Board of Directors Meeting
501 Comfort Place, Conference Room A, Mishawaka
December 16, 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
December 16, 2015
7:30 a.m.

A G E N D A

1. Approval of October 21, 2015 Minutes *(action)* – Amy Kuhar Mauro (2 minutes)

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

3. Finance Committee *(action)* – Wendell Walsh (10 minutes)
   (a) 2016 Flex Spending Limit
   (b) Retirement Plan Audit
   (c) October and November 2015 Financial Statements
   (d) 2016 Budget

4. QI Committee Report *(information)* – Carol Walker (5 minutes)

5. Patient Care Policy Updates *(action)* – Sue Morgan (5 minutes)

6. CHC amended By-laws *(action)* – Amy Kuhar Mauro (5 minutes)
   (a) Board Resolution to Accept By-Laws Amendments

7. Election of New Board Member, Reelection of Board Member to Second Term *(action)* – Amy Kuhar Mauro (4 minutes)

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

9. Video "A Chance to Fly Again" *(information)* – Amy Tribbett (5 Minutes)

10. Chairman's Report *(information)* – Amy Kuhar Mauro (4 minutes)
    (a) Recognition of Outgoing Board Members

Next meeting February 17, 2016 at 7:30 a.m.

# # #

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Center for Hospice Care
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CHAPTER TWO

MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
October 21, 2015

Members Present:	Amy Kuhar Mauro, Anna Milligan, Carol Walker, Corey Cressy, Lori Turner, Mary Newbold, Suzie Weirick, Tim Portolese, Tim Yoder, Wendell Walsh
Absent:	Ann Firth, Becky Asleson, Francis Ellert, Jesse Hsieh
CHC Staff:	Amy Tribbett, Dave Haley, Karl Holderman, Mark Murray, 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 08/19/15 meeting as presented. The motion was accepted unanimously.	T. Portolese motioned C. Walker seconded
3. President's Report	• ADC in September was 415 and so far October is 421. • We interviewed a nurse practitioner. She will let us know by the end of the week if she will accept the position. We are recruiting for three full-time positions including another physician. We are terminating our contract with the recruitment company, because they did nothing for us. • We have signed an agreement with a new pharmacy vendor. HospiScript will start with our home care patients on 11/09 and Hospice House on 01/11. This contract with save us about $270,000 a year. Our electronic medical record will be able to interface with them, which will save our nurses a tremendous amount of time entering medications. Our nurses will also have a drug formulary App on their smartphones. Also patients will get a 25% discount on the medications not covered by hospice that they fill at a local pharmacy. • Our non-formulary drug costs with our current vendor Enclara average $0.08-$0.14 per patient day compared to their benchmark of $1.10. So our staff is doing a great job keeping those expenses very low. • The first Fellow from our agreement with the I.U. School of Medicine (IUSM) finished her four week rotation with us. We now have agreements with Mayo and IUSM for their hospice and palliative medicine doctors. Two more Fellows from IUSM will be here next year. Hopefully this will be a pipeline for us to hire new doctors. We have contracts with about 16 teaching institutions in various disciplines. • Larry Rice, Spiritual Care Coordinator, who did the board education piece at the August board meeting, will have an article published in the November issue of the	

Topic	Discussion	Action
	"Journal of Palliative Medicine" on the spiritual comfort scale. This also meets one of our goals in the current Strategic Plan. • We have created a C.O.M.F.O.R.T information sheet for COPD patients that they can post in their home, so they don't panic, revoke and go to the hospital. We are calling it a "trouble breathing plan." All staff has been educated on it. It will start at admission and then at every visit staff will remind the family about it. The main thing is to call us first and not panic. • The new HMB rate cuts went into effect 10/01 and the new payment system will go into effect 01/01. Many state Medicaid agencies will not be ready. Per federal statute, the states that offer the Medicaid Hospice Benefit have to pay the same as the Hospice Medicare Benefit. The new payment system is very complicated and we don't know how Indiana will deal with it. The biggest fear on the national level is that since hospice under Medicaid it is optional by state, some states may not have a Medicaid Hospice Benefit any more. Indiana didn't have it until 1997. • Next year we will begin to use the PlaymakerCRM customer management tool. Our liaisons will be able to access Medicare data on physicians, how many referrals they made and to whom, and other Medicare data which will be helpful for them to review before they make a visit. The liaisons will also be able to track relationships. Amy T. will have a dashboard for the entire team. So if a doctor that has made referrals that we haven't seen in a few weeks, Amy can push a button and send a message to the liaison to visit that doctor. • Uganda – Mark shared pictures from his visit to Uganda, PCAU, and the 6th Biennial National Palliative Care Conference. 400 people from 20 countries attended. They are so appreciative of what we are doing for them. They are now in 93 out of 112 districts, compared to 34 districts when we started our collaboration with them nearly nine years ago. Two of our staff did poster presentations at the conference. The "Road to Hope" documentary had its world premiere and was very well received. It will have its U.S. premiere tomorrow night at Okuyamba Fest at the Mishawaka office. • Amy T. continues to work on updating the CHC website. The new one will be launched in November. It will be more responsive and user friendly, and people will be able to use it on whatever device they pull it up on. It will have applications for employment and volunteering that can be filled out online and sent to us. The website will have a new look and be more interactive.	

Topic	Discussion	Action
4. Finance Committee	• The committee met last week and approved and recommends for board approval the August and September financial statements. Two main points you will hear about: Everyone in the country lost money in investments in August. Compared to the rest of the country, our loss was 3-4% compared to the benchmark of 4-6%. So we are well served by Vanguard and where we have our funds. Secondly, we continue to work on the Accounts Receivables. Expectations of leadership are very high and we had expected the A/R to go down dramatically by now. We have not met that goal, because we are still down a medical director position. We are not in danger of losing any money, because we have a year to submit the claims. This is reflective of setting our goals high and we feel we should keep going ahead. Also, census has been going up due in part to longer lengths of stay. This shows our message is getting out to families to contact us earlier. We are currently on pace at the current levels to have a year-end ADC of around 400 and we budgeted for 385. • August – Operating income $1,911,697, interest income $109,762, investment loss ($817,206), total revenue $1,058,857, total expenses $1,564,569, net loss ($505,712), net without beneficial interest in Foundation $456,890. YTD August – operating income $14,567,531, interest income $311,517, beneficial interest in Foundation ($271,759), total revenue $14,607,289, total expenses $12,533,043, net gain $2,074,246, net without beneficial interest in Foundation $2,346,005. • September – Operating income $1,886,291, interest income $18,338, beneficial interest in Foundation ($326,729), total revenue $1,577,900, total expenses $1,617,327, net loss ($39,427), net without beneficial interest in Foundation $287,302. YTD September – Operating income $16,453,822, interest income $329,855, beneficial interest in Foundation ($598,488), total revenue $16,185,189, total expenses $14,150,371, net gain $2,034,818, net without beneficial interest in Foundation $2,633,306. The overall net gain was up 17% from a year ago. Without beneficial interest in Foundation was up 51.5%. Combined organizations without investments net was up 152% from a year ago. With the increase in ADC, we are $688,000 ahead of budgeted operating income and $300,000 ahead of budgeted expenses. • A motion was made to accept the August and September financial statements as presented. The motion was accepted unanimously.	A. Mauro motioned M. Newbold seconded
5. QI Committee	• Carol Walker reviewed the minutes from the 08/18 Quality Improvement Committee meeting. There is a lot of diligent work going on behind the scenes. Our	

Topic	Discussion	Action
	aim is to have a totally electronic medical record. Efforts are happening with scanning paper documents and decentralizing, so charts can be closed quicker and reduce the backlog of those charts. We also aim to establish a consistent audit so we have revised the audit forms. Infection control – We have held six TB validation courses resulting in 27 staff members having valid renewals or new TB validation cards. We continue to do Bloodborne Pathogens education and more specifically with individual groups. There was one needle exposure with a staff member that was followed up on. That staff person received education on correct glove and handling procedures. The group is also doing short HIPAA presentations at each staff meeting. Spiritual Care staff is focusing on looking at emotional support of families. Generally it is difficult to meet expected standards, but in the past two years families have rated CHC 93-99%, which is almost unheard of in patient satisfaction surveys. Patients are getting very good holistic care and we are meeting the emotional needs of families. There is a lot of good things going on behind the scenes to make sure quality care is being provided. There is definitely a buy-in from staff and it is very collaborative. Thank you Carol for agreeing to serve as the board representative on this committee.	
6. Foundation Update	• YTD we have raised $1,267,659, which is ahead of last year. Please note that Karl's numbers are different than Mike's report. Karl shows the Foundation revenue YTD as $1.6MM and Mike has $1.2MM, because the revenue is tracked on a cash basis versus an accrual basis. Accrual requires Karl to recognize pledges once they are secured and the Foundation recognizes pledges when the payments are received. We are looking at year over year giving and segregating annual giving from bequests, major one time gifts, and the campaign. So in the second part of the report you will see references made to month to month and year to year basis. Accept for April, we have been about 20% ahead of last year, so we feel very good with where we are at. • Capital Campaign – Is through the first 14 months of a five year campaign. So far we have raised $3.7MM of the $10MM campaign, which includes pledges. Thank you board members for your participation. We have about 70% participation so far. We are very grateful for your support. • Planned giving received $125,000 and YTD $250,000. • Annual Giving – Friends of Hospice campaign runs through the end of November, and then the Annual Appeal campaign kicks off. So far Friends of Hospice has raised about $35,000 and the goal is $40,000.	

Topic	Discussion	Action
	• Bike Michiana for Hospice – 1,058 riders participated. This is the fourth year we had over 1,000 riders. The event raised $110,000, a portion of which will be shared with the Bike Michiana Coalition because we are in this as partners. All of the donations will come to us. • Okuyamba Fest is 10/22 at 5:30 p.m. at the Mishawaka Campus. There will be two screenings of "Road to Hope," one at 6:15 and one at 7:30. There will be a silent auction, and international beers, wines, and food. Tickets are still available. • Road to Hope – There are 22 children enrolled in the Road to Hope program. This is for children that were caregivers for their parents and helping them get education, often in a boarding school. The Road to Hope Coordinator works for PCAU and we support that full-time position. We have raised about $40,000-$45,000 for this program. 15 of the 22 children are now fully sponsored. Another event is planned for next April in Los Angeles hosted by Torrey DeVitto, the narrator of the film. Last year her event raised $27,000. Primary boarding school costs about $300/year and secondary boarding school costs about $500-$600/year, so blending those costs together it takes about $450/year to sponsor a child. Karl has a line item set up in the General Ledger so we can track it for specific children. • Mishawaka Campus – We continue to make improvements. The large rocks at each entrance will have our name and logo emblazoned upon them. Each core value has been carved into the stone benches in the courtyard.	
7. Board Education	• Sue M. reviewed the Quality Assessment and Performance Improvement (QAPI) program. All disciplines participate in the projects. The results are reviewed by management, the board, and external stakeholders like ISDH. The surveyor will ask to see our quality programs.	
Adjournment	• The meeting adjourned at 8:35 a.m.	Next meeting 12/16

Prepared by Becky Kizer for approval by the Board of Directors on 12/16/15

_____ _____

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
December 16, 2015
(*Report posted to Secure Board Website December 10, 2015)*

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:30 AM.
This report includes event information from October 21 – December 16, 2015.
The Hospice Foundation Board meeting follows in the same room.

