Board of Directors Meeting
501 Comfort Place, Conference Room A, Mishawaka
October 21, 2015
7:30 a.m.

BOARD BRIEFING BOOK

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CHAPTER ONE

AGENDA

Center for Hospice Care

BOARD OF DIRECTORS MEETING
Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
October 21, 2015
7:30 a.m.

A G E N D A

1. Approval of August 19, 2015 Minutes *(action)* – Amy Kuhar Mauro (2 minutes)

2. President's Report *(information)* - Mark Murray (20 minutes)

3. Finance Committee *(action)* – Wendell Walsh (10 minutes)
   (a) August and September 2015 Financial Statements

4. QI Committee Report *(information)* – Carol Walker (3 minutes)

5. Foundation Update *(information)* – Corey Cressy (13 minutes)

6. Board Education – *(information)* – Quality Assurance Performance Improvement Update – Sue Morgan, RN, BS, MS, DON (10 Minutes)

7. Chairman's Report *(information)* – Amy Kuhar Mauro (2 minutes)

Next meeting December 16, 2015 at 7:30 a.m.

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Center for Hospice Care
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CHAPTER TWO

MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
August 19, 2015

Members Present:	Amy Kuhar Mauro, Ann Firth, Corey Cressy, Jesse Hsieh, Lori Turner, Mary Newbold, Suzie Weirick, Tim Portolese, Tim Yoder, Wendell Walsh
Absent:	Anna Milligan, Becky Asleson, Carol Walker, Francis Ellert, Michael Method
CHC Staff:	Mark Murray, Amy Tribbett, Dave Haley, Karl Holderman, Mike Wargo, Sue Morgan, 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 06/17/15 meeting as presented. The motion was accepted unanimously.	T. Portolese motioned S. Weirick seconded
3. President's Report	• A copy of the most recent H&P newsletter, a Bike Michiana for Hospice promotional postcard, and Race Play Michiana (RPM) newsletter with coverage of our Bike and Walk events were distributed at the meeting. • Welcome Sue Morgan to the board meetings in her new role as Director of Nursing. She was hired as DON on April 6th and joined the Administrative Team on July 6th. • The ADC for July was 414, a 9% increase. Census was over 400 every day in July. So far ADC in August is 410. Overall referrals are up 5%, the number of patients served is up 1%, and the ADC is up 10%. Original admissions are down 5%. The average length of stay is up. Referrals from self/family are up 30%. People that call us directly for a referral end up having longer lengths of stay than waiting for health care professional to bring up the topic of hospice. The average length of stay is up 33%--73 days compared to 55 days a year ago. This has had a tremendous effect on our finances. Hospice referrals are up 2%. 36% of patients die within seven days or less. Occupancy rate in both Hospice Houses combined is up 2%. Utilization of the GIP level of care is now 88%, the highest since 2009. We did a major educational endeavor as a 2015 goal at the beginning of the year with all staff to make sure patients that are eligible for GIP are getting it. • The new CMS payment system has been delayed until January 1, 2016. The first 60 days we would get more money, less at 61+ days except the last seven days of life if an RN and social worker visit the patient each day up to four hours we would receive around $40 as a "service intensity add-on." CMS is recognizing that expenses are greatest at the beginning and end of the patient's stay. They are also disincentiving	

Topic	Discussion	Action
	long lengths of stay. The new HMB rates go into effect 10/01/15. Due to the hospital market basket wage index component of how local hospice rates are set, we are seeing the greatest year over year decrease in rates than we have ever had. St. Joseph County rates will go down 0.86%, Elkhart down 1.39%, LaPorte increase 2.85%, and rural increase 0.24%. We estimate a reduction in revenue for the last three months of 2015 to be $48,000. With 36% of patients dying within seven days or less, in January we will get that higher rate and the service intensity add-on which may offset some of the lower reimbursement in the middle with the longer length of stay patients. • We have been shopping for a new pharmacy vendor for over a year and a half. We interviewed three in the last six months and have decided to go with HospiScript, which we estimate will save us $275,000-$320,000 annually. The agreement will begin 11/01. They will train our staff, and their system can also interface with Cerner in the future, which should save our nurses time when entering medications. HospiScript will also cover both Hospice Houses. Previously we used Omnicare separately for our inpatient units. Thank you to Dave Haley for assisting us with contract negotiation. We will be the first hospice in the U.S. that will have HospiScript's home delivery system out of Chicago. This is new to them. We expect somewhat better service than our current vendor that delivers mail order to our patients from a pharmacy out of Philadelphia via FedEx. We may also be able to use local pharmacies less often. • We have signed an agreement with the I.U. School of Medicine Fellowship in Hospice and Palliative Medicine program. We will be getting three fellows over the next year. This is in addition to the Mayo Clinic contract where we train Fellows for board certification in hospice and palliative medicine. The Fellows will be unable to assist in the Receivables backlog. Those certifications and recertifications must be done by a Hospice Medical Director who is a W-2 employee. We are still actively recruiting for another medical director and two nurse practitioners. Dr. Cohen started 06/01 and has helped us dramatically on this issue on the certifications causing the receivable backlog. We hope to be back on track by the first quarter of 2016. • We have submitted an application for the 2016 Circle of Life Award. Thank you to Hospice Foundation staff member, Cyndy Searfoss, who compiled and helped write and edit the application from a nine member committee who all had input. We also had unbelievable letters of support from area executives, agencies, and others. We encourage you to read them in the copy of the application in the board packet.	

Topic	Discussion	Action
	• We also applied for the We Honor Veterans Award of Excellence. NHPCO is celebrating the 5th anniversary of this program. Only hospices that have obtained level four WHV status can apply for the award. It will be presented at the NHPCO Clinical Conference in October. We have done a lot since the WHV program began, but there is more we can do to reach out to our local VA entities. A copy of the award application is in the board packet. • We hosted the Northern Indiana Mayors' Roundtable on 06/26. It was Mishawaka's turn to host the event. Mayor Wood was able to show off both the Central Park renovations and talk about the city's collaboration with us in building the Mishawaka Campus. Many of the attendees are mayors of towns in our service area. Thank you to Mike Wargo for representing CHC at the event. We received a nice thank you from Mayor Wood, a copy of which is in the board packet. • On 07/04 we held a staff get together at the Mishawaka Campus to celebrate Independence Day and watch the fireworks from Beutter Park. Over 120 staff and family members attended. We grilled hot dogs, offered potato chips, soft drinks, and glow sticks for kids. We received several thank you notes from staff saying this was a great morale booster. • This year we started offering Third Thursday after hour events as an opportunity for staff to get together to bond and socialize. These are not officially endorsed CHC events and CHC does not fund them, but does publicize their existence. This week 119 staff and family members will be attending a South Bend Cubs game at Four Winds Field. • Three staff members attended the Hospice Action Network Intensive—Mary Janet Swain, Elkhart Triage RN; Kristen Wesolowski, CNA; and Amy Tribbett. They met with Joe Donnelly's office and with Jackie Walorski. HAN wants the people that work on the front lines to tell their stories to the legislators. Jackie agreed to sign onto HR3037 asking CMS to do some proper testing of the new payment structure. • The St. Joe Valley Street Rods gave us a check for $18,000. They sell $10 Barnaby's coupons and this year sold 3,600. Over the years they have donated a total of $66,250. This was also the first time they told us when they were coming so we could take photos. WNDU also covered the event. • We were on the front page twice the past couple months with a couple of stories. The first was 06/22 in the South Bend Tribune. A social worker asked if there was something special we could do for a family of a patient, so we worked with the South	

Topic	Discussion	Action
	Bend Cubs to pull together a day with the Cubs. Unfortunately the patient was too ill to participate on the day of the event, but the family was able to go. They were picked up in a limo and put up in the owner's suite. The other story was an Elkhart patient who was a Cessna pilot who wanted to take one more flight. We posted the story on our Facebook page and within three hours we had it scheduled through the Indiana Flight Center. The patient was able to both fly and land the plane. We had a GoPro in the cockpit and hired our own videographer to record the event. We submitted the video to NHPCO's "Moments of Life" campaign and they will feature it. We will be the only hospice from Indiana with a "Moments of Life" story. • The Walk for Hospice was held on 08/09. 327 walkers participated and raised over $21,200. It was nice to hold the event at the Mishawaka Campus. • We are purchasing our own tents with our logo for events. We can use them in our Campus courtyard, Bike Michiana for Hospice, and other events. In the long run, it will be much less expensive to own than to rent. • Five staff will be traveling to Uganda to attend the biennial PCAU conference—Mark Murray, Mike Wargo, Holly Farmer, Karen Hudson, and Denis Kidde. Holly and Karen will do poster presentations on children and grief, and on children are not little adults. Mark and Mike will be session chairs for some panels. 421 people have registered from ten countries. We will also have the world premiere of the "Road to Hope" documentary. Most staff will be staying on after the conference to visit some hospice programs. • Nursing Preceptor – We are in the process of developing a preceptor program for our nurses. All new nurses have an extensive orientation because many of them don't have hospice experience. They are clinically very sound. Our nurses will apply to be a preceptor and will be paired with a new nurse to see them through their first 90 days. We hope to start this in January. There are certain qualifications nurses need to meet in order to be a preceptor.	
4. Finance Committee	• The Finance Committee met Friday and approved the June and July financial statements for approval. June operating income $1.8MM, total revenue $1.6MM, total expenses $1.5MM, net gain $72,000, net without beneficial interest in Foundation $332,000. YTD June operating income $10.7MM, total revenue $11.4MM, total expenses $9.1MM, net gain $2.2MM, net without beneficial interest in Foundation $1.7MM. • July operating income $1.9MM, total revenue $2MM, total expenses $1.8MM, net	

Topic	Discussion	Action
	gain $289,000, net without beneficial interest in Foundation $151,000. YTD July operating income $12.6MM, total revenue $13.5MM, total expenses $10.9MM, net gain $2.5MM, net without beneficial interest in Foundation $1.8MM, compared to $1.2MM a year ago. • On page 2 of the financial statements you can see that Accounts Receivable decreased $468,000 from June to July. We continue to make headway on that. By the first quarter of 2016 we hope to be back in line where we are historically. Medicare claims are collectable for a year, so we are not in any danger of not collecting them. We are working on the oldest claims first. We experienced this backlog because we were understaffed with physicians and census increased at the same time. Historically the number should be around $5MM instead of $7.5MM. • A motion was made to accept the June and July financial statements as presented. The motion was accepted unanimously.	T. Yoder motioned A. Mauro seconded
5. Policy	• The "Core Services" policy was revised because we cannot use contracted agencies for core services. • A motion was made to accept the revised policy as presented. The motion was accepted unanimously.	W. Walsh motioned T. Yoder seconded
6. Foundation Update	• We are doing really well in fundraising this year. The capital campaign has raised $3.5MM in cash and pledges in the first 13 months of our five year $10MM campaign. We have received over $68,000 in planned giving. The Friends of Hospice appeal has raised over $29,000 as of 08/07. This was the 30th anniversary for the Walk for Hospice, which so far has raised $21,000. The 7th Annual Bike Michiana for Hospice is 09/13. This is a great volunteer opportunity. So far about 650 riders are registered. The summer issue of Crossroads is in process of being written and will be out in the next couple weeks. • A number of projects have been going on over the past several months in Uganda. We are working with the Eck Institute for Global Health at the University of Notre Dame. Brianna Wanless, who received a master's degree in global health from the Eck Institute, will do a presentation at the PCAU conference on the mHealth data collection project and app. She will explain what was done and the implications going forward. • The Notre Dame Executive MBA team also spent time with PCAU, the ministry of health, and other places in Uganda to work on a morphine distribution proposal. They looked at ways to streamline its production and distribution. Part of the problem is	

Topic	Discussion	Action
	when we started with PCAU only 34 districts had access to palliative care. Now due to the resources we have helped them with, they are in 93 of the 111 districts which have put a strain on the morphine distribution system. Thank you to Notre Dame for helping PCAU work on this issue. • We are in the process of putting the finishing touches to the "Road to Hope" documentary. The original music was composed by Dean Marvin Curtis and Prof. Thom Limbert from the Ernestine M. Raclin School of the Arts at I.U.S.B. The documentary runs 70 minutes. We will be screening it at Okuyamba Fest on 10/22 at the Mishawaka office and also enter it into film festivals around the world. We also talked to NHPCO about screening it at the Management & Leadership Conference next April. • Landscaping is completed at the Mishawaka campus. We are in the process of getting cost estimates for the medical office building and beginning design work on the new Hospice House.	
7. Board Education	• Larry Rice, Spiritual Care Coordinator, did a presentation on the "Spiritual Comfort Scale." There is a growing interest in the importance of spiritual care in the health care industry. The scale was originally developed in-house in 2005 as a way to communicate to the IDT what the spiritual care counselor assessed and understands about the patient. The tool has been now been revised to align with the medical 0-10 pain scale, so it is easier for staff to understand the ratings. If the patient is unable to communicate, we use NA. We have submitted an article presenting the scale and information to the *Journal of Palliative Medicine*. It is in the review process now for possible publishing.	
8. Chairman's Report	• Amy M. said how much fun her family had volunteering at the Bike event last year, and encouraged board members to participate in fundraising or other volunteer opportunities at CHC.	
Adjournment	• The meeting adjourned at 8:40 a.m.	Next meeting 10/21

Prepared by Becky Kizer for approval by the Board of Directors on 10/21/15.

