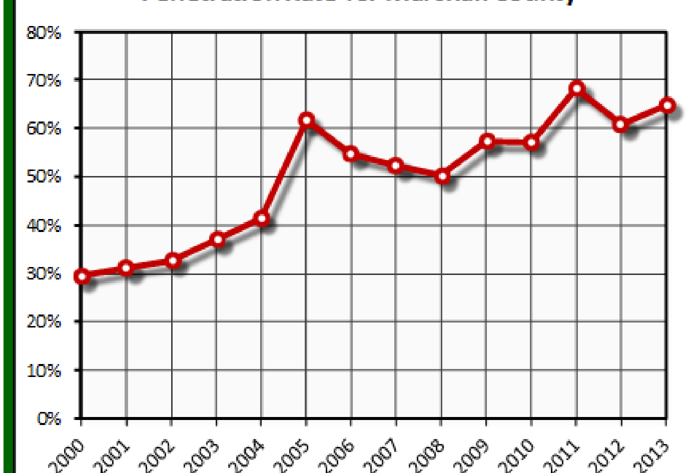
Market Shares in Marshall County for 2013



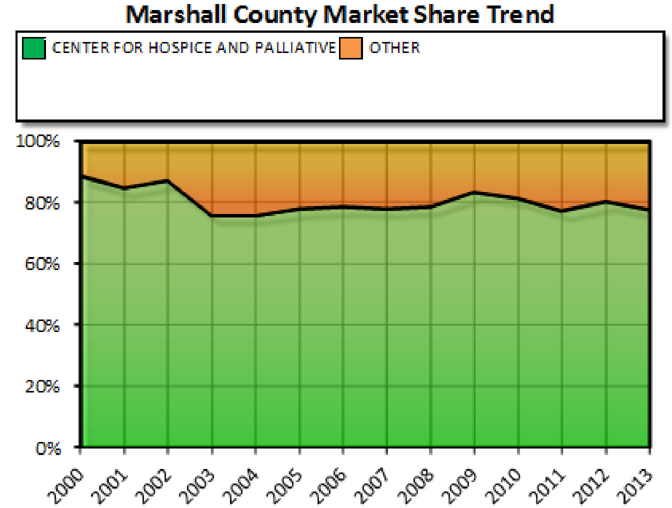
Influence of Identified Factors on Census Growth in Marshall County from 2000 to 2013