CENSUS

At the end of November, year-to-date (YTD) referrals to CHC are up 3% from 2014, while original admissions are down 5%. Eighty-one fewer new patients have been admitted. November's 128 new admissions were the lowest since February 2015. The percentage of patients being referred and then dying before they could be admitted is down slightly from last year, 5.72% compared to 6.63% in 2014. From a patients served standpoint, we are now 1% below where we were last year through the end of November. Generally, admissions slow down during the last quarter of the year and the Average Daily Census (ADC) dips through the end of the year as you can see on Dave Haley's attached census charts. Referrals directly from patients and families are up about 11% from last year, but this category is also the most likely not to be admitted. We have once again used mystery calls with Simione Consulting and identified areas in desperate need of improvement with our Intake staff and how they are handling incoming telephone inquiries from the general public. 39% of November discharges had a length of stay of seven days or less; YTD it is running 36%. YTD occupancy shows Elkhart Hospice House running 2% ahead of last year while South Bend Hospice House is running 2% below last year. We still expect to end the year with the highest ADC in our history, about 9% above last year which has had very positive financial ramifications.

November 2015	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	486	1,967	1,985	(18)
Original Admissions	128	1,599	1,680	(81)
ADC Hospice	381.33	375.47	351.13	24.34
ADC Home Health	18.00	23.25	18.36	4.89
ADC CHC Total	399.33	398.72	369.49	29.23

October 2015	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	525	1,839	1,826	13
Original Admissions	152	1,471	1,521	(50)
ADC Hospice	388.68	374.89	350.53	24.36
ADC Home Health	23.71	23.77	17.68	6.09
ADC CHC Total	412.39	398.66	368.21	30.45

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	**2015** Nov	***2014*** *Dec*
S.B.:	209	207	219	234	230	234	236	233	229	228	214	214
Ply:	68	66	67	72	68	78	78	83	90	89	84	68
Elk:	84	83	87	87	92	86	89	85	86	84	92	86
SBH:	4	6	5	6	4	6	5	5	5	6	5	5
EKH:	3	6	5	5	6	4	6	5	5	5	4	3
Total:	369	369	382	403	401	407	414	411	415	412	399	376

HOSPICE HOUSES

November 2015	Current Month	Year to Date	Prior Year to Date	YTD Change
SB House Pts Served	29	300	295	5
SB House ALOS	5.66	5.84	6.14	(0.30)
SB House Occupancy	78.10%	77.98%	77.42%	-2.44%
Elk House Pts Served	26	262	274	(12)
Elk House ALOS	4.38	6.14	5.69	0.45
Elk House Occupancy	54.29%	68.82%	66.64%	2.18%

October 2015	Current Month	Year to Date	Prior Year to Date	YTD Change
SB House Pts Served	34	274	268	6
SB House ALOS	5.26	5.80	6.24	(0.44)
SB House Occupancy	82.49%	74.67%	78.57%	-3.90%
Elk House Pts Served	28	242	249	(7)
Elk House ALOS	5.25	6.18	5.78	0.40
Elk House Occupancy	67.74%	70.25%	67.67%	2.58%

PATIENTS IN FACILITIES

Of the 486 patients served in November, 179 resided in facilities. Of the 525 patients served in October, 182 resided in facilities. The average daily census of patients in skilled nursing homes, assisted living facilities, and group homes during November was 157; October was 160 and YTD through November it was 140.

FINANCES

Karl Holderman, CFO, reports the November 2015 Financials will be posted to the Board website on Friday morning, December 11th following Finance Committee approval. For information purposes, the un-approved October financials are presented below.

October 2015 Financial Information

Center for Hospice Care *(1)*

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

October Overall Revenue	$	2,599,125	Year to Date Overall Revenue	$	18,784,312
October Total Expense	$	1,583,087	Year to Date Total Expense	$	15,733,457
October Net Gain	$	1,016,038	Year to Date Net Gain	$	3,050,855

Hospice Foundation

October Development Income	$	56,733	Year to Date Development Income	$	1,682,342
Oct. Investment Gains (Loss)	$	799,877	Year to Date Investment Income	$	223,731
October Overall revenue	$	848,898	Year to Date Overall Revenue	$	1,921,402
October August Expenses	$	176,279	Total Year to Date Expenses	$	1,847,267
October Overall Net	$	672,619	Year to Date Overall Net	$	74,235

Combined *(2)*

October Overall Revenue	$	2,775,404	Year to Date Overall Revenue	$	20,631,581
October Overall Net Gain	$	1,016,038	Year to Date Overall Net Gain	$	3,050,855

(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 October 2015, the combined operating income is $18,347,171, up 8% from October 2014 while expenses of $17,580,726 are up just 4% from same time last year. The overall combined net gain for CHC / HF was $3,050,855 representing a 24% increase from YTD October 2014. At 10/31/15, CHC's YTD Net without the beneficial interest in the HF was $2,976,722 representing a 52% increase from same time last year. The combined YTD net at 10/31/15 without counting investment gains/losses was $2,827,124 representing an increase of 88% from YTD same time one year ago.

At the end of October 2015, the Hospice Foundation's Intermediate Investments totaled $1,399,276. Long Term Investments totaled $16,616,948.

CHC's assets on October 31, 2015, *including* its beneficial interest in the Hospice Foundation, totaled $39.7MM. At the end of October HF's assets alone totaled $32.9MM 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 October 31, 2015 of just over $45.7MM.

2016 CHC BUDGET

The 2016 CHC budget will be reviewed by the Finance Committee on Friday morning, December 11. If passed, the budget will be posted to the board website later that morning. Even with the ongoing reimbursement cuts, a new and untested Medicare Hospice Benefit payment system beginning on January 1, additional unfunded and expensive regulatory mandates, and realistic census projections, the 2016 CHC budget does show a net from operations alone. As a reminder, since 2009 Medicare has been cutting hospice reimbursement, leading to financial challenges at most hospices. According to the National Hospice and Palliative Care Organization (NHPCO), through the Affordable Care Act alone, hospice providers are having their rates cut 12% through 2020. In a recent study underwritten by NHPCO, Medicare cuts are expected to reduce hospice provider margins that averaged 2% in 2008 to a -14% margin by 2019.

CHC VP/COO UPDATE

Dave Haley, VP/COO, reports…

Implementation of the new HospiScript pharmacy and DeliverCareRX delivery system occurred on November 9. There were a few small speed bumps, but things overall are going well. This new pharmacy system is expected to save us significant dollars. It is too early at this point to make a meaningful monthly comparison of costs with the previous Enclara Pharmacia system. However, we received an email from a HospiScript Vice President in which he said "…overall you and your team members are doing great! I've been watching the data and overall you have only had 10 prescriptions at the end of last week not on the formulary. That's a formulary adherence of 99.03%. That's the current highest in all of HospiScript and highest I've seen in a while! The current average adherence rate for all of HospiScript to the Calisto formulary is 94%." This is testimony of the excellent job our medical staff is doing in controlling pharmacy costs.

We have received information of the start date of our new nurse practitioner, Dr. Liz Hale, DNP. She is scheduled to join our staff on January 11, 2016. A new fee-for-service nurse practitioner, Ludmila Pichugena-Emerson, NP-C, started doing face-to face visits two days a week beginning November 5. This will help free up our medical staff for other activities, like catching up with the backlog of certifications and re-certifications so we can bill in order to reduce our accounts receivables. Due to the extra help with face-to-face visits, cooperation among our medical staff, and good time management, Chief Medical Officer, Gregory Gifford, MD, has blocked off the majority of his time to concentrate solely on completing certifications of terminal illness. His goal is to complete two months of certifications every month. Dr. Gifford's efforts during November alone allowed us to bill over $1.5MM in outstanding Medicare patient days.

Elise Carey, MD, who has supervisory responsibility over the Hospice and Palliative Medicine Fellowship at the Mayo Clinic, contacted Dave Haley about how we were handling referred patients who died before we could admit them (DBAs) and how we were handle requests for hospital general inpatient care for those who are fragile at the end of life. She expressed great interest in how CHC dealt with both of these issues and asked if the Mayo Clinic could send three or four people here to learn what we were doing. We continue to provide education to Mayo Clinic.

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

DIRECTOR OF NURSING UPDATE

Sue Morgan, DON, reports…

As stated earlier, our new pharmacy and delivery service for our residential and facility patients began on November 9, 2015. Both Hospice Houses will be utilizing the same services beginning January 11, 2016. Another positive for CHC is that the change in vendors has allowed for electronic integration with the Cerner electronic medical record (EMR) suite meaning that medication profiling can be done within Cerner and the CHC nurses are experiencing improved ordering of medications.

The Primary Nurse Job Description and Title will be changed to Case Manager effective 12/2/15 this reflects their role more accurately. "Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes" -- excerpted from CMS.

The Nursing Goals for 2015 have now all been completed and met.

The Quality Assurance Department continues a number of projects to enhance turnaround times of various elements of the medical record with the goal of a total EMR.

We have recently formed the Health Information Management Committee to review and update anything related to medical record documentation and the electronic medical record.

Nursing leadership completed a "mock" Indiana State Department of Health survey for Home Health licensure and Medicare certification on September 30 – October 2, 2015. The purpose was to identify any outstanding deficiencies and areas of improvement for the impending survey. The timing was very good as we had our survey November 6 -10, 2015. The survey run through certainly paid off as you can see in the next section of this report.

CHC STATE / MEDICARE HOME HEALTH SURVEY RESULTS

On Friday, November 6, 2015, a Public Health Nurse Surveyor from the Indiana State Department of Health arrived at the South Bend office to perform our Home Health licensure and Medicare Home Health recertification survey, the first one in just over three years. During her three days

here, she reviewed patient charts, home health policies, patient rights, quality measures, HR materials, and went on home visits with staff to witness in-person our patients' experiences of CHC home health services. Beginning with Friday's arrival, the process continued all day Monday and the majority of the next day. It concluded with an Exit Interview at 4:15 PM on Tuesday where she presented her findings. The Exit Interview lasted five minutes as she reported there would be a finding of "No Deficiencies." This would be our second PERFECT SURVEY in a row for our home health license. Her other comments, as reported to me, included: we should spread what we're doing throughout the State of Indiana; our patients love our staff and bragged about them; and she made mention that our documentation was fantastic.