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Mary Newbold, Secretary Becky Kizer, Recording Secretary

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CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
Hospice Foundation
President / CEO Report
October 21, 2015
(*Report posted to Secure Board Website October 14, 2015)*

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:30 AM.
This report includes event information from August 20 – October 20, 2015.
The Hospice Foundation Board meeting follows in the same room.

CENSUS

At the end of September, year-to-date (YTD) referrals to CHC are up 6% from same time last year. YTD referrals directly from patients and families are 30% of all referrals compared to 26% in 2014. September's average daily census (ADC) of 415 is the highest in CHC history. The YTD percentage of patients dying before admission (very late referrals) is 5.69% compared to 6.61% in 2014 at the same time. September had 122 deaths and YTD we've had 1,179 deaths. YTD deaths with a length of stay of seven days or less is running 41%. CHC's previous single day all-time high census of 422 on July 4 and 5 was broken on October 6 when census hit 426. YTD occupancy of the South Bend Hospice House is running 5% below same time last year and Elkhart Hospice House is running 5% above last year. This could be due to the number of general inpatient level of care patients being seen in Memorial and Saint Joseph Regional Medical Center (Mish and Plymouth) who might have or should have been cared for in our own inpatient units. There were a few times the South Bend Hospice House was full and this was unavoidable. September was also a rare month where the Plymouth office census was higher than Elkhart's. Plymouth's ADC of 90 for the month of September is the highest since the office opened back in 1995.

September 2015	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	509	1,687	1,668	19
Original Admissions	143	1,319	1,363	(44)
ADC Hospice	391.50	373.32	348.30	25.02
ADC Home Health	23.77	23.78	17.03	6.75
ADC CHC Total	415.27	397.10	365.33	31.77

August 2015	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	548	1,544	1,5326	21
Original Admissions	159	1,213	1,227	(14)
ADC Hospice	386.10	371.08	345.52	25.56
ADC Home Health	25.26	23.78	16.45	7.33
ADC CHC Total	411.36	394.86	361.97	32.89

Monthly Average Daily Census by Office and Hospice Houses

	2015 Jan	**2015** Feb	**2015** Mar	**2015** Apr	**2015** May	**2015** June	**2015** July	**2015** Aug	**2015** Sept	**2015** Oct	**2014** Nov	**2014** Dec
S.B.:	209	207	219	234	230	234	236	233	229			214
Ply:	68	66	67	72	68	78	78	83	90			68
Elk:	84	83	87	87	92	86	89	85	86			86
SBH:	4	6	5	6	4	6	5	5	5			5
EKH:	3	6	5	5	6	4	6	5	5			3
Total:	369	369	382	403	401	407	414	411	415			376

HOSPICE HOUSES

September 2015	Current Month	Year to Date	Prior Year to Date	YTD Change
SB House Pts Served	42	249	241	8
SB House ALOS	3.86	5.66	6.22	(0.56)
SB House Occupancy	77.14%	73.78%	78.44%	-4.66%
Elk House Pts Served	23	220	223	(3)
Elk House ALOS	6.91	6.13	5.59	0.54
Elk House Occupancy	75.71%	70.54%	65.20%	5.34%

August 2015	Current Month	Year to Date	Prior Year to Date	YTD Change
SB House Pts Served	33	212	216	(4)
SB House ALOS	4.91	5.89	6.32	(0.43)
SB House Occupancy	74.65%	73.37%	80.25%	-6.88%
Elk House Pts Served	29	204	203	1
Elk House ALOS	5.52	5.83	5.60	0.23
Elk House Occupancy	73.73%	69.90%	66.84%	3.06%

PATIENTS IN FACILITIES

Of the 509 patients served in September, 185 resided in facilities. Of the 548 patients served in August, 182 resided in facilities. The average daily census of patients in skilled nursing homes, assisted living facilities, and group homes during September was 165; August was 160 and YTD through September it was 135.

FINANCES

Karl Holderman, CFO, reports the September 2015 Financials will be posted to the Board website on Friday morning, October 16th following Finance Committee approval. For information purposes, the un-approved August financials are presented below.

August 2015 Financial Information

Center for Hospice Care (1)

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

August Overall Revenue	$	1,058,857	Year to Date Overall Revenue	$	14,607,289
August Total Expense	$	1,564,569	Year to Date Total Expense	$	12,533,043
August Net Gain	$	(505,712)	Year to Date Net Gain	$	2,074,246

Hospice Foundation

August Development Income	$	33,741	Year to Date Development Income	$	1,390,576
Aug. Investment Gains (Loss)	$	(817,206)	Year to Date Investment Income	$	(227,863)
August Overall revenue	$	(745,420)	Year to Date Overall Revenue	$	1,206,457
Total August Expenses	$	217,180	Total Year to Date Expenses	$	1,478,218
August Overall Net	$	962,600	Year to Date Overall Net	$	(271,761)

Combined (2)

August Overall Revenue	$	1,276,039	Year to Date Overall Revenue	$	16,085,505
August Overall Net Gain	$	(505,712)	Year to Date Overall Net Gain	$	2,074,246

(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.

Investment losses for the month of August alone totaled over $800,000 and in the last year have totaled $1.3MM from August 2014. It should be noted that our Vanguard investment pool 3 was down 4.80% for the month, while our benchmark S&P 500 was down 6.26%. The Dow was down 6.57%. Even with YTD investment losses of nearly $228,000, at the end of August 2015, the overall combined net gain for CHC / HF was $2,074,246 representing a 4.08%% increase from YTD August 2014, which was one of the best financial years in history. CHC's YTD Net without the beneficial interest in the HF was $2,346,005 representing a 50% increase from August 2014. The combined YTD net without counting investment gains/losses was $2,302,109 representing an increase of 253% from YTD same time one year ago.

At the end of June, the Hospice Foundation's Intermediate Investments totaled $1,393,845. Long Term Investments totaled $16,170,785.

CHC's assets on August 31, 2015, *including* its beneficial interest in the Hospice Foundation, totaled $38.3MM. At the end of August HF's assets alone totaled $32.3MM and debt related to the low interest line of credit associated with the Mishawaka Campus project totaled almost $5.9MM. Both organizations had combined assets on August 31 of just over $44.2MM.

CHC VP/COO UPDATE

Dave Haley, VP/COO, reports…

Planning for implementation of the new HospiScript pharmacy delivery system continues. We are planning for a "go live" of November 9, 2015 for most areas. We have chosen January 11, 2016 as the tentative "go live" date for our Hospice Houses. Once fully implemented, we expect this arrangement to save us somewhere around $230,000 annually. The Hospice Houses start date may be modified depending upon when we receive information from the Indiana Board of Pharmacy and just what that information is as it relates to their decision to allow us to use an automated drug dispensing device in our Hospice Houses. Historically, Indiana has not allowed hospice inpatient units to use such systems which are routinely used in nursing facilities.

Ivy Lee, M.D. a Fellow at the Indiana University Hospice and Palliative Medicine Fellowship program in Indianapolis, began a month long educational rotation at our facility on September 21. Alexa Morningstar, a senior Medical Student from Lincoln Memorial University-DeBusk College of Osteopathic Medicine in Harrogate, Tennessee is also doing a month rotation. Both rotations will be complete on October 16.

Our Spiritual Care Coordinator, Larry Rice, has been informed that an article he had submitted for publication in the international publication, Journal of Palliative Medicine, will be published. The article is about the update to our Spiritual Comfort Measure scale which our Spiritual Care Department developed and which was the focus of the education section of our last board meeting.

The Spiritual Care department recently hosted a luncheon for area clergy on September 24. Jacqueline Champaign from the Ruth M. Hillebrand Center for Compassionate Care in Medicine at the University of Notre Dame spoke on how to approach end-of-life conversations. 31 people attended the luncheon held here at the Mishawaka Campus.

The Bereavement Department has developed a program for new staff, especially those that have not worked in hospice care before and caring for dying patients exclusively, because it could bring up potential personal grief and loss issues. Bereavement developed a letter to be sent to new staff after their first 90 days to let them know they have the opportunity to contact bereavement. Numbers of staff contacting Bereavement for this service will be shared with each department head but not the names of the staff. Additionally, all CHC staff may use our EAP program at any time.

We recently received a report from EnclaraPharmacia, our current national pharmacy vendor, regarding where we stand compared to their benchmark of 500 hospices serving 85,000 patients daily. For example, our non-formulary drug costs in June 2015 were $0.14 PPD and their

benchmark (average customer hospice cost) was $1.10 PPD. Our shipping charges were $0.04 and their benchmark (average customer hospice cost) was $0.25 PPD. CHC and its medical staff continue to perform in an outstanding manner in monitoring and keeping our pharmacy costs significantly lower than the "average" hospice program in the United States.

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

DIRECTOR OF NURSING UPDATE

Sue Morgan, DON, reports the Nursing Leadership continues to focus on development of the Nursing Goals for 2016.

Nursing Goals 2015 Status Update

Develop and Implement Pediatric ELNEC training: The plan has been completed and it has been developed into ten self-learning modules which RN's will begin one year after their start date, with completion expected by the beginning of their 3rd year with CHC.

Establish Nursing Preceptor Program: The program has been developed and will be reviewed at the next Nursing Leadership meeting. The first class will be held in October 2015.

Evaluate in-house RN triage effectiveness and productivity: Nursing Leadership is assessing staffing on a daily basis in the event that we are in need of more patient visits we have been transferring all triage calls to South Bend. This is in preparation for the future that all triage calls will be answered in South Bend.

Education Programs

The TROUBLE BREATHING PLAN will be initiated in the 4th quarter of 2015. It was developed by the Quality Assurance Performance Improvement team working on revocations and discharges. The implementation of the plan will hopefully reduce the number of revocations related to shortness of breath and/or breathing difficulties. The "C.O.M.F.O.R.T" plan consists of:

C=Call Center for Hospice Care at this number:
O=Observe closely and assess ways to respond
- Raise head of hospital bed Pursed lip breathing
- Turn down lights
- Decrease the number of visitors
- Position
- Quiet the room

M=Medications
F=Fan to Face
O=Oxygen
R=Reassure & use relaxation techniques
T=Timing intervention & repeating

Nursing, Social Work and Spiritual Care will be educated on the plan. The admission nurse will educate the family and leave the form in the home as a reminder of what to do in the event of trouble breathing. The term "trouble breathing" is purposefully being used as that is the term in the CMS post death HCAPS survey (Hospice Consumer Assessment of Healthcare Providers and Systems).