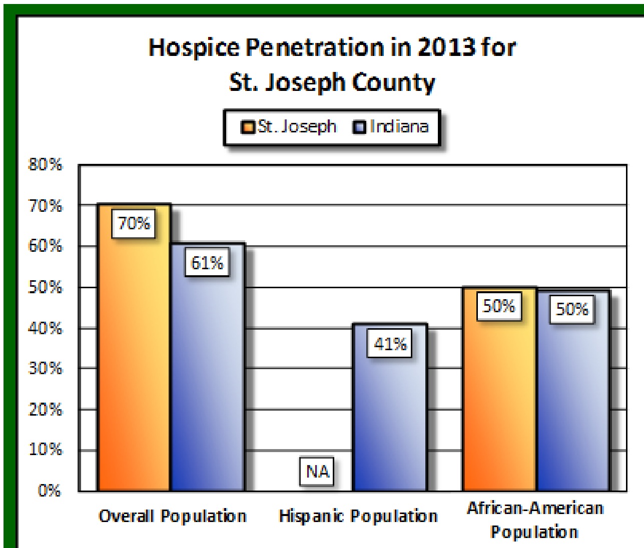
Penetration Rate for Marshall County

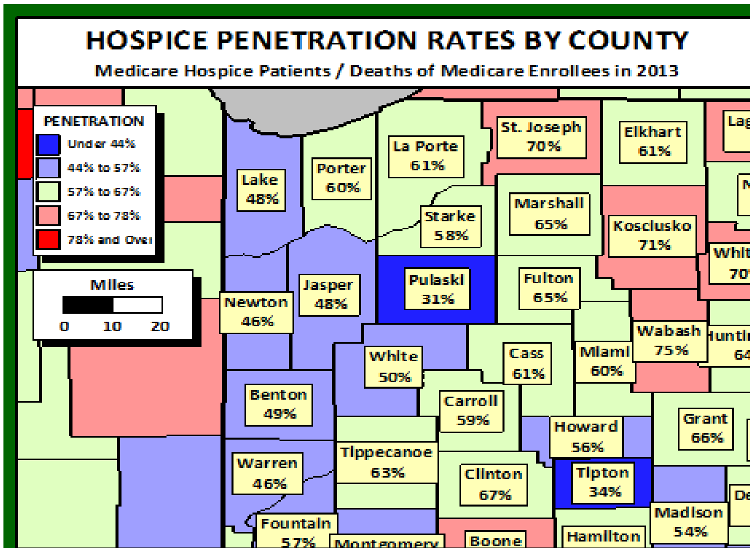


Marshall County Market Share Trend



St. Joseph County, IN

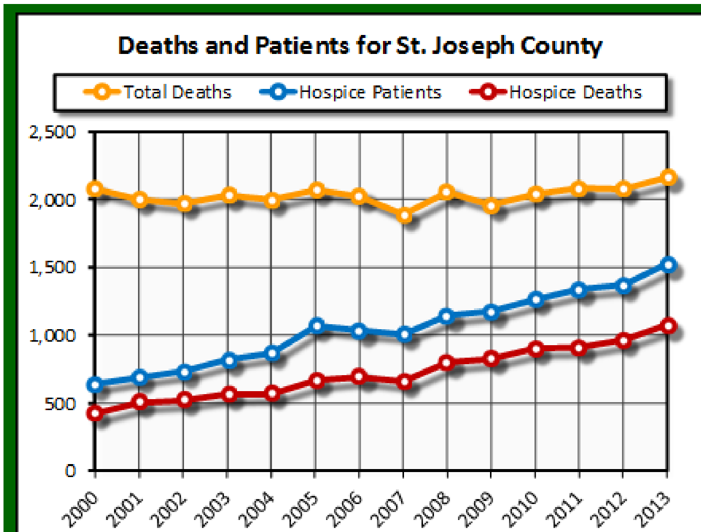


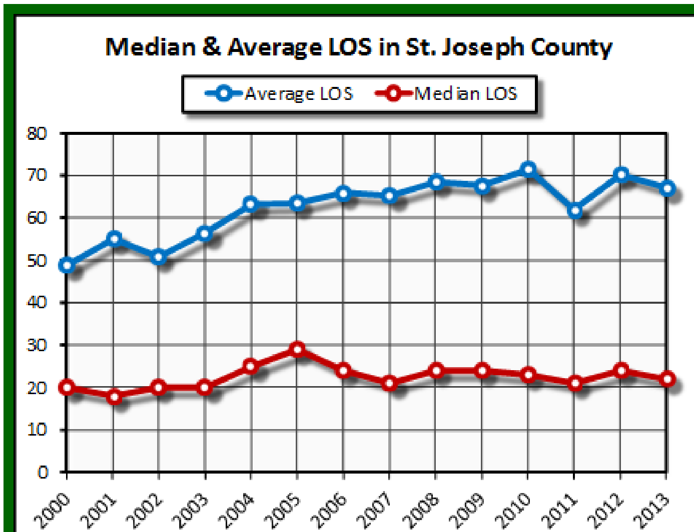


Major Providers for St. Joseph County in 2013	Patients Served in 2013	Average Census in 2013	ALOS in 2013	Market Share in 2013
CENTER FOR HOSPICE AND PALLIATIVE	1,049	168	58	69%
HARBOR LIGHT HOSPICE	144	33	84	9%
SOUTHERNCARE SOUTH BEND	92	23	92	6%
ASERACARE HOSPICE	37	13	132	2%
GRACE HOSPICE	25	7	108	2%

Distribution of Hospice Census in St. Joseph County for 2013	
Home	52%
Nursing Home	31%
Assisted Living Facility	15%
Hospital	0%
Hospice Facility	2%
Other	0%
Total	100%

Level of Care Mix for 2013		Routine Home Care	Continuous Home Care	General Inpatient	Inpatient Respite
St. Joseph County	% Days	98.5%	0.0%	1.2%	0.3%
	% Patients	89.6%	0.9%	17.8%	4.3%
Indiana	% Days	98.0%	0.1%	1.6%	0.3%
	% Patients	86.8%	1.9%	18.6%	3.8%
National	% Days	97.6%	0.4%	1.7%	0.3%
	% Patients	87.0%	5.3%	20.7%	3.5%

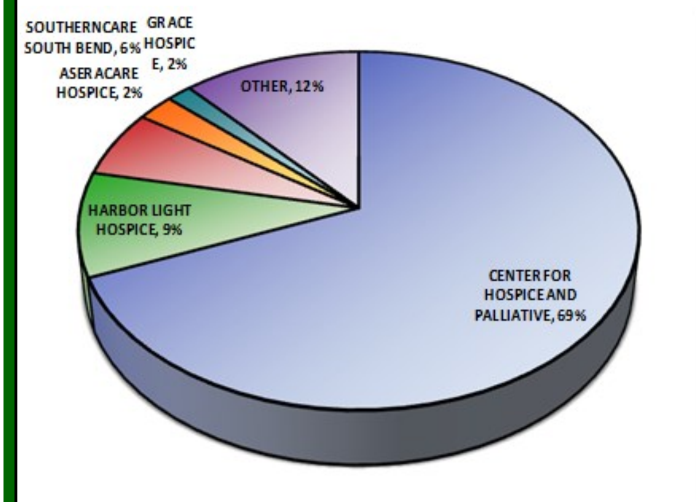




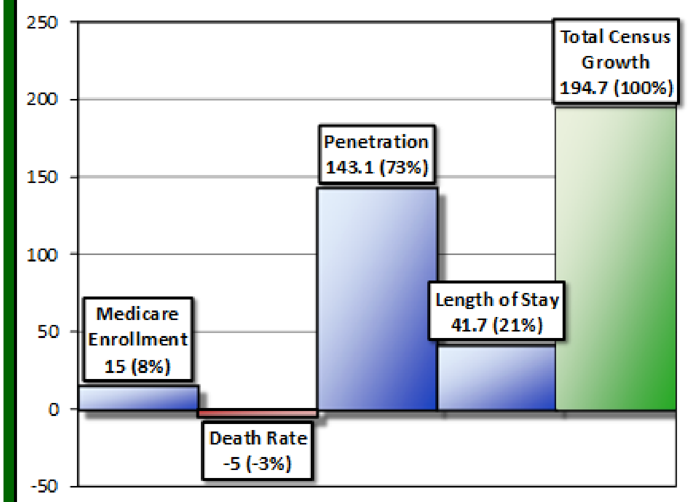
St. Joseph County, IN

Year	Enrollment	Death Rate per 1000	Deaths	Penetration Rate	Hospice Patients	CENTER FOR HOSPICE AND PALLIATIVE - 151501			
						Market Share	Patients	ALOS	ADC
2000	42,394	49	2,077	31%	640	84%	538	47	69
2001	42,247	47	2,001	34%	690	81%	558	53	81
2002	42,132	47	1,969	37%	733	79%	579	49	77
2003	42,150	48	2,033	40%	818	77%	629	56	96
2004	42,161	47	1,997	43%	867	77%	664	61	111
2005	42,495	49	2,069	52%	1,070	76%	818	55	124
2006	42,743	47	2,024	51%	1,033	73%	752	61	126
2007	43,247	44	1,888	53%	1,008	74%	750	64	131
2008	43,789	47	2,056	56%	1,142	76%	868	69	164
2009	44,331	44	1,959	60%	1,173	78%	914	66	165
2010	44,745	46	2,037	62%	1,262	75%	951	70	183
2011	45,820	45	2,081	64%	1,338	72%	961	62	163
2012	47,055	44	2,079	66%	1,365	70%	960	66	175
2013	48,112	45	2,162	70%	1,524	69%	1,049	58	168