HOSPICE FOUNDATION VP / COO UPDATE

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

Fund Raising Comparative Summary

Through November 2015, the Development Department recorded the following calendar year cash gifts 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	51,685.3	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	1,321,352.39
November	1,043,750.46	1,091,575.65	895,164.28	969,395.17	1,376,246.01	1,469,386.01
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	53,693.27
November	49,247.09	48,284.08	46,674.33	47,133.33	44,238.83	46,870.62
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**	**1,095,791.16**

Cornerstones for Living: The Crossroads Campaign

Campaign activity in the form of meetings, presentations, phone calls and email exchanges continues to move forward as we navigate through the quiet phase of the campaign. Through the first 17 months of this five-year campaign (7/1/14 thru 11/30/15) total cash, pledges and documented bequests stand at $4,120,661.

Soliciting lead gifts and cultivating prospective lead gift donors are top priorities. Meetings in October and November with individuals, corporations, foundations and business partners continue to advance our goal to have a minimum of $1 million or more in campaign funding requests under consideration by prospective donors. Recent activity includes meetings with the administrator of a charitable trust capable of making a very significant campaign gift. Initial meetings with him have been positive, and we are preparing a follow up meeting to review funding proposals with him prior to the end of the year. Other cultivation meetings have taken place with individuals and representatives of organizations capable of pledging lead gifts. We are grateful for the support of our campaign cabinet, and we are most appreciative of Catherine Hiler's leadership and support as chair of the campaign cabinet.

Planned Giving

No new estate gifts were received since the last report, and year-to-date bequests remain at a total of $248,043.40. We continue to work with the executor of an estate that is directing a gift of $100,000 to Center for Hospice Care. Based upon our discussions, the gift will likely be directed toward the Camp Evergreen Endowment portion of the campaign in honor of the donor. Details are being finalized with the executor and the donor's family members.

Annual Giving

The *2015 Friends of Hospice* (FOH) appeal is closing as we transition toward launching our 2015 Annual Appeal. The 2015 FOH raised $35,690. The combined total raised during the course of the past year by both our annual giving appeals is $168,767.42 – $18,767.42 over our goal of $150,000. This year's *Annual Appeal*, titled "*Choosing to Soar*," features the story of current CHC patient Terry Meland. Terry's bucket list included the wish to fly over Michiana one last time. With the help of CHC and Indiana Flight Center in Elkhart, Terry was able to cross that item off his list.

This appeal was featured in our *Giving Tuesday* fundraising efforts, which 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 *4th Annual Okuyamba Fest* was held on Thursday, October 22nd. In addition to the international foods, wines and beers, and silent auction items featured in the previous three years, this year's event featured two private screenings of the Road to Hope documentary. Proceeds from the event benefited the Road to Hope fund. More than 80 people attended this year's event and we're pleased to announce that we were able to arrange for four Road to Hope children to be fully sponsored as a direct result of the event. In total, the event raised $7,693 toward our Road to Hope Fund.

We are also pleased to announce that the recipients of the 2016 *Helping Hands Award* have been selected and have agreed to be honored. The 2016 event will focus on fundraising for our We Honor Veterans program. Former South Bend Mayor/Indiana Governor Joe Kernan and former Mishawaka Mayor Bob Beutter will be recognized for their military service. Chair and committee selection will begin in December. Proceeds from the 2016 event will be earmarked for the Veteran's Memorial to be erected on the south lawn adjacent to the East Wing of the Administration building and forthcoming Patient Care Staff Building. Lou Behre will once again be helping us orchestrate the event. The *32nd Annual Helping Hands Dinner* will be held on Wednesday May 4, 2016 at the Hilton Garden Inn. Sponsorship packets and Save-the-Date cards will be sent in January, 2016.

Global Partners in Care/PCAU

We continue to work with the Palliative Care Association of Uganda on the dissemination and implementation of the comprehensive morphine supply chain recommendations from the Notre Dame Executive MBA team, "*Business as Usual*." Currently Rose Kiwanuka is meeting with stakeholders throughout the supply chain to share the findings. In addition we have submitted a new project request to the EMBA program for 2016. This request entails an update of PCAU's 5-year strategic plan as well as a succession strategy.

We are also working with Lacey Ahern of the Eck Institute for Global Health to continue progress on the mHealth pilot program Brianna Wanless initiated this past spring. Lacey has identified a graduate student she thinks will be a good fit for this project. The student has been an ER nurse, so her clinical skills and knowledge should enable her to make additional significant contributions to the existing program as we work toward its expansion to additional clinical sites throughout Uganda.

Road to Hope Program/Documentary

Although seven students were added to the program following our CHC/HF Team's visit to Uganda in August/September, we're pleased to say we currently have more sponsors lined up than we have children available. Denis Kidde, International Program Coordinator, is working with Rashidah Adams, PCAU's Road to Hope program coordinator, to identify additional children in need of sponsorship. As noted earlier, we were able to facilitate the sponsorship of four children at this year's *Okuyamba Fest*. In addition, Roberta Spencer gave a presentation to a church organization in Michigan that's resulted in two additional sponsorships. To top things off, for the first time we have made Road to Hope sponsorships available through our employee giving program, which is processed through bi-weekly payroll deduction. The total annual cost to sponsor a child is $450 and

we already have an additional 17 sponsors lined up through this initiative. Open enrollment, of which employee giving is part, will close on December 15th so this number may increase.
As previously reported, the Uganda private screening of "Road to Hope," which took place during PCAU's bi-annual Palliative Care Conference, received high marks from attendees and we experienced a similar response to the screenings held during Okuyamba Fest. The film has been 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 screen the film as part of a proposed 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 (who is starring in NBC's new hit show "Chicago Med"), Brandi Milloy (recurring guest host/food expert on 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

DJ Construction has provided preliminary cost estimates for the recently designed patient care staff building and Helman Sechrist Architecture continues to work on design options for the new hospice house. We are working with our landscape architect, Chris Chockley, of Jones Petrie Rafinski on the next generation of design options for the veteran's memorial.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

Amy Tribbett, Director of Marketing and Access reports…

Referral & Community Outreach

- Two of our Admission Reps, will transition to Community Outreach Specialists on December 13. Their focus will be veterans, extended care facilities, and community education. They will be available on an as needed basis for Pre-Assessments.
- We were the main sponsor of the Michiana Gerontology Institute fall conference. Pre-conference activities were held at CHC. Our brand was included in all pre conference advertising, in the conference bags and at the conference.
- On November 10, Fox28 was here to capture our first-ever Veterans Day celebration for our bereaved families, as well as volunteers.
- We honored veterans on November 11 at Holy Cross Village in two separate ceremonies. WNDU was there to cover the event.
- We presented to 22 case managers at Elkhart General. They are very happy with our service and had no known issues.

- Staff received personalized gift bags for November, National Hospice Month. Their gifts included: CHC 35 year anniversary football jersey, power bank, lanyard and ID badge holder.

Volunteer Department

- 11 new volunteer interviews
- 16 new volunteer inquiries
- Trained 27 new volunteers in October & November
- Led one Veteran only volunteer training in November
- Outreach has begun for spring 2016 training

Access

October Intake Stats
- 2,318 phone calls
- Average 75 phone calls per day
- Average 25 calls per Referral Specialist per day
- Average 3 phone calls per hour

November Intake Stats
- 2,015 phone calls
- Average 67 phone calls per day
- Average 22 calls per referral specialist
- 2.8 phone calls per hour

Marketing

- The winter issue of Choices will go to press in mid-December.
- Our work with Playmaker CRM continues. We are in the building stage; combining our data with CRM's program. Training is slated to begin in January.
- The digital campaign continues to perform incredibly well. In October & November, 112 phone calls were generated from CHC's digital campaign. In the last 60 days, not only have we received 112 phone calls, but our ads have been clicked 946 times:

Website

- The new CHC website is planning for a launch date before the end of the year. The new site will feature blog posts, fillable applications for careers and volunteers, and several more improvements.
- In October, our current website traffic totaled over 4,000 hits with 8,830 page views and 1,600 total organic searches. The Home page and Patient & Family pages continue to be most popular.
- In November, current website traffic totaled over 3,360 hits with 7,640 total page views and 1,400 organic searches.

Social Media

Facebook (Center4Hospice)

	September	October	November
Posts	37	41	38
Links	15	0	0
Fans (cumulative)	1,360	1,600	1,774
Comments left	4	7	25
Likes across content	318	468	939

Twitter (Center4Hospice)

	September	October	November
Tweets --cumulative	732	792	861
Followers –cumulative	310	327	339
Mentions	3	6	4
Retweets	3	10	13

NEW MEDICARE / MEDICAID HOSPICE PAYMENT SYSTEM BEGINS JANUARY 1

As we have been reporting for several months, after several years of discussion and analysis, the Centers for Medicare and Medicaid Services (CMS) announced changes to the hospice payment model for FY2016. The changes were finalized in the FY2016 Hospice Wage Index final rule, published on August 6, 2015. Effective January 1, 2016, a two-tiered routine home care rate and a service intensity add-on will become effective. The RHC will have a higher rate for the first 60 days of a hospice patient's care, and a lower rate for days 61 and after. There are numerous specific and complicated instructions and potential problems with a new system that is this complicated. One frightening item is that CMS's fiscal intermediary contractors will simply do all of the math on their own "behind the scenes" and pay hospices what they are supposed to receive. There are new issues of counting the days of care as the days of care will now follow the patient when a break in service (revocation, discharge, and readmission) takes place within less than 60 days. A new certification period begins if the break in care spans a period of time greater than 60 days. There is a new service intensity add-on (SIA) payment which will be made for visits conducted by an RN or social worker during the last seven days of a hospice patient's life, if the following criteria are met. 1.) The day of care is a RHC day. 2.) The day occurs during the last 7 days of life. 3.) The patient's discharge is due to death. 4.) Direct care is provided by an RN or social worker. 5.) Only in person visits count toward the payment; no social worker phone calls. 6.) The total hours paid at the SIA cannot exceed four hours in a single day for the RN and social worker combined. When all of these criteria are met, the hospice will be paid the Continuous Care level of care hourly payment (example: $37.45 per hour in St. Joseph County) broken into fifteen minute increments in addition to the RHC rate for those days that qualify. Incredulously, prior to its implementation, there has been no demonstration project or testing of any kind related to this new system that goes LIVE on New Year's Day. Accruing revenue for our billing / finance department will become even more challenging than it already is.