Quality Assurance

The Quality Assurance Department continues a number of projects to enhance turnaround times of various elements of the medical record with the goal of an Electronic Medical Record (EMR)

- Continue to delete paper forms which are no longer being used.
- Identify forms which can be scanned into the EMR.
- Streamline the turnaround times for the Certification of Terminal Illness and signatures by the attending physician and Medical Director.
- Improved processes in the communication with the billing department.
- Reviewing the process related to certifications and recertification of the patient for continued stay in the Hospice Program.
- Reviewing documents needed by the Extended Care Facilities for continued care of the patients with Hospice care.
- Centralizing the process of charts and required documents to the South Bend office to expedite completion of death/discharge charts..

Sue will be presenting the Board Education session at the end of the board meeting on our Quality Assurance Performance Improvement plans and projects.

HOSPICE FOUNDATION VP / COO UPDATE

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

Fund Raising Comparative Summary

Through August 2015, the Development Department recorded the following calendar year gift totals as compared with the same period during the previous six 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	150,006.82
March	231,949.73	165,468.92	194,345.35	264,625.29	176,641,04	257,463.89
April	354,644.69	269,676.53	319,818.81	395,299.97	356,772.11	419,610.76
May	389,785.41	332,141.44	416,792.85	446,125.49	427,057.81	635,004.26
June	477,029.89	427,098.62	513,432.22	534,757.61	592,962.68	794,780.62
July	532,913.52	487,325.01	579,801.36	604,696.88	679,253.96	956,351.88
August	585,168.77	626,466.72	643,819.01	783,993.15	757,627.43	1,042,958.42
September	671,103.04	724,782.28	736,557.59	864,352.82	935,826.45	1,267,659.12
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	67,572.77
March	65,886.51	99,796.42	102,351.84	98,212.12	66,916.68	107,457.07
April	104,544.96	97,332.61	123,998.46	130,674.68	180,156.07	162,146.87
May	33,768.72	51,753.98	90,909.04	40,825.52	100,285.70	160,178.34
June	74,084.48	90,718.18	92,036.89	65,815.51	97,258.66	159,776.36
July	55,278.63	53,536.39	62,069.43	69,939.27	38,243.88	93,586.27
August	51,240.25	83,202.86	64,017.65	92,732.69	79,015.87	86,606.54
September	85,629.27	94,000.56	92,808.58	80,335.67	84,011.71	99,931.45
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**	**995,227.27**

Cornerstones for Living: The Crossroads Campaign

Campaign activity in the form of meetings, presentations, phone calls and email exchanges moves forward as we navigate through the quiet phase of the campaign. Through the first 14 months of this five-year campaign (7/1/14 thru 8/31/15) total cash, pledges and documented bequests stand at $3,557,397.

Soliciting lead gifts and cultivating prospective lead gift donors are top priorities. Meetings in August and September with individuals, corporations, foundations and business partners advanced our goal to have a minimum of $1 million or more in campaign funding requests under review by prospective donors. Upcoming activity includes a follow-up meeting and tour of the Elkhart Campus with an Elkhart-based foundation that toured our Mishawaka Campus and a meeting and tour with the leadership team of a health care related foundation that is interested in pledging a major gift for the new hospice house. Other activity includes working with a donor who expressed an interest in directing an estate gift to Center for Hospice Care. With the appropriate documentation, we will be able to recognize this donor's gift as part of our campaign during his lifetime.

Planned Giving

Estate gifts totaling $108,776 were received since the last report. We were contacted in early September by a representative of a donor with the intent to include Center for Hospice Care as a beneficiary of the donor's estate. Campaign giving opportunities entered into our discussion, and based upon our interaction, we provided detailed information to the representative about the endowment component of the Crossroads Campaign. At this time, we anticipate the gift may total as much as $100,000 and we expect provisions in the bequest to specify the donor's wishes for memorial recognition of deceased family member.

Annual Giving

The 2015 Friends of Hospice appeal continues to bring in gifts, although they have slowed down. The appeal has raised $33,465 as of September 30th. Preparations are underway for this year's Annual Appeal, which will feature the story of Terry Meland. A current CHC patient, Terry's bucket list included the wish to fly over Michiana one last time. That was the request that went viral on the CHC website and led to front page stories in the Elkhart Truth, a feature story on Fox 28 News, and will soon be part of the national campaign, "Moments of Life, Made Possible by Hospice." With the help of CHC and Indiana Flight Center in Elkhart, Terry was able to cross that item off his list. This year's theme will center on how, with the generous support of our donors, CHC helps patients improve the quality of living. This appeal will also be part of our Giving Tuesday fundraising efforts. Giving Tuesday, established in 2012, kicks off the charitable season on a national level as many people focus on their holiday and end-of-year giving. It offers the Hospice Foundation another avenue of exposure, particularly to potential donors who may not already be in our sphere of influence.

Special Events & Projects

The 7th Annual Bike Michiana for Hospice was held on Sunday, September 13th. We welcomed 1,058 participants to this year's event. Survey results indicate that the vast majority of cyclists continue to rate the event as the best in the Midwest. Although participation was down slightly from last year, we continue to receive donations from the event and anticipate a growth of approximately 8% in revenue once the final tally is complete. In-kind gift support from sponsors increased this year and we also experienced an increase in the number of registrations later in the cycle (at a higher registration fee). Based on early inquiries about 2016 sponsorship requests, we are preparing online and print sponsorship appeals to be presented this fall for the 8th Annual Bike Michiana for Hospice, which is scheduled to take place on October 2, 2016. The current gross revenue on the 2015 bike event is $113,623.37 (this includes gifts-in-kind, most notably WSBT-TV/Radio, $18,500 and Waste-Away Group, $3,600). There are still a couple of verbal pledges outstanding, so this number may go up. Since they were verbal, they've not been entered into our system as of yet.

This year's Okuyamba Fest will be held at the Mishawaka Campus on Thursday, October 22nd from 5:30 – 9:30 pm. In addition to the international food, wine and beer/silent auction of Ugandan arts and crafts offered the past three years this year's event will feature two screenings of our new documentary film, "Road to Hope." Seating is limited to 90 seats per screening. Tickets to Okuyamba Fest are $25/person or $45/couple and are available for purchase at EventBrite.com (search "Okuyamba Fest").

Global Partners in Care/PCAU

PCAU hosted the 6th Biennial Palliative Care conference in Kampala on August 27th and 28th. Attendees from CHC/HF were Mike Wargo, Denis Kidde, Holly Farmer, Karen Hudson and me. Holly and Karen were invited by the conference selection committee to make poster presentations, based on the abstracts they submitted to PCAU's Scientific Committee earlier this year. Mike and I chaired some of the conference sessions. I was invited to participate in the distribution of some awards, including the plaque from Global Partners in Care for Kawempe Home Care as the 2015 winner of the Global Partnership Award, the same award that PCAU and CHC won in 2014.

In addition, Brianna Wanless presented the results of her pilot mHealth data collection project. Bri recently received her master's degree in global health from the Eck Institute for Global Health at the University of Notre Dame. In May/June she spent six weeks in Uganda to initiate the pilot program. Mike and Denis submitted the findings of the Notre Dame Executive MBA team, "Business as Usual," from their comprehensive morphine supply chain final report. In addition PCAU and HF team members met with stakeholders throughout the supply chain to reflect on the findings.

Road to Hope Program/Documentary

CHC/HF team members visited a number of Road to Hope students during their time in Uganda. Seven students have been added to the Road to Hope program, making a total of 22 students who are now being sponsored through the program, with a number of them being fully sponsored by individuals and organizations. While in Uganda, Holly Farmer was able to visit Mark, the child she and her family have been sponsoring over the past couple of years.

The Uganda private screening of "Road to Hope," which took place during the Palliative Care Conference, received high marks from attendees. During the next several months, the film will be submitted for consideration to a number of international film festivals. In addition, Mike (along with Rose Kiwanuka, PCAU Country Director and Torrey DeVitto, NHPCO Ambassador and the film's narrator) has submitted a proposal to NHPCO to potentially screen the film as part of a 90-minute workshop at the annual Management & Leadership Conference in April. We are in the process of developing a Road to Hope film web site and making extensive changes to the Road to Hope fund site. We anticipate the film web site will receive a great deal of traffic as the film makes its way through the film festival circuit, which will in turn drive traffic to the fund site. Social media will be used extensively to promote the film. Content will focus both on those who were integral to successfully producing and promoting the film, including Torrey DeVitto (soon to be seen on NBC's "Chicago Med"), Brandi Milloy (recent guest host of the "Today" show) and sound mixer Stephen Tibbo (who recently won his 3rd Prime Time Emmy Award for his work as the production sound mixer on ABC's hit series "Modern Family") as well as information about the documentary and the story behind it.

Mishawaka Campus

The large landscape boulders that will be used as CHC-logoed signage for our Mishawaka Campus have been installed and the engraving will begin in October. Lighting and landscaping will be installed at those locations once the engraving is completed. The final section of fencing is scheduled to be installed later this month at the western portion of the campus, immediately adjacent to the newly renovated Central Park. DJ Construction is working on cost estimates for the recently designed patient care staff building as Helman-Sechrist Architecture continues to work on design options for the new hospice house.

Board Engagement

There are many ways in which CHC board members can become involved in Hospice Foundation activities. Volunteer opportunities exist with all of our major events, i.e. Bike Michiana for Hospice, Walk for Hospice, Okuyamba Fest, Helping Hands Dinner. In addition, we love having board members involved in assisting us with raising funds to support various Center for Hospice Care

initiatives. To express interest in becoming involved in Hospice Foundation activities and fundraising initiatives, feel free to contact either Mike Wargo or me at any time.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

Amy Tribbett, Director of Marketing and Access reports…

Outreach and Liaison News in August, September and October

Referral & Community Outreach:

- Since having a dedicated admissions rep at SJRMC, we have received 22 referrals. It has been well received at Memorial as well.
- On August 3, Lisa Zollinger, Community Liaison presented to IUSB Elkhart's Death and Dying class.
- Lisa continues to schedule luncheons at all Beacon medical office to educate them about hospice appropriateness, having the conversation, and the benefit of earlier referrals.
- Lisa held a Veterans Club at Hubbard Hill Retirement Community Elkhart.

Marketing & Access News August 9 – October 1

Volunteer Department:

- 18 new volunteer interviews
- 31 new volunteer inquiries
- Trained 17 new volunteers in August
- Scheduled 10 volunteers for the October daytime training
- Scheduled 12 volunteers for the October/November 2-day Saturday training
- Blankets for Hospice program gaining interest from several church groups. We will capture these hours as Special Project hours. In August and September, CHC Admissions Department created 30 blankets, St. Paul's Lutheran Church in Middleberry and Granger's Girls Scout Troup 00509 both participated in blanket making service work.

Access:

Through natural attrition we are replacing our Admission Representatives (non-clinical) with RNs to speed up the admission process. We recently added having an Admission Representative stationed at the three largest hospitals for several hours each morning to assist with referrals / intake and getting these patients admitted to CHC faster.