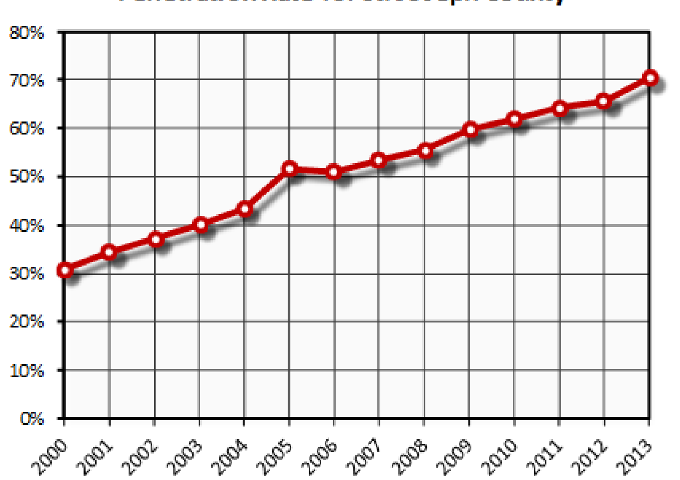
Market Shares in St. Joseph County for 2013



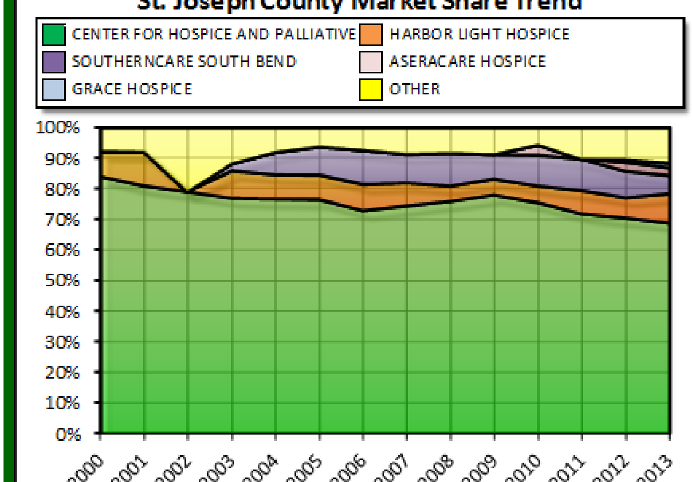
Influence of Identified Factors on Census Growth in St. Joseph County from 2000 to 2013



Penetration Rate for St. Joseph County



St. Joseph County Market Share Trend



Center for Hospice Care
Compliance Committee Meeting Minutes
February 5, 2015

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 3:00 p.m.	
2. Follow Up	• At the 07/22/14 meeting we focused on Health Literacy. One of our goals was to introduce it to staff as the 2014 compliance in-service, which was done at the 09/24/14 staff meeting. The other goal was to create a Health Literacy QAPI. A couple of staff has expressed interest in participating in the QAPI. It will be a goal for 2015.	
3. Palmetto LCD	• No changes.	
4. OIG Report on Hospices in ALFs	• The OIG conducted a study on hospice care provided to Medicare beneficiary patients in ALFs, because Medicare payments for hospice care in ALFs have more than doubled in five years. In 2014 we served a total of 2,123 patients. Of those, 22 (or 1%) spent all or part of the time in a group home, 102 (or 4.8%) in an ALF, and 426 (or 20%) in an ECF. We don’t believe we are at risk to be a target, because our ALF census is very small compared to those agencies where the concern has been raised. Some agencies have two-thirds of their entire census in ALFs. The number of ECF patients we served was down a little in 2014 and the number of ALF patients has stayed pretty flat. So we believe there is no need to be concerned at this time based upon what the OIG is looking for. • The 2015 OIG Work Plan has identified hospice inpatient care and ALFs as an area for further study. Every year Donna T. and Gail educate themselves on what the OIG’s focus has been for the previous or upcoming year. We have worked hard to review the Work Plan on an annual basis and identify any areas where we may want to take a closer look at our own practices. We are very proactive. • The fourth bullet point in the article states 60% of patients admitted to hospice in an ALF had ill-defined conditions, Alzheimer’s and other mental disorders. The OIG portrays these diagnoses as requiring “less complex care.” Most of our dementia patients have very advanced illnesses, so they would likely not be in an ALF to begin	

Topic	Discussion	Action
	with. Some memory units/ Alzheimer units could be either an ALF or ECF.	
5. NOE and NOTR	• In the past there was no specific timeframe for Notices of Election, but delays have led to inaccuracies in the CMS system. CMS had proposed a three-day deadline, but was persuaded to extend it to five calendar days. If the NOE is not signed and processed within five days, we cannot bill for any days of care until the NOE is submitted. Consultants recommend developing a compliance audit process to assess the timely submission of NOEs. We just instituted plans to do a walk behind: one person enters them on Monday and on Tuesday a second person makes sure they went through. In the billing department, everyone knows how to do it, but one person is responsible for it. We will keep this on the agenda for the compliance committee. This issue stems from unscrupulous hospices who admit a patient and then delay filing the NOE while other providers are billing and collecting from Medicare (Part D, ambulance, etc.) and by the time the NOE is filed the hospice is off the hook for covering various items that should have been the payment responsibility of the hospice program.	
6. ZPIC Audits	• According to a published article by a national consultant, there is an uptick in onsite visits by Zone Program Integrity Contractors (ZPICs). They often communicate by fax, resulting in a risk that staff treat the notices as routine and thereby miss important deadlines. As part of preparing for joint commission surveys, hospitals prep their staff on how to answer specific questions if asked by a government auditor, so their answers are consistent and correct. Is there anything else we should be incorporating into an annual in-service in preparation for a ZPIC audit? Does staff know where to find information? We could have something on the staff website. A good annual compliance in-service for staff would be a review of what we already do: how we determine Medicare hospice eligibility, the checks and balances we already have in place, how to answer inquiries, etc. Make education a part of the annual compliance in-service. We could come up with specific questions and educate staff how to respond. • Services provided after hours – Have seen some emails from staff asking how to find out who is on call. Is there a way to put that information on the staff website in a different way? Do we need to identify someone to keep the call schedules updated on the website? Share an on call schedule? We also see emails asking who we have contracts with. It is already on staff website. We have to make sure it gets updated regularly. We need to educate staff on how to access their resources.	
7. Compliance	• This is the year for the biannual review of the Medicare Hospice and Medicare Home	