To further obfuscate matters is the complete unknown regarding the preparedness of Indiana Medicaid to meet these major modifications on 1/1/16. The Social Security Act requires that

Medicaid "payment for hospice care be in amounts no lower than the amounts, using the same methodology," used under Medicare. Therefore the new two-tiered RHC rate applies to both Medicare and Medicaid. CMS communicated with the state Medicaid agencies on September 1, 2015 and issued their expectation that states would implement the new payment structure for Medicaid patients receiving hospice care. As a Board Member for the Indiana Hospice and Palliative Care Organization (IHPCO), I have been inquiring to Indiana Medicaid through IHPCO regarding our state's ability to meet the requirements of the new system. Indiana Medicaid has stated in emails back to IHPCO that their fiscal contractors expect to be ready. Yet they have published no new instructions, released no new forms, scheduled no training sessions. They have also indicated, "There may be a need for mass claims adjustments in the future."

CHC STAFF GROUP HEALTH INSURANCE BENEFITS

At the 2016 Open Enrollment Staff Meeting on November 18, we announced that for the third consecutive year, there would be no increases to the employee portion of the Group Health, Vision, and Dental plans at CHC. We appreciate the fantastic job that Vicki Gnoth, Director of Human Resources, and Karl does each year to keep our costs low and arrest the increases for CHC staff. The staff response was spontaneous and thunderous applause.

NEW POLICIES AND POLICY UPDATES

There are several patient care policies on the Agenda. The revisions are needed due to regulatory changes and to reflect our current practice. There are two sets of policies, one for our Home Health agency and one for our Hospice agency. In many cases, they are very similar and many of the changes are identical. However, separate policies are required due to the separate Medicare Certification and State Licensure of our two separate agencies.

REVISIONS TO CHC BYLAWS

The Hospice Foundation Bylaws needed to be reviewed so we took this opportunity to have our attorney in Indianapolis review the CHC Bylaws at the same time. Our attorney practices exclusively in the nonprofit arena. There are no substantive changes. We are changing the range of needed board members from 12 – 21 to a new range of 9 – 15 with a hoped for target of 12. Other than that, our goal was to accomplish three items. 1.) Provide that the Immediate Past Chairman of the Board of Directors of the Hospice Foundation" serves as a member of the CHC Executive Committee. 2.) Eliminate unnecessary provisions dating back to 1978. 3.) Provide for consistent usage of terms throughout the Bylaws and insure they are substantially similar in structure with respect to the Bylaws of the Hospice Foundation. The CHC Bylaws changes were reviewed and approved by the CHC Executive Committee on December 9, 2015. A Resolution for their approval by the full board will be on the Agenda for our meeting. The Resolution is attached to this report immediately following the redlined and clean version of the proposed new CHC Bylaws Amendments.

ELECTION OF NEW BOARD MEMBERS FOR 2016 / RECOGNIZING OUTGOING BOARD MEMBERS

There is one new board member slated to be approved to join the CHC Board in 2016. Jennifer C. Ewing, RN, MSN, NP-C, AOCNP has agreed to serve on the CHC board next year and is very enthusiastic about the opportunity. She is the Oncology Nurse Practitioner in the practice of Dr. Bilal Ansari, a former CHC Board member, at Michiana Hematology Oncology, PC. Additional information about Jen is available on the 2016 Board of Director Slate which is attached to this report.

The CHC Executive Committee and Board Officers will remain the same and each member will be continuing their terms in the same Officer roles. All will be entering year two of a two-year term.

We welcome Francis Ellert to his second three-year term in 2016.

We sincerely thank Tim Yoder and Becky Asleson for their CHC board service over the last three years.

CHC HOSTS FIRST EVER VETERANS APPRECIATION DAY

November 10 saw nearly 100 people participate in the first CHC Veterans Appreciation Luncheon held here at the Mishawaka Campus. CHC veteran volunteers, some surviving bereaved of veterans, and CHC veteran staff members were invited. The Miller's Veterans Honor Guard presented the colors. The CHC CEO was the emcee. Representatives from Senator Donnelly's office and Representative Walorski's office were on hand to offer comments and thanks. Governor Joe Kernan was a guest speaker and Mishawaka Mayor Dave Wood was the featured speaker. A pinning ceremony was held for all veterans present, special music was provided by a CHC Volunteer, the CHC Spiritual Care department provided a reflection, a video was shown with the theme songs of each branch of service and all present were invited to stand and be recognized when their service branch song was played. The event ended with a complimentary buffet lunch. Response was very positive.

CHC PATIENT PILOT STORY TO BE PART OF NATIONAL HOSPICE CAMPAIGN

In May 2014, the National Hospice and Palliative Care Organization launched a first of its kind national public awareness campaign called *Moments of Life: Made Possible by Hospice*. Research commissioned by NHPCO found a vast majority of people (96%) who've had a personal connection to hospice through a family member or friend are left with a positive impression of what hospice care can do. However, most Americans don't have this personal experience. Many don't really understand how hospice works, how it is paid for, the scope of services offered, or the level of expertise the hospice team brings to every patient. The goal of *Moments of Life: Made Possible by Hospice* is to educate the public about the choices we all have when facing a life-limiting illness, and how choosing hospice (or palliative care earlier in an illness) is not "giving up." The campaign is also about capturing vivid, emotionally powerful "moments" on video that will hopefully shatter myths and change minds. "Moments" features stories from across America from the patient, family caregiver, and hospice professional's point of view reflecting how much more "living" is still possible in the last chapter of life.

Our story on the CHC patient pilot, Terry Meland, a 71-year-old former mortgage banker who has a love of flying airplanes is the next featured story in the Moments Campaign. When Terry was diagnosed with idiopathic pulmonary fibrosis (lung disease) eleven years ago, he had to give up

some of his favorite hobbies. He was no longer allowed to hold a private pilot's license. When Terry began to receive services from CHC, he told his social worker about his bucket list. After they got the go-ahead from his doctors, CHC jumped into action and posted a plea on our Facebook looking for a pilot. Almost immediately we had a reply from Brandon Herzog, department manager for Indiana Flight Center at Elkhart Municipal Airport. Just weeks after the Facebook post a crowd of family, friends and staff from CHC watched Terry step into the Cessna 172. Brandon and Terry took to the skies for a thirty minute flight. A GoPro camera in the plane and a camera team on the ground captured what the day was like for Terry. This story made headlines and the front page of the Elkhart Truth along with extensive coverage on Fox28 News. CHC's pilot story is the 23rd produced so far for the *Moments* campaign. We are the first hospice agency in Indiana to be featured. So far, the campaign's messages have been shared with tens of millions of people through television public service announcements, digital and mobile advertising, press coverage, social media and via their website. We will show the two and a half minute video at the December Board Meeting.

CHC CEO TO CONTINUE AS NATIONAL CHAIR OF HOSPICE ACTION NETWORK FOR 2016

The CHC President/CEO will continue as the national Chair of the Hospice Action Network (HAN) for 2016. HAN's mission is to advocate for national policies that ensure the best care for patients and families facing the end of life by mobilizing a growing network of Hospice Advocates throughout the nation. HAN implements its agenda through direct lobbying, grassroots advocacy and by working with Hospice Advocates to expand the message through education and by sharing the hospice story with Congress. Because HAN is an affiliate of NHPCO, continuing as national Chair of HAN the CHC President/CEO will continue to be a member of the full NHPCO Board of Directors and the NHPCO nine-member Board Executive Committee for 2016.

2015 HAPPY HOLIDAYS AND CHC STAFF FAMILY FUN

130 staff and their family members signed up for "Donuts with Santa" held here at the Mishawaka Campus on Saturday morning December 5th from 9 – 11 AM. Donuts, juice, a candy cane walk, crafts, surprises, and visits with Santa along with photos were provided by CHC. This event was open to any CHC employee and their families, children and grandchildren from any CHC office. This is the third year we have done this and response was very favorable.

2015 CHC MEMORIAL SERVICES

On Sunday, December 6, CHC held three Memorial Services for surviving family members. Locations included the Kroc Center in South Bend, Trinity United Methodist Church in Elkhart, and Christo's Banquet Center in Plymouth. Attendance in South Bend was 206, Elkhart was 145 and Plymouth was 101 for a total of 452.

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.

OUT AND ABOUT

Mike Wargo and I attended the Foundation for Saint Joseph Health System's "Faithful Lives" dinner on November 5th.

Dave Haley, Mike Wargo, CHC Nurse Practitioner Dr. Cathie Whitcroft, and former CHC board member Denny Beville attended the Medicine Ball on November 7th. This is an annual fundraising event for the Indiana University School of Medicine at South Bend which honors the School, their faculty and their medical students.

Several staff, including Mike Wargo, along with Hospice Foundation volunteers attended the South Bend Alumni Hall of Fame dinner on November 17. The Veldman Family was inducted and Mike Wargo presented their introductory remarks.

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

Redlined version of CHC Bylaws changes followed by a clean copy of the new version followed by a Resolution for the board to accept the changes.

Board Member slate for new board member for 2016.

Dave Haley's Census Charts

Notre Dame Research department press release on Brianna Wanless and her project, "Developing a Surveillance System to Support and Strengthen Palliative Care Services in Uganda," which she presented at PCAU's 6th Biennial Palliative Care Conference with us in Kampala in August.

WNDU-TV story regarding CHC honoring Veterans at Holy Cross Village.

Fox28-TV story about the same event.

Copy of a "Thank You" flyer from the Penn High School Counseling Center for the many years we have been facilitating grief support groups for students at that location.

Baltimore Sun Op-Ed piece by an assistant professor of anesthesiology for the School of Medicine at the University of Maryland entitled, "The High Cost of Dying."

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

October and November 2015 Financials.

2016 CHC Budget

Board Resolution for Acceptance of the Bylaws Amendments

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, February 17, 2016 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 .

# # #

BY-LAWS
OF
THE CENTER FOR HOSPICE AND PALLIATIVE CARE, INC.

~~BY-LAWS~~
ARTICLE I

~~I. TITLE: NAME, AIMS, AND PURPOSES~~
Identification and Purpose

~~1.10~~ **Section 1 Corporate Name**

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

~~1.20~~ **Section 2 Aims, Purposes, and Powers**

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

~~1.21~~(a) To improve the quality of living.

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

~~1.23 To have and exercise all the general rights, privileges and powers permitted under~~

~~The~~(c) To have and exercise all the general rights, privileges and powers permitted under the Indiana Nonprofit Corporation Act of 1991, as amended~~, (hereinafter referred to as~~ (the ~~"~~"Act~~"~~"); provided, however, that it shall engage in no activity which is not permitted by ~~a corporation which is exempt from Federal Income Tax~~an organization that has been determined by the Internal Revenue Service to be a tax-exempt organization as described under Section 501(c)(3) of the Internal Revenue Code of ~~1954 or any corresponding future provision of the Revenue Code (hereinafter referred to as the "Code"~~1986, as amended (the "Code"). The Corporation shall not intervene in, or participate in, any political campaign on behalf of any candidate for public office. No part of the net earnings of this Corporation shall inure to the benefit of any private individual and no director or officer of the Corporation shall receive any pecuniary benefit from the

Corporation, except such reasonable compensation as may be allowed for services actually rendered to the Corporation.