August Intake Stats
- 2,601 phone calls
- Average of 84 calls per day
- Average of 28 calls per Referral Specialist per day
- Average of 3.5 phone calls per hour per Referral Specialist

September Intake Stats

- 2,269 phone calls
- Average of 76 calls per day
- Average of 25 calls per Referral Specialist per day
- Average of 3.5 phones calls per hour per Referral Specialist

Marketing:

- The summer issue of Choices was mailed in early September.
- The fall issue of H&P is at the designer and will be mailed by mid-October.
- CHC's Facebook Page has 1,376 likes and has been reaching more people with recent posts. CHC has 310 followers on our Twitter (center4hospice) handle – a gain of 11 new followers.
- Marketing has entered into a contract with PlayMaker CRM. Playmaker CRM is a customer relationship management software that will change how we currently manage our sales efforts and grow our referrals. It interfaces with Cerner and will be loaded with the most current Medicare data available. PlayMaker CRM has a mobile component that will work with our existing iPads and will allow sales representatives to easily access up-to-date information related to critical referral source profiles, scheduled events, and previous visit and call notes while working in the field, even without an Internet connection. They will be able to enter visit and call notes, schedule events, and enter expenses throughout the day, and sync any new information to their PlayMaker account when connectivity becomes available.
- On August 26, Congresswoman Walorski paid a visit to our Mishawaka office. She enjoyed a tour and a delicious cake, thanking her for her support of HR3037.
- Amy is serving on the 2016 NHPCO Management Leadership Conference planning committee through NHPCO. She recently reviewed 30 presentation proposals.
- Amy has been meeting with local media reps in preparation for the 2016 marketing plan.
- The new CHC website is planning for a launch date of November.
- In August and September, 139 phone calls were generated from CHC's digital campaign. The digital campaign continues to perform incredibly well. In the last 60 days, not only have we received 139 phone calls, but our ads have been clicked thru 963 times:

NATIONAL REGULATORY CHANGES HIT ON OCTOBER 1

There are several regulatory requirements for hospice providers which became effective on October 1, 2015.

ICD-10 implementation

Providers are required to use ICD-10 diagnosis coding on the claim form for patient service dates of 10/1/15 and going forward. ICD-10 codes must be valid. A code is invalid if it does not include the full number of correct characters that are required.

All Diagnoses on the Claim Form

For service dates of October 1, 2015 and going forward, all diagnoses (related & unrelated) must be entered on the hospice claim form. This is a provision in the FY2016 Final Hospice Wage Index rule. An unrelated diagnosis on the claim form does not necessarily equal hospice financial responsibility. If a hospice physician determines that a diagnosis does not medically contribute to the terminal prognosis, he/she is now required to document why it does not medically contribute to the terminal prognosis in the clinical record.

Medicare Payment Rates for FY2016

Effective with services provided October 1, 2015 or later, all hospices will use the new FY2016 payment rates as outlined by CMS in the FY2016 Hospice Wage Index final rule and CR 9301. You may remember from the last board meeting that due to the multiplier used in the Core Based Statistical Area, as of 10/1 CHC received the largest year-over-year cut to its Hospice Medicare rates in history. The Routine level of care rate for St. Joseph County is down $1.33 per patient day (PPD), Elkhart County down $2.12 PPD. South Bend Hospice House General Inpatient rate is down $4.73 PPD, Elkhart Hospice House down $8.02 PPD. This will perhaps be mitigated to some extent on January 1 when the new payment system is scheduled to become effective. We will receive an approximate 15% increase in the Routine rate for the first 60 days of a patient's stay and an approximate decrease of 8% for all days after that along with a "Service Intensity Add-on" of approximately $37.00 per hour for up to four hours per day during the last seven days of a patient's life for all visits made by an RN or Social Worker. This doesn't appear like this is going to be pretty. The new payment system also affects all state Medicaid systems that are required to meet the rates and systems set by Medicare. NHPCO polled each state Medicaid system a few weeks ago asking if their software systems would be ready for the new hospice payment system by January 1. Of the 34 states who responded, one said "yes." The new payment system was originally scheduled to become effective on October 1 when the new rates became effective, but CMS delayed it to January 1 due to concerns and hundreds of written comment letters indicating that it was too complicated to be implemented that soon and national software providers like Cerner could not possibly be ready with the 60 day advance notice of such a massive need for system changes.

NATIONAL UPDATE: STATE MEDICAID AGENCIES COMPLETELY UNPREPARED FOR 1/1/16 DEBUT OF NEW HOSPICE PAYMENT MODEL

Hospice under Medicaid is an optional benefit for states. Indiana did not adopt it until 1997. Federal statute says that under Hospice, state Medicaid agencies cannot pay less than Medicare pays. The new Medicare Hospice payment model which we have discussed in past reports goes into effect January 1, 2016. Under the Routine Home Care level of care hospices will be paid two different rates, one for 60 days or less (a 15% increase in the regular rate) and one for 61 days or more (an 8% decrease from the regular rates), plus a Service Intensity Add-on payment equal to Continuous Home Care hourly payment rate (St. Joseph County for example is $37.13 per hour) multiplied by the amount of direct patient care by a registered nurse (RN) or social worker provided during the last seven days of a beneficiary's life.

NHPCO met with CMS Medicaid in Baltimore on October 8, 2015. CMS staff included representatives from the Center for Medicaid and CHIP Services, Disabled and Elderly Health

Programs Group, the Division of Benefits and Coverage and the Division of Managed Care plans. In preparation for the meeting, over the last several months, NHPCO surveyed state hospice organizations about Medicaid readiness and met with the National Association of State Medicaid Directors. In addition, NHPCO has contracted with a consulting firm specializing in Medicaid managed care to assess requirements for hospice providers and hospice patients when the state has moved to Medicaid managed care. There is no firm answers yet to the questions asked.

1. Implementation of FY2016 Hospice Wage Index Final Rule Among State Medicaid Agencies
NHPCO first alerted CMS to the implementation issues with Medicaid in June 2015 during meetings with CMS during the FY2016 hospice wage index comment period. They have shared the data collected from 38 states on the status of implementation. Many states report that they do not have the capacity to implement these changes by the January 1 2016 deadline. Among the concerns:

- There may be no way for the state Medicaid agency to pay differentially for hospices that have not participated in quality reporting and should have a 2% reduction in the FY2016 payment rate.
- State Medicaid agencies do not have a way to count days of care, so there are questions about how the hospice and the Medicaid agency will keep the day count accurate and determine how to pay at the high RHC and the low RHC based on that day count.
- Most state Medicaid agencies do not currently ask for visit data and visit intensity data for Medicaid only patients. In the discussions with CMS, NHPCO confirmed that the hospice can provide visit and discipline information but that it has, for the most part, never been on the Medicaid claim. The lack of visit data will make it difficult to do a seven day lookback for the Service Intensity Add-on payment.
- If a state is not ready on January 1, 2016, what rate should they pay for FY2016 for Medicaid only patients?

Neither CMS nor the National Association of State Medicaid Directors has heard from state Medicaid agencies about hospice implementation issues. CMS confirmed that their instruction to states about these changes was the memo released by CMS Medicaid on September 1, 2015. They instructed NHPCO to encourage state Medicaid agencies to talk to their contacts at the CMS Regional Offices about their implementation concerns. There is no answer yet about whether a state Medicaid agency will be required to retroactively reimburse for payments if they are not in compliance on January 1, 2016. NHPCO and CMS agreed to continue discussions and troubleshooting with individual states.

2. Medicaid Managed Care

NHPCO has received numerous questions about Medicaid managed care and how it applies to hospice.

- Is there a requirement in the waiver application that adjustments to the Medicaid hospice benefit be mentioned?
- What are the requirements for Medicaid managed care organizations to comply with the statutory requirement for the Medicaid rates to be linked to Medicare rates?

CMS staff and NHPCO legal counsel agreed to continue to research the answers to this issue, working with the NHPCO Medicaid consultants, and continue this conversation.

3. Nursing Home Room and Board Under Medicaid Managed Care

One of the strange quirks of hospice under Medicaid is that dual eligible Medicare / Medicaid patient under hospice has 95% of the state Medicaid room and board charge paid to the hospice who then reimburses the nursing home at 100%. This pass-through is a loser for the hospice who has to make up the 5% of the R&B charges out of their own pocket.
Questions posed by NHPCO on nursing home room and board include:

- On what beginning amount should the 95% rate be figured?
- How will payment rates be set for room and board in the Medicaid managed care environment?
- How should nursing home room and board payments be handled in the various duals demonstration projects?
- How should hospices respond to concerns that Medicaid managed care organizations offer room and board rates that range from 50% of the Medicaid rate to 90% of the rate?

The biggest concern I have is that if CMS strong arms state Medicaid agencies to be in compliance with the statute on January 1, 2016, that because it is an "optional" benefit, some states will simply drop hospice coverage under Medicaid altogether.

NATIONAL HOSPICE EXECUTIVE ROUNDTABLE UPDATE

Cathie Whitcroft, DNP, ACHPN, FNP-BC and I attended the National Hospice Executive Roundtable (NHERT) meeting at the NHERT member program in Colorado Springs, CO on October 4 – 6. The NHERT is a collection of twelve hospice CEOs from leading non-profit hospice agencies throughout the United States who meet in-person three times per year to develop and share industry best practices. This meeting included the lead Palliative Care person from each program. Everyone met together for Day One and then Cathie had the opportunity to meet her counterparts from the other NHERT programs as a group without the CEOs for a half day on Day Two. At previous NHERT meetings we have included our lead physicians, clinical leaders, and CFOs and marketing staff. Various departments meet by telephone on a semi-regular basis to share information. This most recent meeting also offered to the Palliative Care attendees tours of the Pikes Peak Hospice and Palliative Care inpatient unit located on the entire sixth floor of Penrose Hospital. The NHERT meetings are facilitated by nationally recognized healthcare consultant Peter Benjamin from Miami, FL. Topics this time included:

1. When your organization says "we have a palliative care program" – what exactly do you mean? Please identify/inventory what you mean and without getting too detailed, give some perspective about the size and scope of your "inventory". For example:

    a. Program/Services Inventory: we have
        i. By site of care: inpatient consultative services (hospital, SNF, ALF), home, clinic
        ii. Breadth of care: physician, advance care practitioner (NP, PA), RN, social worker, chaplaincy, home health aide, volunteer, other
        iii. Consult Definition:

b. Size of programs/volume: using whatever measures are easiest and in your mind representative – how "much" do you provide? For example:
   i. How many patients (and families if appropriate) are served each year?
   ii. How much service is provided to each patient (for example, number of visits)?
   iii. Annual revenue – dollars and percent of overall program revenue

c. Payor Mix: to whom do you bill? For example, what percent of billing is Medicare, Medicaid, Commercial insurance and how much to you bill patients (likely in copayments)?

d. Licensure/Organizational Structure: for example, do you have a "physician practice management entity" or are you licensed as a home health agency, etc.

2. Why do you have the palliative care programs that you do? For example, because…

   a. This a "pure" business opportunity in which you intend to have positive economics?

   b. This a "pure" mission driven service in which you invest because it is the right thing to do and there is a void in the community?

   c. These services are necessary to protect your hospice business from competition that threatens your ability to provide hospice services (meaning this is defensive)?

   d. You believe your programs effectively stimulate utilization of your hospice. If so, do you believe you have compelling data to demonstrate this (meaning this is a business growth strategy)?

   e. You believe these services are a "bridge" to broader programming opportunities with payors (which can be traditional health insurance companies or at risk providers)?

   f. This is a mix of "mission" and "margin" and/or competitive pressure and/or hospice growth strategy and/or payor strategy and/or a bridge to broader payor programming?

3. How do you determine "victory" in your palliative care efforts?

4. What do you anticipate in the coming years; meaning, are you investing in these programs, do you expect greater revenue, etc.

Each participant had 25 – 30 minutes to cover the above in a PowerPoint presentation. With questions and discussion, this took the entire day. It was an interesting and worthwhile day spent learning how many similarities among our programs there are as well as the differences in maturity of programming.

OUT AND ABOUT

Five staff members, including Mike Wargo and me, attended and presented at the 6th Biennial National Palliative Care Conference by the Palliative Care Association of Uganda in Kampala August 27 and 28th. 400 attendees from 20 nations were present.
Several staff members and clergy from throughout the area attended the Spiritual Care Luncheon held here at the Mishawaka Campus on September 24.