Topic	Discussion	Action
Plans	Health Compliance Plans. We do want to continue to do it at least biannually. At the next meeting we will review the hospice compliance plan, and then home health at the next meeting. They are on the staff website under Policies. Please review your area of responsibility and bring recommendations for any changes and updates to the meeting.	
8. Other	• What other topics do we want to discuss this year? What direction do you see the committee going? Feel free to send comments or agenda items to Vicki.	
Adjournment	• The meeting adjourned at 3:40 p.m.	Next meeting 05/07

Center for Hospice Care

Goals for Calendar Year 2014

Updated 12/18/14

Goal A: Enhance Patient Care

Category	Status	Goal
Administration	In Process	1. Investigate and correct the low utilization of GIP at CHC Hospice Houses.
	In Process	2. Contract with SNF medical directors to do Face-to-Face visits of CHC patients in their facilities.
	Met	3. Explore creating a separate physician practice corporation/entity to expand billing possibilities and positions for the future.
Admissions	In Process	1. Increase referral conversion rate to 70%.
	In Process	2. Increase same day referral/admissions by 33%.
	In Process	3. Decrease number of missing prognosis on diagnosis screen by 75%.
	In Process	4. Scanning compliance 100%.
Volunteers	Met	1. Finalize and implement online training program.
	In Process	2. Update volunteer section of the CHC website to include an electronic application packet, FAQ, and volunteer opportunities.
	Met	3. Increase collaboration and support of ECFs in all service areas.
	In Process	4. Get new volunteer training manual to all volunteers.
	Met	5. Continue to provide ongoing education and skills validation of patient care volunteers.
	Met	6. Improve collaborate with the Hospice Foundation staff in terms of volunteer participation and support for events.
	Met	7. Increase communication with the community liaisons.
	Met	8. Update volunteer training manual.
	Met	9. Recruit more male volunteers and patient care, pet visitation, and barber/hair stylist volunteers.

Category	Status	Goal
Nursing	Met Met In Process Met Met Met Met Met In Process	1. Develop and implement Pediatric ELNEC training program for new nurse orientation. 2. Establish clinical staff training on QIS process and staff interviews for ECF survey audits. 3. Establish patient acuity rating and process to update changes in the medical record as the patient condition changes. 4. Complete Pediatric ELNEC staff training. 5. Establish nursing preceptor program. 6. Implement discharge hospice item set. 7. Implement OASIS C1. 8. Implement structured, internal study aids to assist staff nurses in preparation for the CHPN exam. 9. Perform QAPI studies over next year to improve quarterly FEHC scores on "top three opportunities for improvement." (D8 – Confidence in expectations while patient was dying; G2B – Family agreed with changes in the plan of care; D9 – Confidence in knowing what to do at time of death.)
Bereavement	Met Met Met Met Met	1. Create and implement a systematic process for the Bereavement Department to contact and offer services to DBA bereaved. 2. Develop and implement an educational training program for the Mayo Clinic Fellows in Hospice and Palliative Medicine who will be rotating through CHC. 3. Explore possible resources for obtaining appropriate referrals from veteran organizations as an extension of the "We Honor Veterans" program. 4. Utilize a researched and validated tool to measure art counseling client improvement. 5. Perform QAPI study over next year and initiate procedures to further improve quarterly FEHC scores on question E4 (Emotional support to family AFTER patient's death).
Social Work	In Process In Process Met Met Met	1. Develop and implement new problems, goals and objectives for the social work plan of care. 2. Assist in the development of the CHC Pediatric Palliative Care Program. 3. Ensure social workers are documenting in a timely manner and in the appropriate places in the chart. 4. Develop social work educational materials regarding initial assessment talking points, caregiving, VA benefits, algorithm for calling the police, reporting to APS. 5. Perform QAPI study over next year and initiate procedures to further improve quarterly FEHC scores on question B10 (Help with patient's feelings of anxiety or sadness).

Category	Status	Goal
Spiritual Care	Met Met Met Met Met Met Met Met	1. Establish guidelines to offer enough spiritual care contact to patients and families to improve FEHC scores. 2. Define process for reviewing care plans – best practices. 3. Professional Chaplaincy Education – monthly from SCC who is assigned Reflection. 4. Address scale changes for Spiritual Comfort Measurement. 5. Host Pastoral Care Breakfast, October, 2014. 6. Coordinate with Bereavement and Admissions the offering of Spiritual Care services to families of patients who die before they are admitted (DBA's). They have chosen us, but just did not live long enough to become a patient. 7. Co-host annual Memorial Service, December 2014. 8. Perform QAPI study over next year and initiate procedures to improve quarterly FEHC scores on question E2 (Right amount of religious or spiritual contact).
Medical Directors	Met In Process In Process In Process Met In Process	1. Establish CHC Medical Staff members as medical director/co-director/committee member of the Palliative Medicine Services of Memorial Hospital of South Bend and Kindred Hospital Northern Indiana, and then use these positions as opportunities to re-educate staff physicians regarding earlier H&PM referrals. (These positions have already been achieved at EGH and SJRMC.) 2. Assist in development of the CHC Pediatric Palliative Care Program. 3. Assist in recruitment of a fourth Board-Certified Hospice and Palliative Medicine Physician. 4. Staff the CHC Palliative Care Center upon its completion on the Mishawaka Campus. 5. Successfully function in our new capacities as Staff Physicians of both the Mayo Clinic and the Indiana University School of Medicine South Bend, teaching the Mayo Palliative Care Fellows, IU-SOM-SB medical students, and the SJRMC and Memorial Family Medicine residents. 6. Recruit new Face-to-Face Visit physicians from the local medical and ECF Medical Director community.