ARTICLE II. MEMBERSHIP

2.10 Membership in Regional and/or National Organizations

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

2.20 Management

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

2.30 Fiscal Year

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

ARTICLE III. BOARD OF DIRECTORS

Membership

The Corporation shall have no members.

ARTICLE IV

Board Of Directors

3.10Section 1 Government

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

~~3.20~~ **Section 2 Disqualification of Board Members**. No individual, who is a ~~Director~~member of the Board of Directors of the Corporation, can at the same time be an employee of the Corporation.

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

~~3.30~~**Section 3 Number**. The Board of Directors shall consist of not less than ~~twelve~~nine (~~12~~9) nor more than ~~twenty-one (21~~fifteen (15) members. The terms of office for members of the Board of Directors shall be three (3) years. Members of the Board ~~members~~of Directors may serve no more than two (2) consecutive three (3) year terms. The term of a ~~board~~ member of the Board of Directors shall commence at the first board meeting of the fiscal year. If a ~~board~~ member of the Board of Directors is serving as an officer of the ~~board~~Board of Directors at the expiration of his second board term, then his ~~board~~ term on the Board of Directors shall be extended to coincide with the expiration of his position as an officer of the ~~board~~Board of Directors. In addition, former ~~Board~~ members of the Board of Directors shall be eligible for re-election to the Board of Directors following a lapse of one year as a member of the board.

~~3.40~~ **Section 4 Duties**. The duties of the Corporation~~'~~'s Board of Directors include the following:

~~3.41~~(a) To review and approve the annual operating budget of Corporation~~.~~;

~~3.42~~(b) To be charged with the responsibility of reviewing, approving, and developing a total program of quality services~~.~~;

~~3.43~~(c) To assess community needs for services to patients with a life threatening illness and their families~~.~~;

~~3.44~~(d) To review and approve program planning and development of long range objectives to meet those identified needs~~.~~;

~~3.45~~(e) To recommend implementation, modification, termination, or monitoring of programs and services of the Corporation~~.~~;

~~3.46~~(f) To hire and discharge the President/CEO based upon recommendations from the Executive Committee of the Board of Directors~~.~~;

~~3.47~~(g) To support The ~~Hospice~~ Foundation for the Center for Hospice and Palliative Care, Inc. (d/b/a "The Hospice Foundation") (hereinafter referred to as the

"Foundation") in its efforts to raise and allocate funds in the best interest of the Corporation's mission;

~~3.48~~(h) To perform any other duties the Board of Directors of a ~~non-profit~~nonprofit Corporation can perform consistent and in accordance with the Act.

~~3.50~~Section 5 Resignation

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

~~3.60~~Section 6 Removal

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

~~3.70~~Section 7 Vacancy

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

~~3.80~~Section 8 Order of Business

. Robert~~'~~'s Rules of Order are to apply at all meetings of the Board of Directors unless waived by a majority of the members of the Board of Directors present.

~~3.90~~Section 9 Delegation of Authority Among the Board of Directors

. It is agreed that the Board of Directors shall elect, at its annual meeting each year—applicable to the two~~-~~ (2) year term of the position, a Chairman, Vice Chairman ~~Elect~~, Immediate Past Chairman, Secretary, and Treasurer of the Board of Directors to assume and perform the ~~following~~ responsibilities~~:~~ set forth below.

~~3.91~~(a) Chairman of the Board of Directors

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

~~3.92~~ (b) Vice Chairman ~~Elect~~ of the Board of Directors

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

~~3.93~~(c) Secretary of the Board of Directors

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

~~3.94~~(d) Treasurer of the Board of Directors

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

~~3.95~~(e) Immediate Past Chairman of the Board of Directors

. The Immediate Past Chairman shall continue to serve as a member of the Executive Committee for the two~~-~~ (2) year period immediately following his/her service as Chairman of the Board. The primary purpose of this position is to ensure continuity and to serve in an advisory capacity.

~~3.96~~(f) Right to Vote

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

~~3.100~~ (g) Election of Officers on Board of Directors . The Chairman, Vice Chairman ~~Elect~~, Secretary, and Treasurer of the Board of Directors shall be elected by the Board of Directors at the time of the Annual Meeting of the Board of Directors for two (2) year terms.

~~IV. OFFICERS OF CORPORATION~~ARTICLE IV

Officers

~~4.10~~**Section 1 Appointment** . The officers of the Corporation shall include a President/CEO, a Vice-President/COO, and a Chief Financial Officer. The President/CEO shall

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

~~4.20~~Section 2 Duties

. The principle duties of the officers are as ~~follows:~~set forth below.

~~4.21~~(a) President/CEO . The President/CEO shall attend all meetings of the Board of Directors. The President/CEO shall be the chief executive officer of the Corporation and shall have the general supervision, direction, and active management of the property, affairs and business of the ~~corporation~~Corporation subject to the discretion, control and approval of the Board of Directors. S/he shall perform such other duties as may be prescribed from time to time by the Board of Directors, ~~by the~~these By-~~laws~~Laws, or the Articles of Incorporation of the Corporation. S/he shall be a non-voting member of the Board of Directors and all standing committees. The President/CEO shall also be the President/CEO of ~~The Hospice~~the Foundation and shall be responsible for the overall relationship between the two (2) entities.

~~4.22~~ (b) Vice-President/COO . The Vice-President/COO shall help with the discharge of duties of the President/CEO and shall serve in his/her absence and shall perform such additional duties as may be prescribed from time to time by the Board of Directors, by the By-~~laws~~Laws, or by the Articles of Incorporation. The Vice-President/COO shall be a non-voting member of the Board of Directors and standing committees as appointed by the President/CEO.

~~4.23.~~(c) Chief Financial Officer . The Chief Financial Officer shall help with the discharge of duties in the absence of both the President/CEO and the Vice-President/COO and shall perform such additional duties as may be prescribed from time to time by the Board of Directors, ~~by the~~these By-~~laws~~Laws, or~~ by~~ the Articles of Incorporation. The Chief Financial Officer shall be responsible and accountable for the receipt of the Corporation~~'~~'s funds and pay out of the same under policies approved by the Board of Directors and under the direction of the President/CEO. The Chief Financial Officer shall be accountable for the deposit of all moneys, checks and other credits to the account(s) of the Corporation in accordance with policies approved by the Board of Directors. The Chief Financial Officer shall enter regularly into the books of the Corporation to be provided for that purpose a full and accurate account of all moneys received and paid out on account of the Corporation. The Chief Financial Officer shall be a non-voting member of the Board of Directors and standing committees as appointed by the President/CEO. The Chief Financial Officer shall also be the Chief Financial Officer of ~~The Hospice~~the Foundation and be responsible and accountable for the financial relationship between the two (2) entities.

~~4.30~~ **Section 3 Vacancies** . Whenever any vacancies occur in the office of the President/CEO of the Corporation, such vacancy shall be filled by the appointment of an Interim President/CEO as detailed within Board of Directors approved policy in place at the time.

~~4.40~~**Section 4 Loans to Officers and Directors** . No loans of money or property shall be made to any officer or director by the Corporation.

~~V. AUTHORITY TO OBLIGATE CORPORATION~~ARTICLE V

Authority To Obligate Corporation

~~5.10~~**Section 1 Checks, Drafts, and Similar Negotiable Instruments** . The President/CEO, the Vice-President/COO, and the Chief Financial Officer of the Corporation shall have authority to sign checks or similar negotiable instruments on behalf of the Corporation. Any of the three (3) can sign checks up to $25,000.00 for ordinary budgeted items. Any check over $25,000.00 would require two (2) of the three (3) signatures.

~~5.20~~**Section 2 Authority to Borrow Funds** . The President/CEO of the Corporation along with the Chairman of the Board of Directors or the Treasurer of the Board of Directors shall have the authority to obligate the Corporation for lending transactions on behalf of the Corporation as approved by the Board of Directors from time to time.

~~5.30~~**Section 3 Execution of Documents** . The President/CEO of the Corporation shall have the authority to bind the Corporation, to contracts or other similar business agreements entered during the ordinary course of the Corporation~~'~~'s business.

Section 4 Membership in Regional and/or National Organizations. The Corporation may maintain membership in other regional and/or national organizations whose purposes are consistent with those of the Corporation. The Corporation may support financially such an organization to the degree deemed appropriate and as allowed by the Act and the Code.

ARTICLE VI

Meetings

~~VI. MEETINGS~~

~~6.10~~**Section 1 Annual Meeting** . The Annual Meeting of the Board of Directors shall be the final meeting of the fiscal year and shall be designated as the Annual Meeting for election of directors, officers of the Board of Directors and the Corporation, and for conducting any other business that may come before the Board of Directors.

~~6.20~~**Section 2 Regular Meetings** . Regular meetings of the Board of Directors shall be held at least four (4)

times a year. Directors shall be notified, in writing, in advance of all meetings.

~~6.30~~Section 3 Special Meeting of Board of Directors

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

~~6.40~~Section 4 Quorum for Board Meetings

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

~~6.50~~Section 5 Voting . Each director shall have one (1) vote on all issues presented for the vote of the Board of Directors of the Corporation.

ARTICLE VII~~. COMMITTEES~~

Committees

~~7.10~~ Section 1 Standing Committees

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

~~7.11~~Section 2 Executive Committee.

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

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

~~7.12~~**Section 3 Finance Committee.**

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

~~Review~~(b) Duties. The Finance Committee shall review budgets for proposed lands and projects, review and approve annual recommended budget proposals to be submitted to the Board of Directors and review the annual audit after each fiscal year. ~~Review~~ The Finance Committee shall also review and plan long-range financial goals for the Corporation.

~~7.13~~**Section 4 Personnel Committee.**

(a) Membership. The Personnel Committee shall consist of appointees by the Chairman of the Board of Directors, and be chaired by the Chairman of the Board of Directors. ~~This committee~~

(b) Duties. The Personnel Committee shall concern itself with the review and recommendations for approval of the Personnel Policies governing the staff of the Corporation.

~~**7.14 Professional Advisory Group**~~

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

Section 5 Professional Advisory Group.

(a) Membership. Membership is to include, but not be limited to:

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

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

~~7.15 Nominating Committee~~

(b) Duties. The Professional Advisory Group shall advise the Corporation on professional clinical issues, participate in the review of the Corporation's clinical programming, patient care policies, procedures and clinical records as required by the federal and/or state Home Health regulations.

Section 6 Nominating Committee.

(a) Membership. The Nominating Committee shall consist of appointees by the Chairman of the Board of Directors in such numbers as they deem necessary. ~~It~~

(b) Duties. The Nominating Committee shall have responsibility for nominating candidates for positions on the Board and officers of the Board of Directors.