Several staff members from CHC and HF attended the History Museum's Annual Dinner honoring South Bend Cubs owner Andrew Berlin on September 24. CHC/HF was a "silver" dinner sponsor.

I attended the National Hospice Executive Roundtable Meeting held at member program Pikes Peak Hospice and Palliative Care in Colorado Springs, CO on October 4 – 6. A main focus of the Monday meeting was Palliative Care Programming and each of the 12 CEOs brought with them a lead person for this from their program. Cathie Whitcroft, DNP, ACHPN, FNP-BC, joined me for that section of the meeting.

I attended the Board Meetings for the Hospice Action Network and the Executive Committee and Board Meetings for NHPCO in Grapevine, TX on October 13 and 14.

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

Dave Haley's Census Charts

Thank you letter from family member for CHC care.

Press Release on CHC training physicians from Mayo and Indiana University School of Medicine.

New York Times article on "A Racial Gap in Attitudes Toward Hospice Care."

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

August and September 2015 Financials.

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, December 16, 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 .

# # #

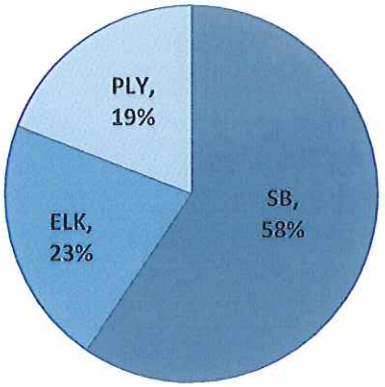
Center for Hospice Care

2015 YTD Average Daily Census (ADC)

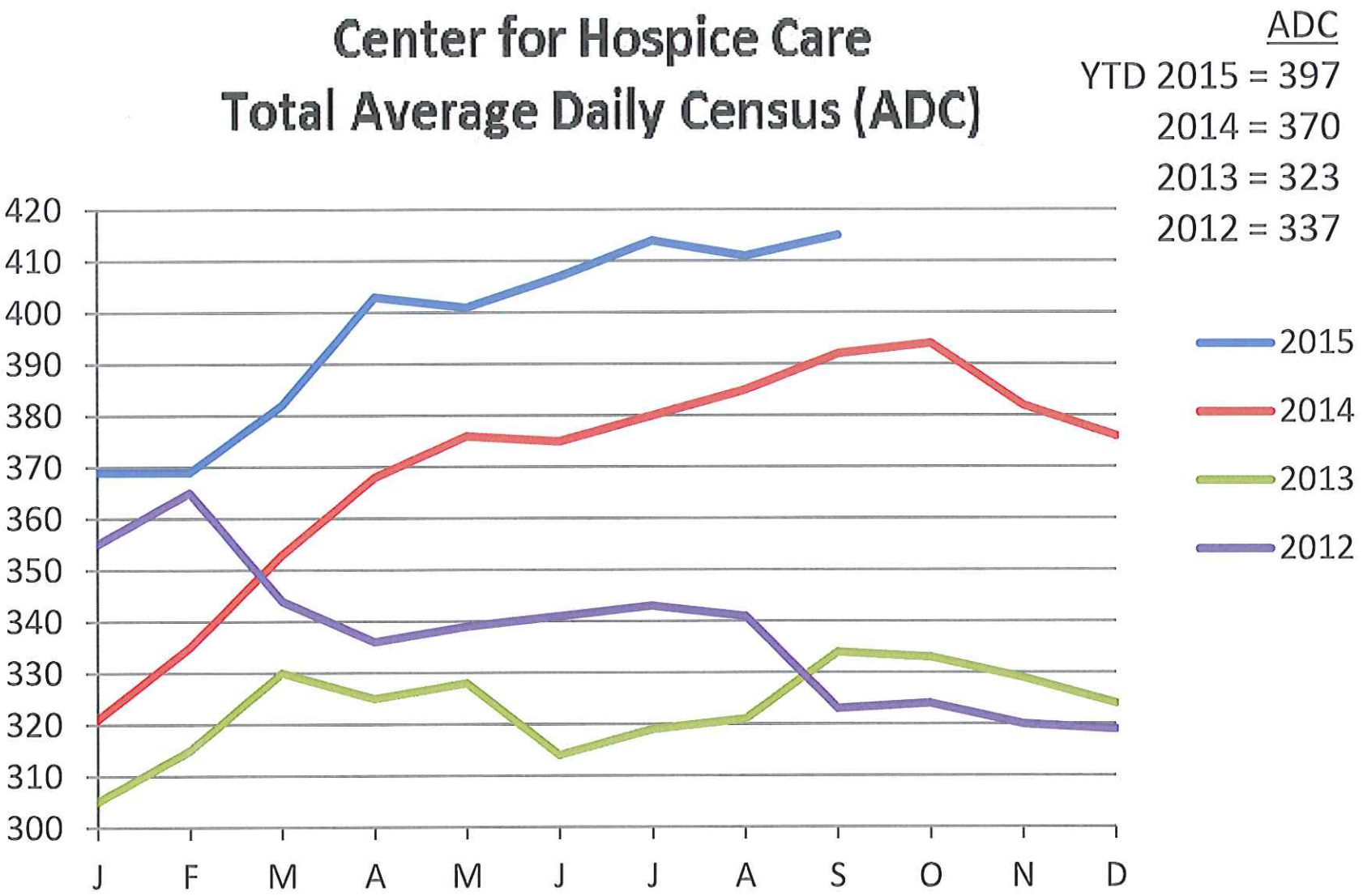
(includes Hospice House and Home Health)

	All	South Bend	Elkhart	Plymouth
J	369	213	88	68
F	369	213	86	64
M	382	224	92	67
A	403	240	92	72
M	401	235	98	68
J	407	240	89	78
J	414	241	95	78
A	411	238	90	83
S	415	235	91	90
O				
N				
D				
2015 YTD Totals	3571	2079	821	668
2015 YTD ADC	**397**	**231**	**91**	**74**
2014 YTD ADC	365	218	76	71
YTD Change 2014 to 2015	32	13	15	3
YTD % Change 2014 to 2015	**8.7%**	**6.0%**	**20.0%**	**1.4%**