Goal B: Position for Future Growth

Category	Status	Goal
Administration	Not Doing Not Met	1. Apply for the CMS Concurrent Care Demonstration Project. 2. Explore creating a Geriatric Physician Practice component of part-time physicians (possibly retired) and specifically target ALFs.
Foundation Staffing	In Process	1. Hire Director of Education.
Mishawaka Campus	Met Met Met In Process In Process In Process	1. Secure a lead gift and cultivate prospective major donors. 2. Complete Palliative Care Center remodel. 3. Update internal and external communication strategy. 4. Complete Campus Grounds Project. 5. Design Phase II new construction. 6. Secure New Market Tax Credits for Phase I.
Uganda	Met In Process Met Met Met	1. Secure grant funding for PCAU. 2. Complete Road to Hope Film. 3. Host a *Circle of Caring* event in conjunction with Rose's visit. 4. Recruit and fund eight additional CPCC students from underserved districts in Uganda. 5. Establish internship program with Holy Cross College.
Education	In Process In Process Not Met Not Met Not Met Not Met Met	1. Develop Institute for Advance Care Planning website. 2. Work with IU School of Medicine to become a site for their fellowship program in palliative medicine. 3. Develop comprehensive end-of-life planning curriculum which can be delivered through local area professionals and faith communities. 4. Work with local college(s) to develop programs to offer CEU awarding seminars for local area professionals about end-of-life issues relevant to their profession. 5. Develop initial online courses. 6. Develop video education series about end-of-life planning matters using various local area professionals. 7. Develop an *Okuyamba* teaching guide for delivery by FHSSA partners, colleges and universities.

Goal C: Maintain Economic Strength

Category	Status	Goal
Administration	Not Met Not Doing	1. Begin the development of new CHC resources to measure and manage pain and other symptoms in hospice patients using teachable innovative systems. 2. Begin a private duty line of business and test it first on the home health side of CHC's business.
Fund Raising and Stewardship	In Process Met Met Met In Process Not Doing In Process	1. Develop and implement planned giving program and materials. 2. Solicit corporate sponsors to underwrite printing and postage costs for Crossroads. 3. Ask board members to invite friends to a campus event as a way in which to raise awareness, potential donors, and prospective board members. 4. Launch silent phase of 5-year "Cornerstones for Living: The Crossroads Campaign." 5. Create a Helping Hands Award Wall of Fame. 6. In collaboration with "We Believe" committee, host a thank you/stewardship event for all current "We Believe" fund donors. 7. Establish Mishawaka Campus outdoor memorial giving/commemoration opportunities similar to those at Elkhart Campus' Gardens of Remembrance.

Goal D: Continue Building Brand Identification

Category	Status	Goal
Administration	Met Not Met In Process Not Met Met	1. Explore finding partners with extended care facilities using the FHPC Pittsburg model as a basis for creating a partnership and formal affiliation agreement. 2. Begin exploring a program where the general public can make an appointment and come to the office and receive education and materials regarding advanced directives from a trained CHC professional. 3. Involve CHC staff in the creation of innovative, remarkable, memorable experiences to delight the senses for: the First Day of Patient Care, the First Day of Patient Care with children present, the First Day of Employment with CHC, the First Day of Volunteering, the First Contact from a new Referral Source, etc. 4. Begin the steps necessary to apply for the Circle of Life Award in 2015. 5. Begin efforts to gain an understanding of basic and advanced CHC customer segmentation and then create mechanisms to meet the diverse needs of CHC constituents.

Category	Status	Goal
Marketing	In Process In Process In Process Met Met In Process In Process Met	1. Begin “score carding” by using explicit tools to create report cards between CHC and referral sources. Publish our pain and symptom scores. Promote CHC’s QAPI data, FEHC scores, etc. 2. Update print collateral material (core and condensed brochures, dementia, Breathe Easy, grief services, volunteer, CAM). 3. Create a HeartWize brochure for referral sources. 4. Begin a digital marketing campaign focusing on St. Joseph County; track progress in three-month increments. 5. Enhance social media presence on Facebook and Twitter. 6. Post President’s blog twice a month (24 blogs written and ready to post). 7. Post Medical Director’s blog twice a month (24 blogs written and ready to post). 8. Update web photos and graphics.

Center for Hospice Care

Goals for Calendar Year 2015

Updated 02/10/15

Goal A: Enhance Patient Care

Category	Status	Goal
Administration		1. Investigate and correct the low utilization of GIP at CHC Hospice Houses by creating and implementing a protocol to insure appropriate levels of GIP for CHC census size when compared to like organizations' census and use of GIP as a percent of all days. . 2. Contract with Family Medicine residents at SJRMC and Memorial Hospital to do face-to-face visits of CHC patients. 3. Reboot Palliative Care programming with the Center for Palliative Care, promote availability of palliative care consults at the CPC, develop promotional materials for clinical indicators for referring a palliative care consultation and expand those into disease specific programs for Cardiac, COPD, Cancer, Dementia, and Neurological diseases with a strong emphasis on CHC's expertise in advance care planning, goals of care assistance, and education on end-of-life decision-making. 4. Develop a specific pediatric palliative care program along with the marketing materials to support it with an emphasis on CHC clinical staff having been trained in the ELNEC Pediatric Palliative Care education modules. 5. Begin tracking and reporting monthly the percentage of deaths that had a seven day or less LOS. 6. Adopt Hospice of Northwest Ohio's "Every Person Every Time" for standardized, predictable patient care experiences. 7. Implement a Healthcare Literacy QAPI to increase our patients' and families' capacity to obtain, process, and understand the information provided to them regarding hospice services. 8. Establish an effective internal process to add related diagnoses codes to the primary diagnosis code within the Cerner software suite allowing them to appropriately be listed on the Medicare billing sent to Palmetto GBA.
Admissions		1. Increase referral conversion rate to 70%. 2. Increase same day referral/admissions by 33%. 3. Decrease number of missing prognosis on diagnosis screen by 75%. 4. Begin process for tracking the percentage of Palliative Care Consults that convert to hospice admissions, as well as the location where the consultation took place, along with the number of days between consult and hospice admission. 5. Complete training and begin utilizing phone reporting capabilities in the intake department.