~~7.20~~**Section 7 Special Committees**

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

~~7.30~~**Section 8 Appointment of Permanent Committees** . New permanent committees, as needed, may be appointed by a majority vote of a quorum of the Board of Directors from time to time.

~~7.40~~**Section 9 Terms**

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

ARTICLE VIII~~. NONDISCRIMINATION PRACTICES~~

~~**8.10 Services**~~

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

~~**8.20 Employment**~~

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

Indemnification and Conflict Of Interest

~~IX. INDEMNIFICATION AND CONFLICT OF INTEREST~~

~~9.10~~Section 1 **Indemnification of Representatives** . The Corporation shall indemnify its employees, officers, directors and agents from any claim, lawsuit, administrative action or other proceeding, provided that

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

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

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

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

~~X. DISSOLUTION OF CORPORATION~~

~~10.10 Resolution to Dissolve~~

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

~~10.11 Winding Up~~

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

~~10.12 Administrative and Judicial Dissolution~~

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

~~XI. REQUIREMENTS AS TO OPERATIONS~~

ARTICLE IX

~~11.10~~ Investment and Distribution of Income and Prohibitions.

~~11.11~~ All income of the Corporation for each taxable year shall be managed, invested, distributed and maintained in such a manner, and shall be distributed at the appropriate time and manner so as to not subject the Corporation to tax under Section 4942 of the Code, as amended, or any other tax. ~~11.12~~ The corporation is prohibited in engaging in any act of self dealing (as defined in Section 4941(d) of the Code, as amended, from obtaining any excess business holdings as defined in Section 4943(c) of the Code, as amended, from taking any investments in such manner as to subject the Corporation to tax under Section 4944 of the Code, as amended, and for making any taxable expenditures as defined in Section 4945(d) of the Code, as amended.

ARTICLE X

Amendments

~~XII. AMENDMENTS~~

~~12.10 Procedure~~

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

~~12.20 Review~~

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

These By-~~laws~~Laws were approved at a meeting of the Board of Directors on the

6th day of July, 1978, were first amended by the Board of Directors on the 18th day of September, 1990, amended a second time by the Board of Directors on the 17th day of May, 1994, amended a third time on the 24th day of March, 1998, amended a fourth time on the 19th day of September, 2000, amended a fifth time on the 16th day of September, 2003, amended a sixth time on the 19th day of April, 2005, amended a seventh time on the 20th day of May, 2008, amended an eighth time on the 16th day of February, 2011, and amended a ninth time on October 23, 2013.the 23rd day of October, 2013, and amended a tenth time on December 16, 2015.

* * * * *

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~~SIGNATURES ON NEXT TWO PAGES~~

CERTIFICATE

The undersigned hereby certifies that the foregoing By-Laws of the Corporation were duly approved and adopted by action of the Board of Directors of the Corporation to be effective as of the 16th day of December, 2015.

~~THE CENTER FOR HOSPICE AND PALLIATIVE CARE, INC.~~

THE CENTER FOR HOSPICE AND PALLIATIVE CARE, INC.

By: _____
Mark Murray, President

~~By: _____~~

~~President/CEO Date~~

~~Chairman, Board of Directors Date~~

~~Board Member Date~~

~~Board Member Date~~

~~Board Member Date~~

~~Board Member Date~~

~~Board Member Date~~

~~Board Member Date~~

~~_____~~

~~Board Member Date~~

~~_____~~

~~Board Member Date~~

~~_____~~

~~Board Member Date~~

~~_____~~

~~Board Member Date~~

~~ATTEST:~~

~~By:_____~~

~~Secretary, Board of Directors Date~~

~~*Administration/CHC By-laws 2013*~~

QB\37621833.1

BY-LAWS
OF
THE CENTER FOR HOSPICE AND PALLIATIVE CARE, INC.

ARTICLE I

Identification and Purpose

Section 1 Corporate Name. The name of this Corporation shall be The Center for Hospice and Palliative Care, Inc. (d/b/a "Center for Hospice Care") (hereinafter referred to as the "Corporation").

Section 2 Aims, Purposes, and Powers. The Corporation is a nonprofit, public benefit corporation serving citizens of St. Joseph, Marshall, Starke, Fulton, Elkhart, LaPorte, Kosciusko and LaGrange Counties in the State of Indiana. Its aims, purposes, and powers are:

(a) To improve the quality of living.

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

(c) To have and exercise all the general rights, privileges and powers permitted under the Indiana Nonprofit Corporation Act of 1991, as amended (the "Act"); provided, however, that it shall engage in no activity which is not permitted by an organization that has been determined by the Internal Revenue Service to be a tax-exempt organization as described under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). The Corporation shall not intervene in, or participate in, any political campaign on behalf of any candidate for public office. No part of the net earnings of this Corporation shall inure to the benefit of any private individual and no director or officer of the Corporation shall receive any pecuniary benefit from the Corporation, except such reasonable compensation as may be allowed for services actually rendered to the Corporation.

ARTICLE II

Fiscal Year

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

ARTICLE III

Membership

The Corporation shall have no members.

ARTICLE IV

Board Of Directors

Section 1 Government. The management of the affairs of the Corporation and corporate power shall be vested in a Board of Directors. New members of the Board of Directors shall be elected by current member of the Board of Directors at the Annual Meeting of the Board of Directors and at other times throughout the year, as the Board of Directors may deem appropriate.

Section 2 Disqualification of Board Members. No individual, who is a member of the Board of Directors of the Corporation, can at the same time be an employee of the Corporation.

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

Section 3 Number. The Board of Directors shall consist of not less than nine (9) nor more than fifteen (15) members. The terms of office for members of the Board of Directors shall be three (3) years. Members of the Board of Directors may serve no more than two (2) consecutive three (3) year terms. The term of a member of the Board of Directors shall commence at the first board meeting of the fiscal year. If a member of the Board of Directors is serving as an officer of the Board of Directors at the expiration of his second board term, then his term on the Board of Directors shall be extended to coincide with the expiration of his position as an officer of the Board of Directors. In addition, former members of the Board of Directors shall be eligible for re-election to the Board of Directors following a lapse of one year as a member of the board.

Section 4 Duties. The duties of the Corporation's Board of Directors include the following:

(a) To review and approve the annual operating budget of Corporation;

(b) To be charged with the responsibility of reviewing, approving, and developing a total program of quality services;

(c) To assess community needs for services to patients with a life threatening illness and their families;

(d) To review and approve program planning and development of long range objectives to meet those identified needs;

(e) To recommend implementation, modification, termination, or monitoring of programs and services of the Corporation;

(f) To hire and discharge the President/CEO based upon recommendations from the Executive Committee of the Board of Directors;

(g) To support The Foundation for the Center for Hospice and Palliative Care, Inc. (d/b/a "The Hospice Foundation") (hereinafter referred to as the "Foundation") in its efforts to raise and allocate funds in the best interest of the Corporation's mission;

(h) To perform any other duties the Board of Directors of a nonprofit Corporation can perform consistent and in accordance with the Act.

Section 5 Resignation. A director may resign at any time by filing his/her written resignation with the Secretary of the Board of Directors.

Section 6 Removal. Any director may be removed for cause by the affirmative vote of the majority of the Board of Directors of the Corporation. Any director who has been absent from three (3) consecutive regular meetings may be removed by the affirmative vote of the majority of the Board of Directors present at the meeting. In other respects, a member of the Board of Directors can be removed as allowed by the Act.

Section 7 Vacancy. Any vacancy in the Board of Directors caused by death, resignation, increase in number of directors or otherwise may be filled by appointment by the Board of Directors for the remainder of the vacated term.

Section 8 Order of Business. Robert's Rules of Order are to apply at all meetings of the Board of Directors unless waived by a majority of the members of the Board of Directors present.

Section 9 Delegation of Authority Among the Board of Directors. It is agreed that the Board of Directors shall elect, at its annual meeting each year—applicable to the two (2) year term of the position, a Chairman, Vice Chairman, Immediate Past Chairman, Secretary, and Treasurer of the Board of Directors to assume and perform the responsibilities set forth below.

(a) Chairman of the Board of Directors. The Chairman shall preside at all meetings of the Board of Directors. S/he shall have chief official responsibility for directing and implementing each meeting of the Board of Directors, and shall be responsible to perform other duties as may be prescribed from time to time by the

Board of Directors, these By-Laws, the Articles of Incorporation of the Corporation, or as deemed appropriate within the discretion of said Chairman.

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

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

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

(e) Immediate Past Chairman of the Board of Directors. The Immediate Past Chairman shall continue to serve as a member of the Executive Committee for the two (2) year period immediately following his/her service as Chairman of the Board. The primary purpose of this position is to ensure continuity and to serve in an advisory capacity.

(f) Right to Vote. The Chairman, Vice Chairman, Immediate Past Chairman, Secretary, and Treasurer of the Board of Directors shall be members of the Board of Directors and shall be entitled to vote on all matters submitted for a vote of the Board of Directors.

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

ARTICLE IV

Officers

Section 1 Appointment. The officers of the Corporation shall include a President/CEO, a Vice-President/COO, and a Chief Financial Officer. The President/CEO shall be appointed by the Board of Directors based upon a recommendation from the Executive

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

Section 2 **Duties.** The principle duties of the officers are as set forth below.

(a) President/CEO. The President/CEO shall attend all meetings of the Board of Directors. The President/CEO shall be the chief executive officer of the Corporation and shall have the general supervision, direction, and active management of the property, affairs and business of the Corporation subject to the discretion, control and approval of the Board of Directors. S/he shall perform such other duties as may be prescribed from time to time by the Board of Directors, these By-Laws, or the Articles of Incorporation of the Corporation. S/he shall be a non-voting member of the Board of Directors and all standing committees. The President/CEO shall also be the President/CEO of the Foundation and shall be responsible for the overall relationship between the two (2) entities.

(b) Vice-President/COO. The Vice-President/COO shall help with the discharge of duties of the President/CEO and shall serve in his/her absence and shall perform such additional duties as may be prescribed from time to time by the Board of Directors, by the By-Laws, or by the Articles of Incorporation. The Vice-President/COO shall be a non-voting member of the Board of Directors and standing committees as appointed by the President/CEO.

(c) Chief Financial Officer. The Chief Financial Officer shall help with the discharge of duties in the absence of both the President/CEO and the Vice-President/COO and shall perform such additional duties as may be prescribed from time to time by the Board of Directors, these By-Laws, or the Articles of Incorporation. The Chief Financial Officer shall be responsible and accountable for the receipt of the Corporation's funds and pay out of the same under policies approved by the Board of Directors and under the direction of the President/CEO. The Chief Financial Officer shall be accountable for the deposit of all moneys, checks and other credits to the account(s) of the Corporation in accordance with policies approved by the Board of Directors. The Chief Financial Officer shall enter regularly into the books of the Corporation to be provided for that purpose a full and accurate account of all moneys received and paid out on account of the Corporation. The Chief Financial Officer shall be a non-voting member of the Board of Directors and standing committees as appointed by the President/CEO. The Chief Financial Officer shall also be the Chief Financial Officer of the Foundation and be responsible and accountable for the financial relationship between the two (2) entities.