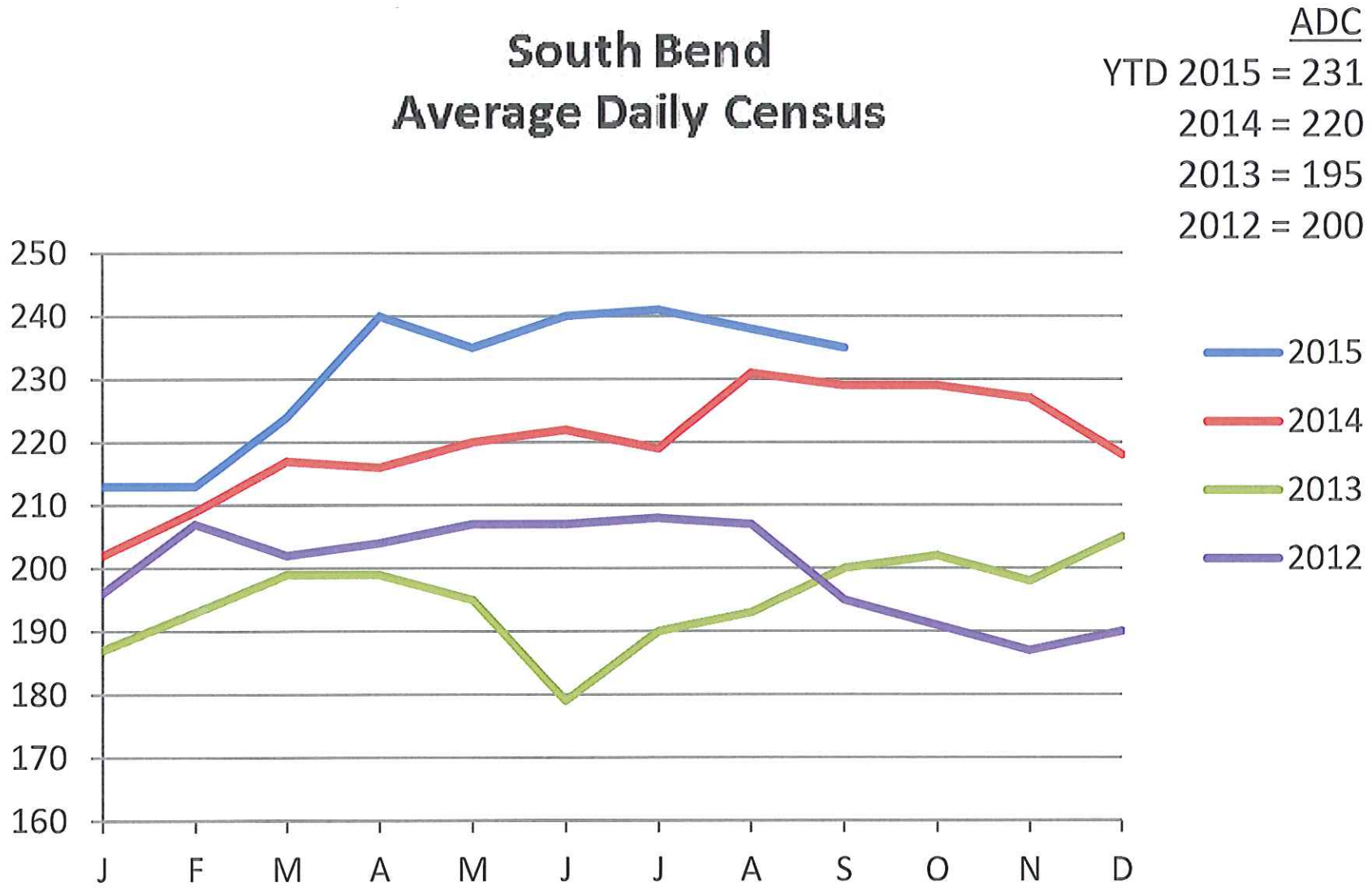
2015 YTD ADC by Branch



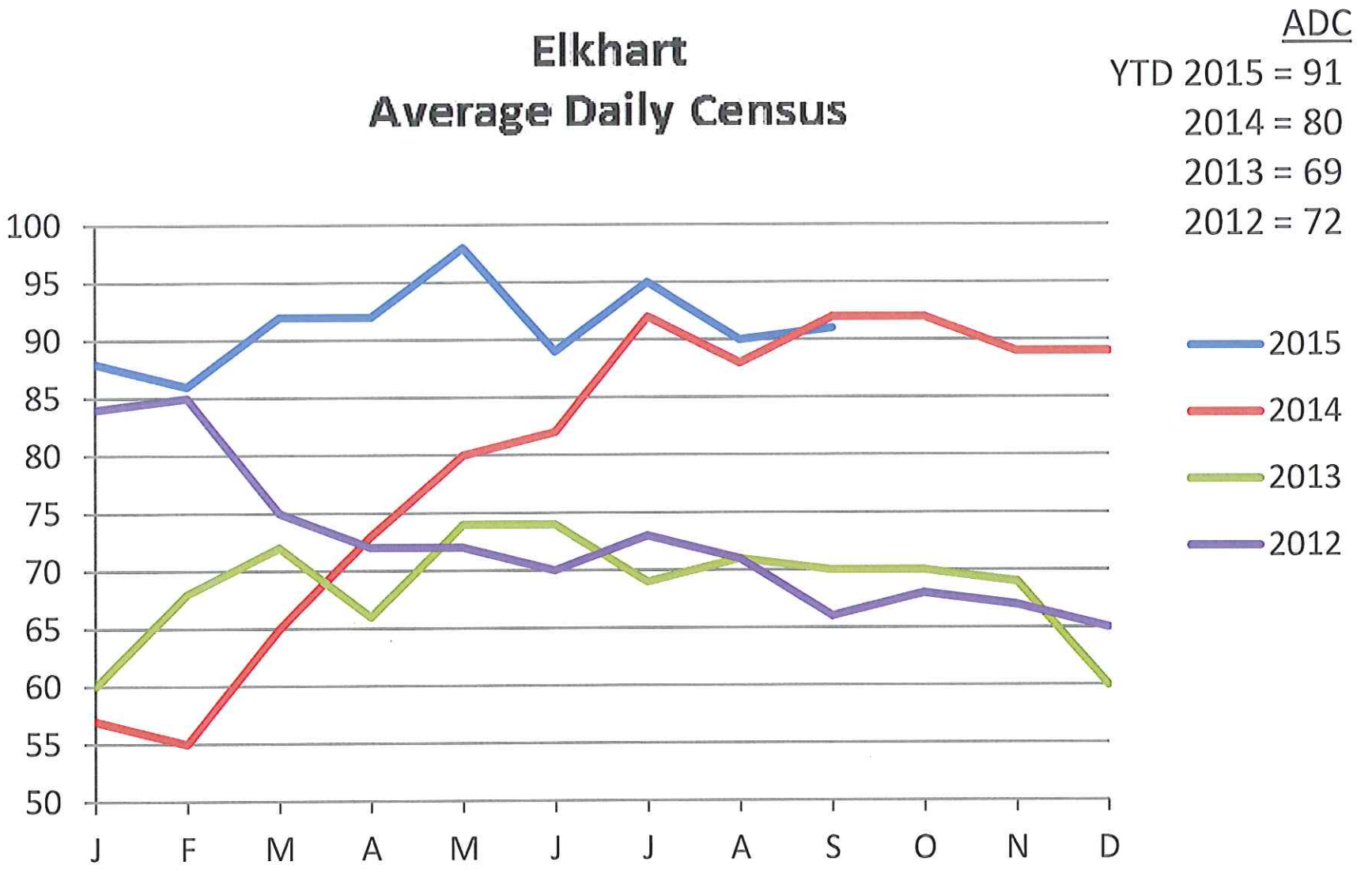
Center for Hospice Care
Total Average Daily Census (ADC)



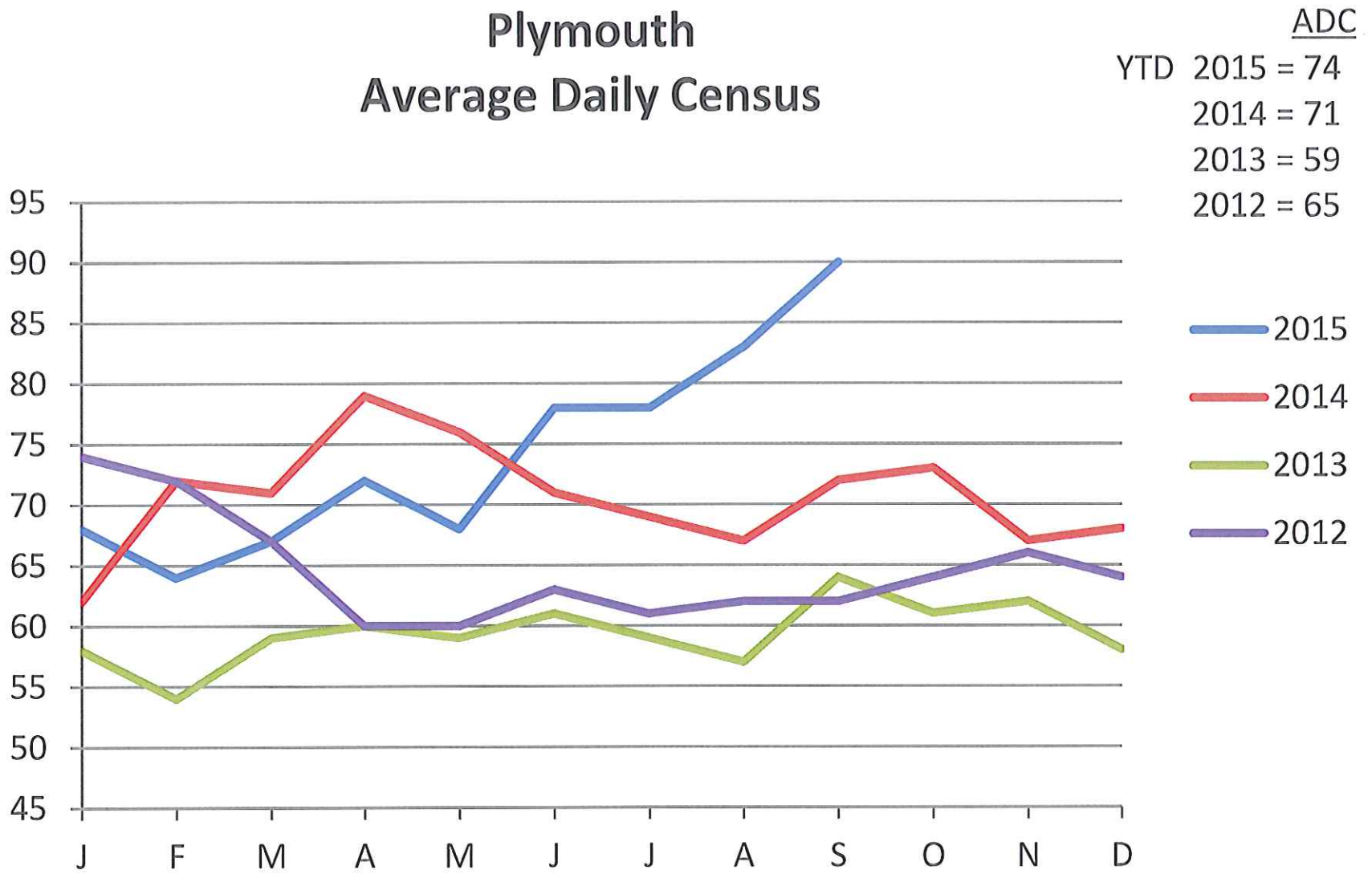
South Bend
Average Daily Census



Elkhart
Average Daily Census



Plymouth
Average Daily Census



August 14, 2015

Center for Hospice Care
501 Comfort Place
Mishawaka, IN 46545

Attention: Mr. Mark M. Murray, President

Dear Mr. Murray:

On July 17th, my beloved wife of nearly 45 years, Kerry "Kathleen" Gillen Klawitter, passed away. She fought metastatic cancer for many years, and entered the palliative care program offered by your organization at the end of March, after her oncologist informed us that there were no further treatment options.

The compassion, dignity, and support that your entire organization, the nursing team in particular, displayed while Kathleen was under hospice care compels me to write this testimonial letter - in part, to provide you with perspective, but also to sincerely thank those who were so instrumental in providing Kathleen with exceptional end-of-life care. And, for my part, this was the most emotional, most challenging, and most foreign experience of my life – something that I felt I might not be able to manage, but which I did, only because of the support received from the caring and knowledgeable people in your organization.

The phone receptionists and triage nurses were always courteous, helpful and quick to act when the situation warranted. Supplies and medicines were always timely provided. Jim was thorough and helpful when needed. Trevor was someone that Kathleen always looked forward to seeing (and hearing – with his wonderful Irish-flavored speech). And then there were Ann and Julie, respectively Kathleen's primary care nurse and the nurse who made urgent visits the day before, and the morning of, her passing. There is no other way to express my thanks to them than to tell them (and I did) and Ms. Tieman and the entire organization that they were and are "angels".

Ann was so caring and so professional and wise in her advice, and, in particular, her handling of pain management. She brought support, help, hope, and a big smile into our home every time she entered. It was clear to me after the first few visits that Ann was going to help us, and I knew that we needed loads of help, to get through this difficult process. And she certainly did that. Thank you so much, Ann.

Julie came twice during Kathleen's last two days with us – the second time was in response to my desperate call to the hospice office for help. At that point, I did not know what to do to help Kathleen – her condition was changing so quickly and on so many different levels. It was Julie who recognized that Kathleen was entering the final stages and it was Julie who was able to calm Kathleen and to allow me to tell

her how much I loved her and that she should feel free to go. Thank you so much, Julie.

Our family was allowed to write our own Prayers of the Faithful that were presented during Kathleen's Mass of Christian Burial at the Basilica of the Sacred Heart at Notre Dame. The following prayer was specifically written and included to reflect our appreciation of the hospice care Kathleen received:

> Hospice nurses accompanied Kathleen as angels on her difficult journey through illness and parting from this mortal world.
> Bring them comfort and bless them in their hour of need.
> We pray to the Lord.

Because of the hospice care we received, Kathleen was able to be at home in our bed in her final hour – with me at her side – and to leave us so peacefully at the very end. In many ways, the unexpected speed at which she left us in the end was a powerful gift in view of the suffering that she had to endure over the final few months, but the pain and sense of loss is nevertheless so very profound.

This letter is perhaps unnecessarily long just to convey my appreciation, but it seems to also serve a need I have to express the depth of my thanks and to help and be part of my grieving process. May God bless all those, seen and unseen, in your organization who helped Kathleen and I make her final journey together.

Most sincerely,

A L Klawitter

Andrew L. Klawitter

c: Ms. Donna Tieman, Head of Nursing

P.S. A memorial donation has been made this day to your organization via your website.

Physicians from Mayo Clinic and Indiana University to Complete Hospice & Palliative Medicine Training at Center for Hospice Care

Mayo School of Graduate Medical Education of Mayo Clinic, Rochester, MN, and Indiana University, Indianapolis, have chosen Center for Hospice Care (CHC) for physician Hospice and Palliative Medicine Fellowship training rotations.

South Bend, IN (PRWEB) September 03, 2015 -- Mayo School of Graduate Medical Education of Mayo Clinic, Rochester, MN, and Indiana University, Indianapolis, have chosen Center for Hospice Care(CHC) for physician Hospice and Palliative Medicine Fellowship training rotations. Beginning immediately, physicians from these institutions will train at CHC as part of fulfilling their requirements for obtaining national Board Certification in Hospice and Palliative Medicine.