Category	Status	Goal
Volunteers		1. Update volunteer section of the CHC website to include an electronic application packet, FAQ, and volunteer opportunities. 2. Get new volunteer training manual to all volunteers. 3. Explore ways to improve the TB process portion of volunteer training. 4. Explore ways to improve the Volunteer Training Manual, making it more user-friendly. 5. Create a specialized training for Veterans to become volunteers in the We Honor Veterans initiative. 6. Explore ways to modify and enhance the Volunteer Refresher Training Course. 7. Write one volunteer feature each quarter to be used in Choices, CHC's website, and social media. 8. Explore options of paperless time sheets for volunteers to increase efficiency. 9. Devise a letter to be included in the admission packet regarding volunteer services. 10. Explore volunteer-to-volunteer program which utilizes current volunteers to mentor new volunteers at designated intervals. 11. Explore the job opportunities for volunteers that want to work from home.
Nursing		1. Develop and implement Pediatric ELNEC training program for new nurse orientation. 2. Establish patient acuity rating and process to update changes in the medical record as the patient condition changes and use this system as a trigger for Hospice House admissions. 3. Establish nursing preceptor program. 4. Implement OASIS C-1. 5. Implement structured, internal study aids to assist staff nurses in preparation for the CHPN exam. 6. Evaluate in-house RN Triage effectiveness and productivity. 7. Develop employee appreciation program within the Nursing department.

Category	Status	Goal
Bereavement		1. Improve the bereavement page of the CHC website by including grief education and links to bereavement resources. 2. Create a folder of information for Perinatal Referral Families in conjunction with the Admissions Department. 3. Update the Bereavement Mailing Program by returning to the “Reflections” publication used in the past, and to distribute it one month after a death, and then every other month for a total of six distributions. 4. Improve bereavement counseling support for Veterans by having all Bereavement Counselors complete Tier One Veterans Training and for eligible counselors to continue with Tier 3 Trainings. 5. Develop plan for partnering with local Veterans agencies to honor Veterans around Veterans Day. 6. Work with the Spiritual Care and Social Work Departments to develop and conduct a self-care educational program for care staff during the last quarter of 2015.
Social Work		1. Assist with the development of the Center for Pediatric Palliative Care program and create a resource library for patients/families and staff. 2. Complete development and implementation new problems, goals and objectives for the social work plan of care. 3. Develop a format for IDT notes and other documentation and educate the social workers regarding appropriate content and where to consistently document various notes in the Cerner EMR. 4. Work with the Bereavement and Spiritual Care Departments to develop and conduct a self-care educational program for care staff during the last quarter of 2015. 5. Ensure each social worker views 12 NHPCO webinars in the year. 6. Explore NASW CHP-SW credentialing and decide whether to pursue this option.

Category	Status	Goal
Spiritual Care		1. Review and update the Spiritual Comfort Measure for patients and convert from a scale of -3 to +3 to a scale of 0-10 scale to align with the medical patient pain scale, and by 06/30/15 write an article for publication in an industry journal or newsletter by the end of the year. 2. Establish a Community Faith Leaders Liaison list of 40 individuals—five per SCC. This liaison list will then serve a number of purposes, including educational, marketing, and resource. 3. Work with the Bereavement and Social Work Departments to develop and conduct a self-care educational program for care staff during the last quarter of 2015. 4. Develop two questions for the new Press Ganey CAHPS Hospice Survey which address the quality of spiritual care services provided to patients and to caregivers. 5. Develop a format for IDT notes and other documentation and educate the spiritual care counselors regarding appropriate content and where to consistently document various notes in the Cerner EMR.
Medical Directors		1. Assist in recruitment of two NPs and two HPM physicians. 2. Assist in recruitment of F2F physicians/NPs to offload all of our F2F visits from present medical staff. 3. Complete development of CHC Pediatric Palliative Care Program. 4. Open the Center for Palliative Care on the Mishawaka campus. 5. Complete original Certification of Terminal Illness within seven calendar days of admission. 6. Decrease the number of days delay in billing to less than the national average.

Goal B: Position for Future Growth

Category	Status	Goal
Administration		1. Investigate the development of a Geriatric Physician Practice. 2. Continue seeking advisory board opportunities for CHC participation, consultations, speaking opportunities. 3. To make our mission irreplaceable in the community, begin work on the next Strategic Plan by beginning processes to convene healthcare leaders to design what end-of-life care should look like within the communities we serve.
Mishawaka Campus		1. Complete Campus Grounds Project. 2. Design Phase II new construction. 3. Continue to attempt to secure New Market Tax Credits.
Uganda		1. Complete Road to Hope Film. 2. Co-sponsor bi-annual palliative care conference, including participation by two CHC staff members. 3. Improve messaging strategies for Hospice Foundation's international initiatives regarding the correlation between palliative care for patients and educational support for orphaned child caregivers in Uganda. 4. Work with PCAU leadership to ID and implement methods to improve ability to communicate electronically and digital.
Education		1. Hire Director of Education. 2. Develop and launch Institute for Hospice/Advance Care Planning website. 3. Similar to the Mayo Clinic, work with IU School of Medicine in Indianapolis to become a site for their Fellowship program in palliative medicine. 4. Develop comprehensive end-of-life planning curriculum, which can be delivered through local area professionals and faith communities. 5. Work with local college(s) to develop programs to offer CEU awarding seminars for local area professionals about end-of-life issues relevant to their profession. 6. Develop initial online courses, e.g., how to choose a healthcare representative, how to effectively document advance directives, etc. 7. Develop online video education series about end-of-life planning matters using various local area professionals.