Section 3 **Vacancies.** Whenever any vacancies occur in the office of the President/CEO of the Corporation, such vacancy shall be filled by the appointment of an Interim President/CEO as detailed within Board of Directors approved policy in place at the time.

Section 4 **Loans to Officers and Directors.** No loans of money or property shall be made to any officer or director by the Corporation.

ARTICLE V

Authority To Obligate Corporation

Section 1 **Checks, Drafts, and Similar Negotiable Instruments.** The President/CEO, the Vice-President/COO, and the Chief Financial Officer of the Corporation shall have authority to sign checks or similar negotiable instruments on behalf of the Corporation. Any of the three (3) can sign checks up to $25,000.00 for ordinary budgeted items. Any check over $25,000.00 would require two (2) of the three (3) signatures.

Section 2 **Authority to Borrow Funds.** The President/CEO of the Corporation along with the Chairman of the Board of Directors or the Treasurer of the Board of Directors shall have the authority to obligate the Corporation for lending transactions on behalf of the Corporation as approved by the Board of Directors from time to time.

Section 3 **Execution of Documents.** The President/CEO of the Corporation shall have the authority to bind the Corporation, to contracts or other similar business agreements entered during the ordinary course of the Corporation's business.

Section 4 **Membership in Regional and/or National Organizations.** The Corporation may maintain membership in other regional and/or national organizations whose purposes are consistent with those of the Corporation. The Corporation may support financially such an organization to the degree deemed appropriate and as allowed by the Act and the Code.

ARTICLE VI

Meetings

Section 1 **Annual Meeting.** The Annual Meeting of the Board of Directors shall be the final meeting of the fiscal year and shall be designated as the Annual Meeting for election of directors, officers of the Board of Directors and the Corporation, and for conducting any other business that may come before the Board of Directors.

Section 2 **Regular Meetings.** Regular meetings of the Board of Directors shall be held at least four (4) times a year. Directors shall be notified, in writing, in advance of all meetings.

Section 3 **Special Meeting of Board of Directors.** Special meetings of the Board of Directors may be called by the President/CEO or on written application of five (5) directors made to the Secretary who shall mail notices to all members of the Board of Directors not less than one (1) week prior to the meeting stating the purpose of the meeting, unless waived. No other business may be transacted at a special meeting.

Section 4 **Quorum for Board Meetings.** A majority of the total number of directors shall constitute a quorum. Directors must be present, in person.

Section 5 **Voting.** Each director shall have one (1) vote on all issues presented for the vote of the Board of Directors of the Corporation.

ARTICLE VII

Committees

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

Section 2 **Executive Committee.**

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

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

Section 3 **Finance Committee.**

(a) Membership. The Finance Committee shall consist of the Treasurer of the Board of Directors who will Chair the Committee and other appointees by the Chairman of the Board of Directors. This committee is responsible for review and recommendations to the Board of Directors regarding the financial matters of the Corporation.

(b) Duties. The Finance Committee shall review budgets for proposed lands and projects, review and approve annual recommended budget proposals to be submitted to the Board of Directors and review the annual audit after each fiscal year. The Finance Committee shall also review and plan long-range financial goals for the Corporation.

Section 4 Personnel Committee.

(a) Membership. The Personnel Committee shall consist of appointees by the Chairman of the Board of Directors, and be chaired by the Chairman of the Board of Directors.

(b) Duties. The Personnel Committee shall concern itself with the review and recommendations for approval of the Personnel Policies governing the staff of the Corporation.

Section 5 Professional Advisory Group.

(a) Membership. Membership is to include, but not be limited to:

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

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

(b) Duties. The Professional Advisory Group shall advise the Corporation on professional clinical issues, participate in the review of the Corporation's clinical programming, patient care policies, procedures and clinical records as required by the federal and/or state Home Health regulations.

Section 6 Nominating Committee.

(a) Membership. The Nominating Committee shall consist of appointees by the Chairman of the Board of Directors in such numbers as they deem necessary.

(b) Duties. The Nominating Committee shall have responsibility for nominating candidates for positions on the Board and officers of the Board of Directors.

Section 7 Special Committees. Special committees may be appointed by the Chairman of the Board of Directors as the need arises.

Section 8 Appointment of Permanent Committees. New permanent committees, as needed, may be appointed by a majority vote of a quorum of the Board of Directors from time to time.

Section 9 Terms. Terms of all committees shall expire at the annual meeting of the Board of Directors.

ARTICLE VIII

Indemnification and Conflict Of Interest

Section 1 Indemnification of Representatives. The Corporation shall indemnify its employees, officers, directors and agents from any claim, lawsuit, administrative action or other proceeding, provided that

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

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

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

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

ARTICLE IX

Investment and Distribution of Income and Prohibitions.

All income of the Corporation for each taxable year shall be managed, invested, distributed and maintained in such a manner, and shall be distributed at the appropriate time and manner so as to not subject the Corporation to tax under Section 4942 of the Code, as amended, or any other tax. The corporation is prohibited in engaging in any act of self dealing (as defined in Section 4941(d) of the Code, as amended, from obtaining any excess business holdings as defined in Section 4943(c) of the Code, as amended, from taking any investments in such manner as to subject the Corporation to tax under Section 4944 of the Code, as amended, and for making any taxable expenditures as defined in Section 4945(d) of the Code, as amended.

ARTICLE X

Amendments

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

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

These By-Laws were approved at a meeting of the Board of Directors on the 6th day of July, 1978, were first amended by the Board of Directors on the 18th day of September, 1990, amended a second time by the Board of Directors on the 17th day of May, 1994, amended a third time on the 24th day of March, 1998, amended a fourth time on the 19th day of September, 2000, amended a fifth time on the 16th day of September, 2003, amended a sixth time on the 19th day of April, 2005, amended a seventh time on the 20th day of May, 2008, amended an eighth time on the 16th day of February, 2011, amended a ninth time on the 23rd day of October, 2013, and amended a tenth time on December 16, 2015.

* * * * *

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CERTIFICATE

The undersigned hereby certifies that the foregoing By-Laws of the Corporation were duly approved and adopted by action of the Board of Directors of the Corporation to be effective as of the 16th day of December, 2015.

THE CENTER FOR HOSPICE AND PALLIATIVE CARE, INC.

By: _____
Mark Murray, President

QB\36713351.3

RECITAL AND RESOLUTIONS
OF THE
BOARD OF DIRECTORS
OF
THE CENTER FOR HOSPICE AND PALLIATIVE CARE, INC.

Approval of Amended By-Laws

WHEREAS, the Board of Directors of The Center for Hospice and Palliative Care, Inc. ("CHC"), has determined, in its best judgment and in good faith, that it is in the best interest of CHC to amend CHC's By-Laws, in part, to achieve the following purposes: (i) provide that the Immediate Past Chairman of the Board of Directors of The Foundation for the Center for Hospice and Palliative Care, Inc. (the "Foundation") is to serve as a member of the Executive Committee of CHC; (ii) eliminate unnecessary provisions; and (iii) provide for consistent usage of terms throughout the By-Laws and substantially similar organization and structure with respect to the By-Laws of the Foundation.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Directors hereby approves and adopts the amended By-Laws of CHC, substantially in the form attached to these resolutions.

RESOLVED, FURTHER, that the officers of CHC, and each of them singly, be and they hereby are severally authorized and empowered, for and on behalf of CHC, to do, or cause to be done, any and all acts and things and to execute, deliver and file such documents, certificates and other writings and to take such additional action as may be necessary or advisable to carry out the intent and purpose of these resolutions, and all such acts, things, instruments, certificates and documents shall be those of CHC for all purposes, and they hereby are approved, ratified and confirmed in all respects.

QB\37620550.1

Center for Hospice Care

choices to make the most of life

Election of New Board Member

Jennifer Ewing

Re-Election to Second Term

Francis Ellert

Center for Hospice Care

2016 Board of Directors Candidate

JENNIFER C. EWING, RN, MSN, NP-C, AOCNP

Jennifer Ewing RN, MSN, NP-C, AOCNP is the Oncology Nurse Practitioner in practice with Dr. Bilal Ansari at Michiana Hematology Oncology, PC. She is a Certified Nurse Practitioner by the American Academy of Nurse Practitioners and Certified Advanced Oncology Nurse Practitioner by Oncology Nursing Certification Corporation. Previously she was the Health Education Coordinator at The Retreat Women's Health Center of Goshen Health System. She also worked at Northern Indiana Oncology Associates. Since 2012 she has been Associate Editor, Clinical Journal of Oncology nursing writing an Advanced Practice Column. She received her Bachelor of Science in Nursing from St. Mary's College and Masters of Science in Nursing-Adult Nurse Practitioner Program from Ball State University. She has been a guest lecturer for the American Cancer Society, Riverbend Cancer Services, and St. Mary's College