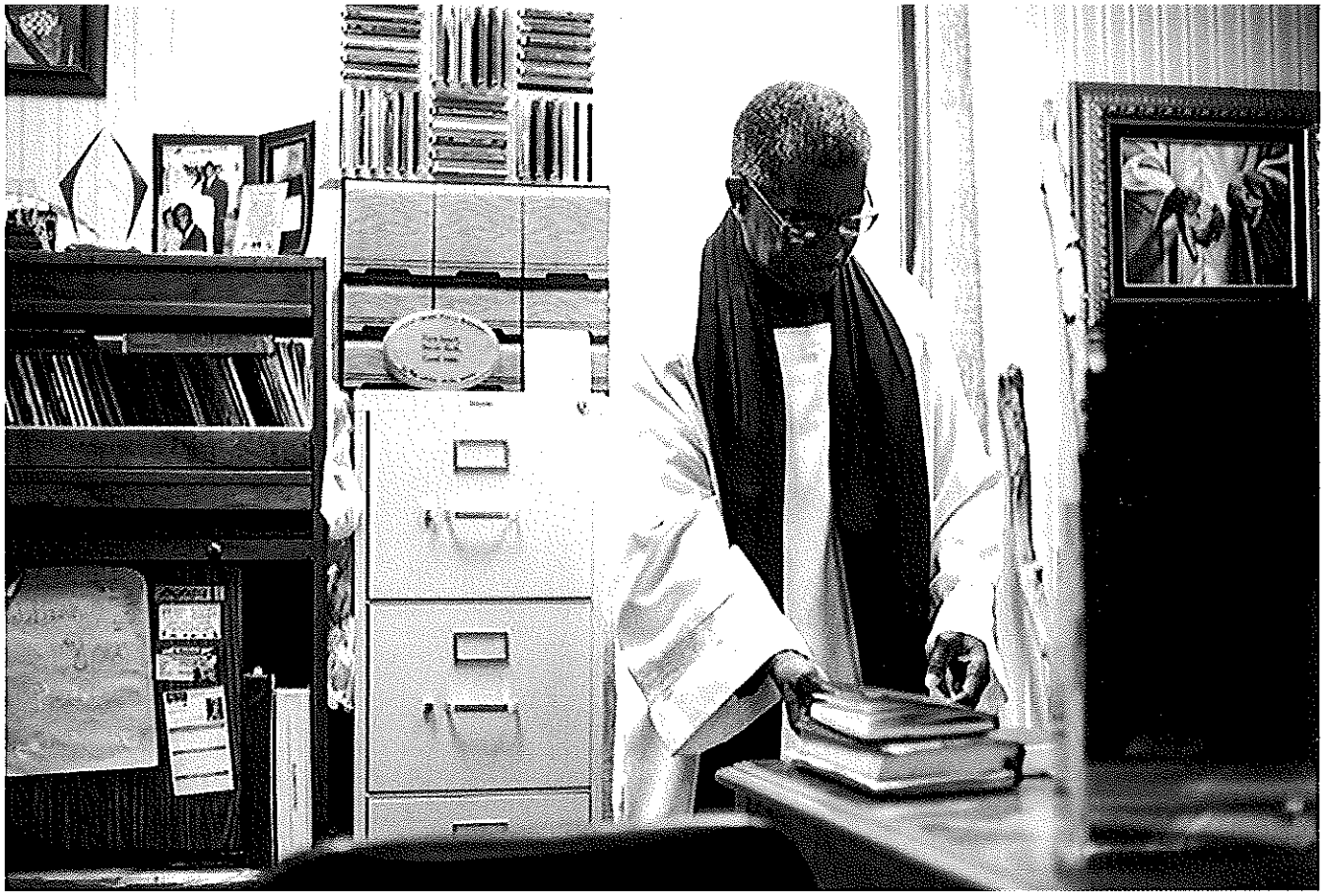
According to David Haley, Center for Hospice Care's COO, the rotations are designed to further physician education in hospice and palliative medicine through professional training and experience in different clinical and residential settings with a variety of patients and their families. "Fellows from Indiana University and Mayo Clinic will also gain knowledge through lectures, discussions and mentoring," Haley said. "We are honored that both Mayo Clinic and Indiana University have selected Center for Hospice Care as an important teaching site for their Hospice and Palliative Medicine Fellows. While we are a community-based not-for-profit hospice provider in northern Indiana, our program has rightfully earned respect and recognition nationally."

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

The New York Times

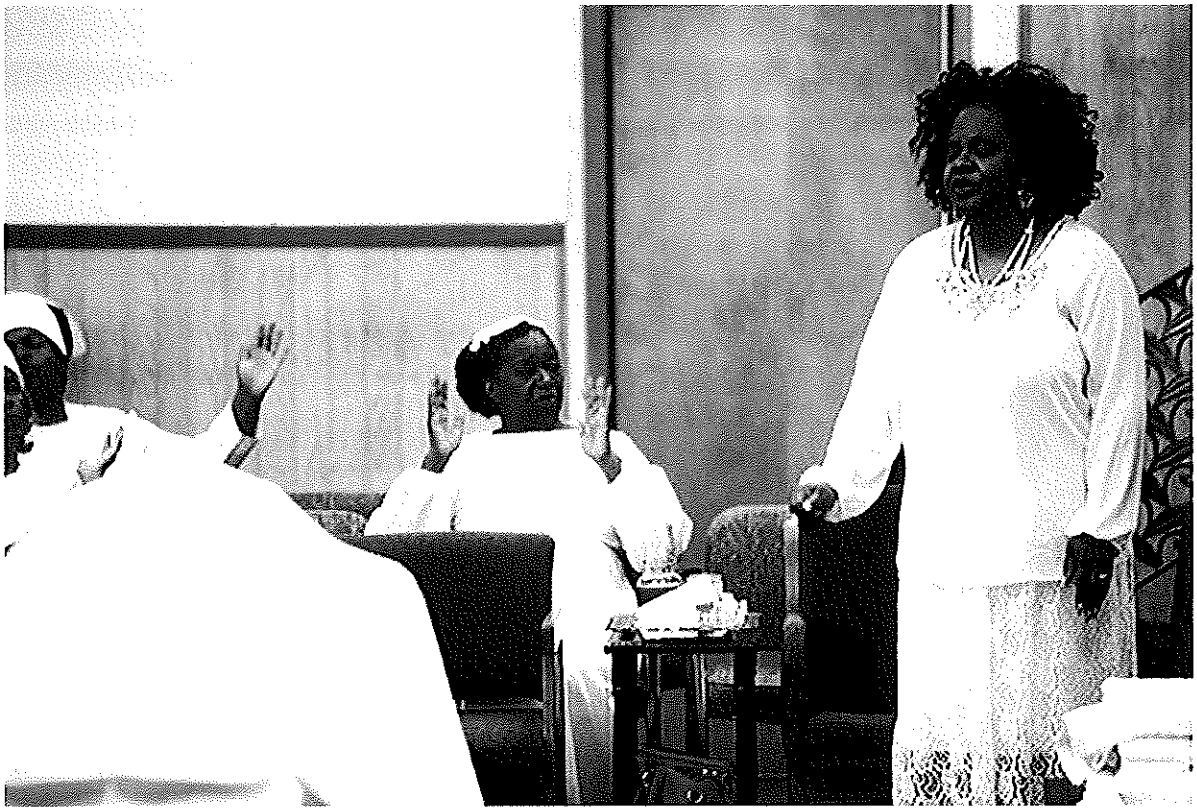
A Racial Gap in Attitudes Toward Hospice Care

By SARAH VARNEYAUG. 21, 2015



Vernal Harris, the pastor of Prince of Peace Temple Church of God in Christ in Buffalo, has lost two sons to sickle cell disease. He and his wife now advocate the use of hospice care for the terminally ill in the communities they serve

It is an attitude borne out by recent federal statistics showing that nearly half of white Medicare beneficiaries enrolled in hospice before death, compared with only a third of black patients. The racial divide is even more pronounced when it comes to advance care directives — legal documents meant to help families make life-or-death decisions that reflect a patient's choices. Some 40 percent of whites aged 70 and over have such plans, compared with only 16 percent of blacks.



Of her experience with hospice care, Narseary Harris, right, said "I think our experience was powerful enough that it changed people's attitudes." Credit Brendan Bannon for The New York Times

Instead, black Americans — far more so than whites — choose aggressive life-sustaining interventions, including resuscitation and mechanical ventilation, even when there is little chance of survival.

The racial gaps may widen after January 2016, when Medicare is to begin paying physicians for end-of-life counseling. In 2050, blacks and other minorities are projected to make up 42 percent of people aged 65 and over, up from 20 percent in 2000.

At the root of the resistance, researchers and black physicians say, is a toxic distrust of a health care system that once displayed "No Negroes" signs at hospitals, performed involuntary sterilizations on black women and, in an infamous Tuskegee study, purposely left hundreds of black men untreated for syphilis.

"You have people who've had a difficult time getting access to care throughout their lifetimes" because of poverty, lack of health insurance or difficulty finding a medical provider, said Dr. Maisha Robinson, a neurologist and palliative medicine physician at the Mayo Clinic in Jacksonville, Fla. "And then you have a physician who's saying, 'I think that we need to transition your mother, father, grandmother to comfort care or palliative care.' People are skeptical of that."

Federal policies surrounding hospice also arouse suspicion in black communities because Medicare currently requires patients to give up curative therapies to receive hospice benefits.

That trade-off strikes some black families, who believe they have long had to fight for quality medical care, as unfair, said Dr. Kimberly Johnson, a Duke University associate professor of medicine who has studied African-American attitudes about hospice.

Dr. Johnson said her black patients were more likely to believe there are actual religious prohibitions against limiting life-sustaining therapy, and that suffering can be redemptive, or "a test from God." And those beliefs, she added, were "contrary to the hospice philosophy of care."

But some doctors and clergy members are trying to use church settings to reshape the black community's views, incorporating the topic in sermons, Bible study groups and grief and bereavement ministries.

Dr. Robinson, who is black and a daughter of Tennessee pastors, has been helping pastors develop faith-based hospice guidelines. She tells them, "God can work miracles, yes he can, but even in hospice."

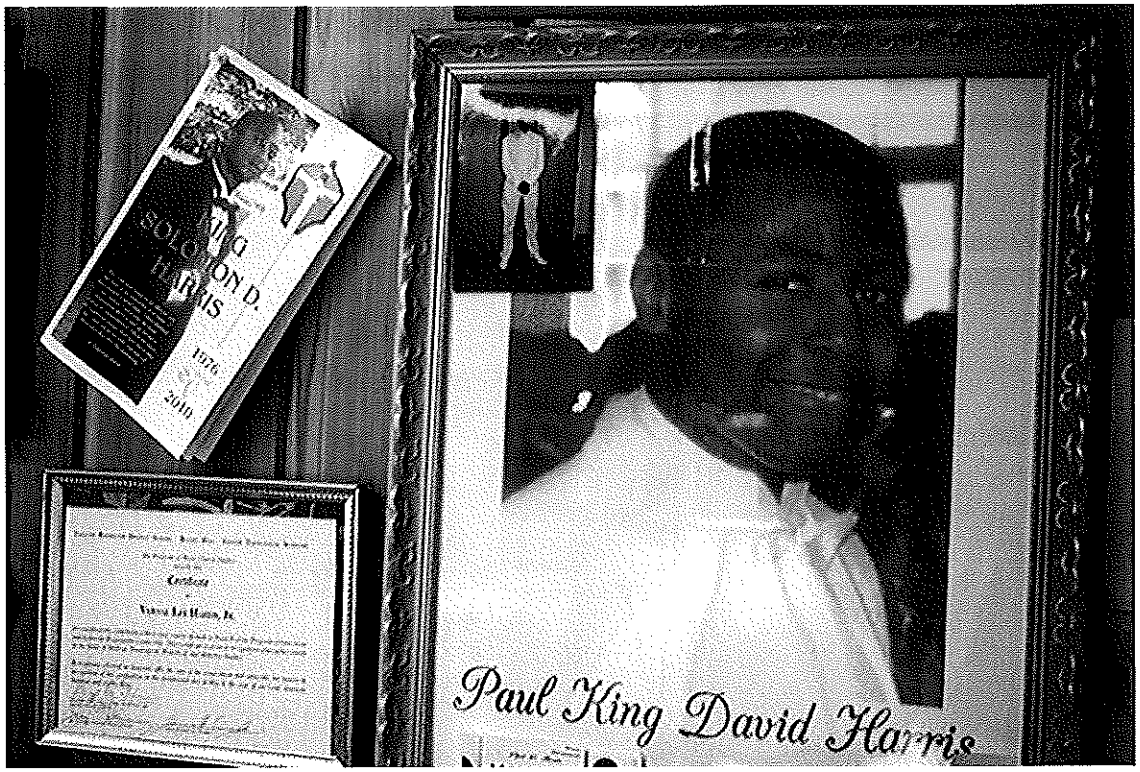
That message recently rang out from the pulpit at God Answers Prayer Ministries, an African-American church in South Los Angeles, as Bishop Gwendolyn Coates-Stone delivered a sermon on advance care planning.

"It's such a great cost to hold on to some of those sicknesses and diseases that eventually are going to take us out," she exclaimed into a microphone, bobbing and weaving in a swirl of royal purple robes. "Just like Jesus talked about his death and prepared his disciples for his death, we ought to be preparing our disciples for our death!"

In a moment of benediction, Bishop Coates-Stone made a direct plea: "Help us Lord to have the courage to have conversations with our families," she said, "that will also not leave them wandering and wondering, 'What should I do in case of the death of a loved one?' "

A gathering of older blacks convened recently by Dr. Robinson in Leimert Park, a middle-class Los Angeles neighborhood, underscored the challenges such efforts still face.