Goal C: Maintain Economic Strength

Category	Status	Goal
Administration		1. Adopt a spend management approach by using Atlanta-based Brookside Group to perform recovery audit contracting and begin with CHC's Enclara pharmacy costs.
Fund Raising and Stewardship		1. Develop and implement planned giving program and materials. 2. Create a Helping Hands Award Wall of Fame. 3. Establish Mishawaka Campus outdoor memorial giving/commemoration opportunities similar to those at Elkhart Campus' Gardens of Remembrance. 4. Secure Leighton Foundation match for palliative care initiative. 5. Develop strong Quality Management Review process to improve quality and consistency of communications across functional areas, which includes testing of all electronic communications (websites, e-newsletters, etc.) to ensure they are accurate, current and properly linked prior to dissemination. 6. Complete design and begin fundraising efforts for a Veteran's Memorial to be located on the Mishawaka Campus. 7. Reach $4 million in total combined pledges and cash-in-hand for Cornerstones for Living: The Crossroads Campaign by 12/31/15.

Goal D: Continue Building Brand Identification

Category	Status	Goal
Administration		1. Move beyond WOW to the original intent of creating innovative, remarkable, and memorable "tell your friends about it" experiences for the constituencies listed in the Strategic Plan and involve CHC staff in the development of the program.
Marketing		1. Roll out new CHC website. 2. Begin "score carding" by using explicit tools to create report cards between CHC and referral sources. Publish our pain and symptom scores. Promote CHC's QAPI data, FEHC scores, etc. 3. Create a HeartWize brochure for referral sources. 4. Explore ways to promote our pediatric palliative care initiative. 5. Review and update existing referral source handouts, e.g., HeartWize, hospice triggers, etc. 6. Post President's blog twice a month (24 blogs written and ready to post). 7. Post Medical Director's blog twice a month (24 blogs written and ready to post. 8. Include "value propositions" in marketing materials to physicians and ECFs regarding both hospice and the rebooted palliative care program. 9. Begin actively promoting CHC's membership in the Advisory Board Company. 10. Get the re-admission data from The Advisory Board Company's Post-Acute Care Mapping Tool by hospital for CHC and its competitors and use it with hospitals and discharge planners. Promote and use the data, for example, "If they use another hospice, patients are six times more likely to be readmitted to the hospital within 30 days." 11. Begin a CHC "Book Club" in CHOICES magazine with the assistance of various CHC departments to recommend books and resources to help the general public with end-of-life issues and challenges.

Center for Hospice Care

Conflict of Interest Policy

Article 1

Purpose

The purpose of the conflict of interest policy is to protect the Center for Hospice Care's (CHC) interest when it is contemplating entering into a transaction or arrangement that might benefit the private interest of an officer or director of CHC or might result in a possible excess benefit transaction. This policy is intended to supplement but not replace any applicable state or federal laws governing conflict of interest applicable to nonprofit and charitable organizations.

Article II

Definitions

1. Interested Person – Any director, principal, officer, or member of a committee with governing board delegated powers, who has a direct or indirect financial interest, as defined below, is an interested person.

2. Financial Interest – A person has a financial interest if the person has, directly or indirectly, through business, investment, or family:
   a. An ownership or investment interest in any entity with which CHC has a transaction or arrangement,
   b. A compensation arrangement with CHC or with any entity or individual with which CHC has a transaction or arrangement, or
   c. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which CHC is negotiating a transaction or arrangement.

Compensation includes direct and indirect remuneration as well as gifts or favors that are not insubstantial.

A financial interest in not necessarily a conflict of interest. Under Article III, Section 2, a person who has a financial interest may have a conflict of interest only if the appropriate governing board or committee decides that a conflict of interest exists.

Article III

Procedures

1. Duty to Disclose – In connection with any actual or possible conflict of interest, an interested person must disclose the existence of the financial interest and be given the opportunity to disclose all material facts to the directors and members of committees with governing board delegated powers considering the proposed transaction and arrangement.

2. Determining Whether a Conflict of Interest Exists – After disclosure of the financial interest and all material facts, and after any discussion with the interested person, he/she shall leave the governing board or committee meeting while the determination of a conflict of interest is discussed and voted upon. The remaining board or committee members shall decide if a conflict of interest exists.

3. Procedures for Addressing the Conflict of Interest –
   a. An interested person may make a presentation at the governing board or committee meeting, but after the presentation, he/she shall leave the meeting during the discussion of, and the vote on, the transaction or arrangement involving the possible conflict of interest.
   b. The chairperson of the governing board or committee shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.
   c. After exercising due diligence, the governing board or committee shall determine whether CHC can obtain with reasonable efforts a more advantageous transaction or arrangement from a person or entity that would not give rise to a conflict of interest.
   d. If a more advantageous transaction or arrangement is not reasonably possible under circumstances not producing a conflict of interest, the governing board or committee shall determine by a majority vote of the disinterested directors whether the transaction or arrangement is in CHC's best interest, for its own benefit, and whether it is fair and reasonable. In conformity with the above determination it shall make its decision as to whether to enter into the transaction or arrangement.

4. Violations of the Conflicts of Interest Policy
   a. If the governing board or committee has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest, it shall inform the member of the basis for such belief and afford the member an opportunity to explain the alleged failure to disclose.
   b. If, after hearing the member's response and after making further investigation as warranted by the circumstances, the governing board or committee determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

Article IV
Records of Proceedings

1. Records of Proceedings – The minutes of the governing board and all committees with board delegated powers shall contain:
   a. The names of the persons who disclosed or otherwise were found to have a financial interest in connection with an actual or possible conflict of interest, the nature of the financial interest, any action taken to determine whether a conflict of interest was present, and the governing board's or committee's decision as to whether a conflict of interest in fact existed.
   b. The names of the persons who were present for discussions and votes relating to the transaction or arrangements, the content of the discussion, including any alternatives to proposed transaction or arrangement, and a record of any votes taken in connection with the proceedings.

Article V
Compensation

1. A voting member of the governing board who receives compensation, directly or indirectly, from CHC for services is precluded from voting on matters pertaining to the member's compensation.