"Hospice has not been a good place for African-Americans, unless you're in a white facility and usually you're one of few black people there," said one woman, who along with others attending the gathering asked not to be identified in order to speak frankly.



Tributes to his sons hang on the wall of the office of Pastor Harris.

Others in the group nodded. "It gets into money," another woman said. "The treatment is a little bit better, but then there is still the discrimination."

Advance directives, in particular, are often seen as sinister, a way for insurance companies to maximize profits. "If you say you want at all costs to live, and they say, 'Well, your insurance company doesn't allow that,' then they're going to pull the plug anyway," said the host of the gathering, Loretta Jones, 73, the founder of Healthy African-American Families in Los Angeles.


Loretta Jones, the chief executive and founder of Healthy African American Families.

To help allay those concerns, physicians need to be more explicit during end-of-life discussions, Dr. Robinson said. "We have to be much clearer about why we're trying to have those conversations, or we'll continue to see a pattern of people who really want life-sustaining interventions even when there's limited potential benefit."

Camille Wicher, the vice president for clinical operations at Roswell Park Cancer Institute in Buffalo, who has studied African-Americans' end-of-life choices, said hospitals needed to enlist black families who have had good hospice experiences to share their stories with friends and church members.

"That's how we learn," she added. "We learn from each other."

The Harrises are trying to use their experience to carry out that work.

The agony of their son Paul's death in a hospital room informed their treatment decisions when their next son, Solomon, became gravely ill. When his doctor conceded that blood transfusions were of little help, Solomon assented to hospice care in his parents' home. If he was going to be robbed of his future, Solomon would not, his parents decided, be robbed of a good death.

As his health failed, nurses from the hospice in Buffalo managed his pain and bathed him tenderly. A social worker helped the family grieve and counseled his young children. All the while, parishioners from his parents' church visited Solomon, amazed to find that hospice was not the grim banishment they had envisioned.

"One of the members said, 'I thought you were going to put Solomon in hospice,' " Mrs. Harris recalled. "I said, 'We did.' 'Well, when is he going?' I said, 'They come here.' 'They come to your house?' 'Yeah, they're taking care of him right here.' "

There was even time for reflection, as Solomon wrote in a poem called "After Life."

"Fear death?" he wrote. "No, I await death."

Solomon died a short while later, but the Harrises say his death has had a lasting effect.

"The people in our immediate circle now view hospice positively," Mrs. Harris said. "I think our experience was powerful enough that it changed people's attitudes."

Mr. Harris, the pastor of Prince of Peace Temple Church of God in Christ, often evangelizes about hospice during his Sunday morning sermons, while Mrs. Harris has enlisted the wives of black pastors in Western New York, known as the First Ladies, to counter negative views about palliative care. At a recent meeting, the women discussed older church members who might benefit from hospice, and Mrs. Harris wanted to hear how parishioners in the women's churches responded to some recent outreach.

"It really opened up people's eyes to the negative stigma of it, feeling like, 'I'm just putting my loved one away, and not caring for them,' " said Joyce Badger of Bethesda World Harvest

International Church in Buffalo. "The power of knowledge that we've gained is really going to help our community."

This article was produced in collaboration with Kaiser Health News, an editorially independent program of the Kaiser Family Foundation.

Center for Hospice Care
choices to make the most of life

CHAPTER FOUR

QI Committee Report

Center for Hospice Care
QI Committee Meeting Minutes
August 18, 2015

Members Present:	Alice Wolff, Amy Knapp, Amy Tribbett, Brett Maccani, Carol Walker, Dave Haley, Denise Scroggs, Gail Wind, Greg Gifford, Holly Farmer, Larry Rice, Mark Murray, Rebecca Fear, Sue Morgan, Vicki Gnoth, Becky Kizer

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m.	
2. Introductions	• Welcomed new committee member, Carol Walker, who also serves on the CHC Board of Directors.	
3. Minutes	• The minutes of the 05/19/15 meeting were approved by consensus.	
4. QAPI Programs / Education	• An overview was presented of the Quality Assessment & Performance Improvement (QAPI) program. Quality Assurance focuses on structure and processes that are then audited to insure we are doing them well and according to regulations. QAPI is an approach that is proactive and continuous. Improvement projects are chosen and are not exclusively regulatory driven. They are selected internally based on whether good outcomes are being achieved. There are many internal and external stakeholders who care about QAPI outcomes. The purpose of a QAPI is to set clear expectations to improve performance and activities that impact patient health and safety. We look at both clinical and operations. • We created a formalized process for creating a QAPI Team to monitor all QAPI projects to make sure they have measurable aims and completion targets. The committee would decide which projects are more important. We have an excellent program, but we didn't have a handle on what projects were out there. So we wanted to develop a formalized quality plan and have all of ones currently in place report to an overall committee. If a new project is developed, then we will ask that a formal proposal be submitted and the person submitting the proposal would be the facilitator of that QAPI. A small group would decide whether the project would be worth our efforts, expense, and what the end result will be. The facilitator would come to the first committee meeting to explain what they are doing. The next step is to pull together a plan to bring to the next QI Committee meeting. Part of an overall QAPI program is to have some required elements like infection control, HIPAA, adverse	

Topic	Discussion	Action
	events, and consumer concerns. • The committee approved by consensus to move forward with the QAPI Program plan as presented by Rebecca Fear.	
5. Medical Records & QA Monitoring Process	• QA and Medical Records – Aim is total conversion to electronic medical record (EMR) by scanning paper records, eliminating obsolete paper forms, and utilizing/ creating electronic documentation for current paper forms in order to increase efficiency in processing medical records. Eventually we will have one complete EMR. We have centralized the handling of medical records for physician orders and the COTI to the South Bend office. We also decentralized the scanning of documents so it is now done in each branch office. We streamlined the closed chart process. We are scanning documents into the EMR of current and discharged patients. All of these changes have greatly reduced the backlog of closing charts and processing COTIs. • QA Monitoring/Auditing Process – Aim is to establish efficient audit and monitoring activities, and have a standardized process and procedures for records review and auditing tools throughout the agency. We were able to eliminate an audit form and also standardize the ECF chart audit tool. We established a standard for ECF record audits and have given the auditors printers so if a document is missing they can print and file it in the ECF chart immediately.	
6. Infection Control	• We held six TB validation courses resulting in 27 staff members having valid renewals or new TB validation cards through the American Lung Association. We implemented an electronic version of the TB skin test form. The annual Bloodborne pathogens in-service was presented at the 05/27 all staff meeting. The QAPI will be reviewing the infection control policy for any revisions, and also review CHC's Exposure Control Plan. There was one adverse event in the second quarter—a needle stick by a nurse. We followed the necessary exposure plan and educated the nurse on correct glove and needle handling procedures.	
7. HIPAA	• We are now doing short HIPAA presentations at the all staff meetings. IT tested our firewall soundness. We have overall training for staff and then annually within departments we want the coordinators to dedicate time and activities for HIPAA that is job specific to their department.	
8. Revocations & Live Discharges	• Percentage of non-revocation live discharges was down in the second quarter compared to a year ago—1.69 compared to 2.11. Moved out of service area – there	

Topic	Discussion	Action
	were none in June compared to six a year ago. Percent of revocations mean is 1.82 compared to 2.15 in 2014. Reason for revocation – number one is going to an acute care facility. Second is seeking treatment that won't be included in the hospice plan of care as approved by the IDT. Percentage of revocations to acute care – numbers are still below 2014 levels. Percent of revocations within 25 days of admission – average 43 compared to 39.3 a year ago. Percent of live discharges with IDT input – A QAPI reviews all the live discharges. They look to see if any staff member needs education and coaching. It is pretty much hard wired now. Percentage of attending physicians notified of non-revocation live discharge – In 2011 started with staff not consistently contacting the physician, but now it is nearly 100%. • We are developing a new initiative that will be rolled out to all groups in September with a new tool and education that will hopefully have a positive effect on patients with shortness of breath (SOB). One on one education will be done with the caregiver as to what to do when the patient is experiencing SOB. The written out tool will be kept in the home with a list of things the caregiver can do when the patient is short of breath. The majority of patients that go to the hospital while with CHC are due to SOB. The QAPI is deciding what we will measure and Gail will report on it at the next meeting. The new CAHPS survey uses the term "trouble breathing," so we will teach staff to use that phrase so families get used to hearing it when they see it on the survey.	
9. Clinical Quality Measures	• We are using the HIS as one of our guides. We started with pain management and that is now a forced field in the computer that nurses must complete. The second symptom we focused on was constipation. We are sustaining in the 90's or close to 100 on this. The QAPI established a threshold of 93%, so unless we fall below that, we will consider this met. The third symptom we will focus on is dyspnea.	
10. Hospice House Volunteers	• We still need to do some education with some staff and volunteers. Denise S. would like to see the QAPI continue. We created three levels of Hospice House volunteers and made some changes in staffing. Sue will look for Donna Tieman's records on this QAPI.	
11. Caregiver Confidence	• We will have the results of the new CAHPS survey at the next meeting, so we do not have information to report today.	
12. Adverse Events	• Fall Trends – May had 65 falls, June 33, and July 50. We looked at it closely and	

Topic	Discussion	Action
	most falls occur in an ECF. Three patients fell twice. The majority are due to the patient getting out of bed, usually to go to the bathroom. We had a Hospice House fall at the end of June. About eight days later we discovered the patient had a fractured femur, but it was determined to be pathological and not a result of the fall. • We had an issue in Hospice House trying to start an IV to administer blood, because the nurse couldn't get it started and didn't know who to contact for assistance. We had not administered blood in Hospice House in a long time. As a result, we developed a nursing resource list that staff can refer to it if they need help starting an IV, work with pediatric patients, who is TB certified, etc. Then they will know who to contact that is experienced and could assist. We also educated all South Bend Hospice House nurses on hanging blood. We will bring in a nurse to assist with the blood administration, because we need two nurses to start it. We have done it three times now with success. Elkhart Hospice House staff still needs that education and going forward it will be a part of orientation. • We continue to have problems with locked med boxes in the home disappearing or being damaged. We are monitoring this. • Medication Errors – The biggest area of concern was a patient who usually received her meds from FedEx who said her meds disappeared. We investigated and FedEx did deliver the meds and it was signed by the patient's daughter. So now the local FedEx for that home will require the patient's signature only or they won't deliver. Since that time, there have been no further issues.	
13. Consumer Concerns	• There were six concerns this quarter. All were resolved. No trends. • The ISDH visited last Friday on a complaint from an event last December. It will be a substantiated concern and we should receive a final report and at the time if requested further follow up will occur. Thank you to Dave Haley, Rebecca Fear and Gail Wind for assisting with the investigation by the ISDH.	
14. Spiritual Care Contacts	• Percentage of families that responded on the FEHC survey that they were satisfied with the amount of spiritual support they received. Over the past two years the results have been 93-99%. We are waiting for the results on the CAHPS survey.	
15. Emotional Support to Families	• Amount of emotional support before and after the patient's death. Last two years in the 90's. Staff is now using the phrase "emotional support" when they talk to families about bereavement and social work, which are the words in the CAHPS survey.	

Topic	Discussion	Action
16. ECF Professional Management	• This has been put in sustaining mode at this time. Staff is on board with the process of doing daily visits near the end of life and communicating with each other. Fluctuations are more related to patients that died unexpectedly with no indication that they were actively dying, so we didn't make those daily visits the last few days of life. We are also working with QA staff on electronic ECF charts, because it is hard for our staff to access information on our patients in ECFs.	
17. Next Meeting	• Next meeting 11/17. We will be looking at QAPI plans, membership of groups, quarterly reports, and education. We will also see the CAHPS survey results.	
Adjournment	• The meeting adjourned at 9:00 a.m.	Next meeting 11/17