2. A voting member of any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from CHC for services is precluded from voting on matters pertaining to that member's compensation.
3. No voting member of the governing board or any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from CHC, either individually or collectively, is prohibited from providing information to any committee regarding compensation.

Article VI

Annual Statements

1. Annual Statements – Each director, principal officer and member of a committee with governing board delegated powers shall annually sign a statement which affirms such person:
   a. Has received a copy of the conflicts of interest policy,
   b. Has read and understands the policy,
   c. Has agreed to comply with the policy, and
   d. Understands CHC is charitable and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of its tax-exempted purposes.

Article VII

Periodic Reviews

1. Periodic Reviews – To ensure CHC operates in a manner consistent with charitable purposes and does not engage in activities that could jeopardize its tax-exempt status, periodic reviews shall be conducted. The periodic reviews shall, at a minimum, include the following subjects:
   a. Whether compensation arrangements and benefits are reasonable, based on competent survey information and the result of arm's length bargaining.
   b. Whether partnerships, joint ventures, and arrangements with management organizations conform to CHC's written policies, are properly recorded, reflect reasonable investment or payments for goods and services, further charitable purposes and do not result in inurement, impermissible private benefit or in an excess benefit transaction.

Article VIII

Use of Outside Experts

1. Use of Outside Experts – When conducting the periodic reviews as provided for in Article VII, CHC may, but need not, use outside advisors. If outside experts are used, their use shall not relieve the governing board of its responsibility for ensuring periodic reviews are conducted.

________________________________ ________________

Signature **Date**

2010

Center for Hospice Care
choices to make the most of life

CHAPTER FOUR

POLICIES

New

CLINICAL RECORD REVIEW

REGULATION: 42 CFR 418.58 – Quality assessment and performance improvement

PURPOSE: To ensure all patient clinical records are reviewed for compliance with state and federal guidelines, and established Agency policies.

POLICY: Designated employees will audit patient medical records on a monthly basis. Identified results will be reported to the Quality Improvement Committee on a quarterly basis. There will be at least one committee member to represent each scope of service provided each quarter.

PROCEDURE:

1. Clinical records will be reviewed monthly by designated employees from the Quality Assurance (QA) department. Portions of the medical record related to therapies will be reviewed by individuals trained in the therapy specialty.

2. Each person completing a review of the medical record will utilize the QA Chart Review form and the Documentation Audit form.

3. Monthly clinical record reviews will be reported to the managers of each Interdisciplinary Team (IDT) discipline.

4. Results of the medical record audits will be reviewed and approved at the quarterly Quality Improvement Committee meeting, which includes at least one member of the Agency Board of Directors.

Effective Date: 01/15	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

DRESS CODE

Our organization's image is reflected by our employees. We ask that all employees take pride in their professional appearance, and that everyone is clean, well groomed, and appropriately dressed for their position.

Employees who come in contact with patients and families should be aware as professionals that attention to details in appearance will help instill confidence in patients and families. Projecting a professional appearance projects professional care.

CHC has established the following guidelines, which include, but are not limited to:

1. Agency i~~I~~dentification must be worn at all times by patient care staff.
2. Fingernails should be clean, well-trimmed, and not interfere with duties. Based on CDC and OSHA guidelines to reduce the risk of healthcare acquired infection, artificial nails (including acrylics, gels, wraps, overlays, etc.) are not to be worn by anyone with patient contact or patient food preparation. Nail polish may be worn on natural nails by patient care staff, but it should not be chipped.
3. Perfume/cologne should not be worn by patient care staff ~~with discretion~~.
4. Hair should be clean and neatly fashioned. Patient care staff must keep long hair tied back when performing patient care. Hospice House staff must do so at all times.
5. Jewelry can be worn sparingly, for example, rings, watches, short necklaces, and small earrings. Jewelry may not be worn on visible pierced body parts (excluding ears).
6. Clothing should not be form fitting (spandex, Lycra) or reveal lines/color of undergarments.
7. Clothing cannot display questionable ~~wording or~~ graphics or any wording; this includes, but is not limited to, alcohol or tobacco logos.
8. Non-canvas athletic shoes may be worn by direct patient care staff, if they are appropriate to dress. They must also be solid in color. Nurses and Aides providing patient care must wear closed toe shoes.
9. Bib overalls, sweat pants, shorts, and denim pants are not permitted.
10. Business Capri pants must be of a length to cover the calf portion of the leg. Individual supervisors will be responsible for ensuring that staffs who wear Capri pants meet agency expectations for professional appearance.
11. Skirts or dresses should not be more than two inches above the knee.
12. Patient care staff is required to wear Agency~~CHC~~ issued logo wear~~scrubs or jackets~~ when making patient visits~~going into ECF's or Assisted Living Facilities~~. All Nurses and Aides are required to wear Agency issued scrubs when providing patient care. Additional Agency issued logo wear and scrubs will be available for purchase on the CHC website.

Individual supervisors are responsible for ensuring that the appearance of their employee is appropriate, and may, at his/her discretion, in consultation with the Director of Human Resources, implement and define appearance standards which are more restrictive than those listed above, but never less restrictive. Employees who appear for work inappropriately dressed may be sent home and directed to return to work in proper attire. Under such circumstances, hourly employees will not be compensated for the time away from work. Dress Code policy violations will be handled in accordance with the Progressive Discipline policy.

Revised 12/14~~04/14~~

D R A F T - New

USE OF CHC OWNED FACILITIES FOR STAFF PERSONAL EVENTS

CHC will occasionally grant permission for staff to hold events for co-workers only such as baby showers, retirement parties, etc., at one of our owned facilities. All requests require approval by a member of the CHC Administrative Team. If approved, staff must be present on a volunteer basis and may be required to take on responsibility and accountability for the event and the facility use, including being personally present before, during and after the event, clean up, and ensure the security of the facility. It is the general intent that such events would only be held outside CHC's regular weekday business hours of 8 AM to 5 PM. No alcohol will be permitted at these events.