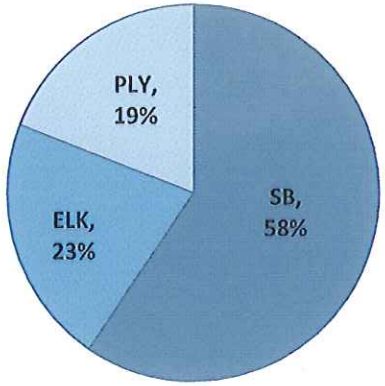
Center for Hospice Care

2015 YTD Average Daily Census (ADC)

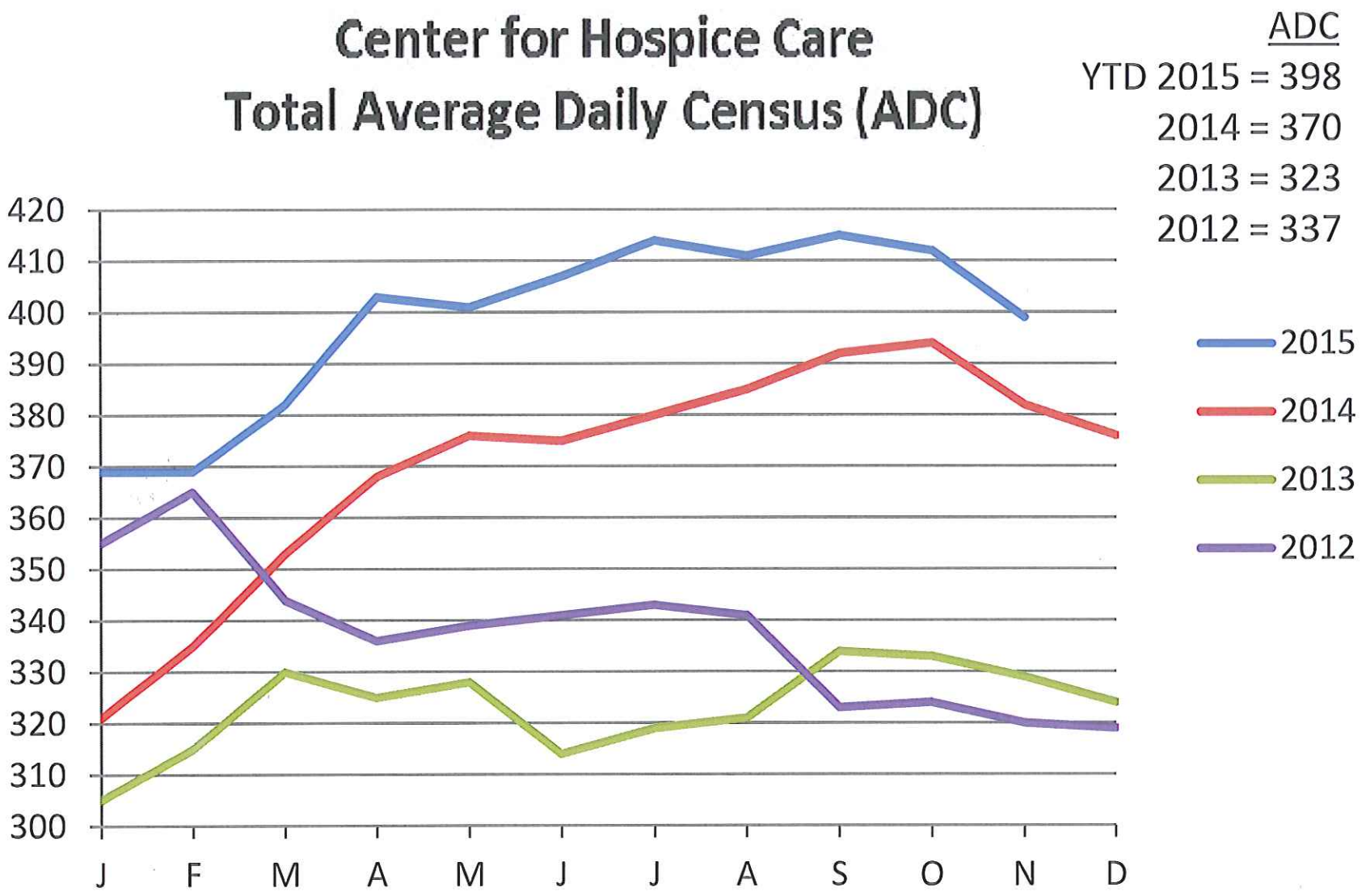
(includes Hospice House and Home Health)

	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	412	234	89	89
N	399	220	95	84
D				
2015 YTD Totals	4382	2533	1005	841
2015 YTD ADC	**398**	**230**	**91**	**76**
2014 YTD ADC	369	220	79	71
YTD Change 2014 to 2015	29	10	12	5
YTD % Change 2014 to 2015	**8.0%**	**4.7%**	**15.7%**	**1.4%**

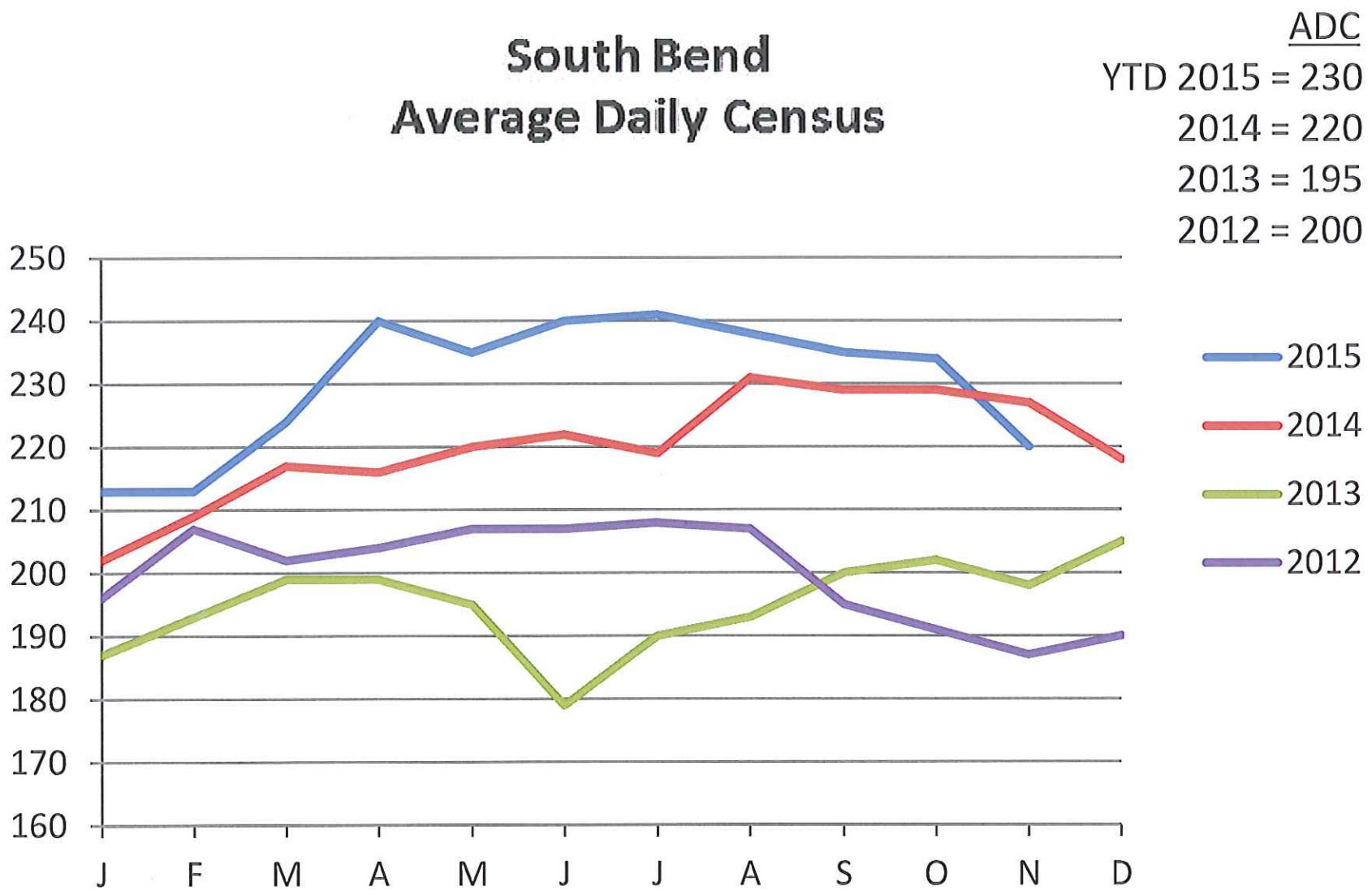
2015 YTD ADC by Branch



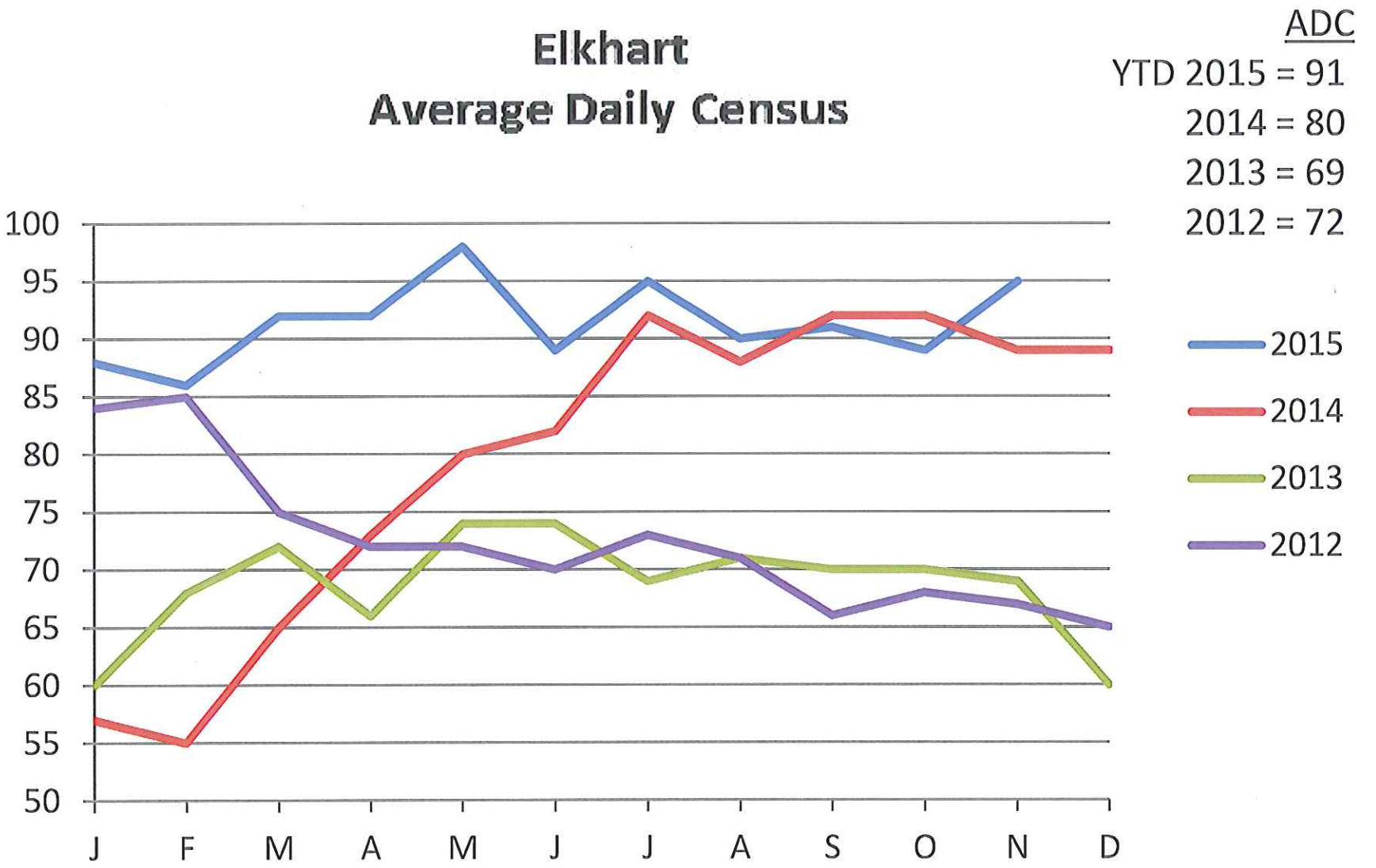
Center for Hospice Care
Total Average Daily Census (ADC)



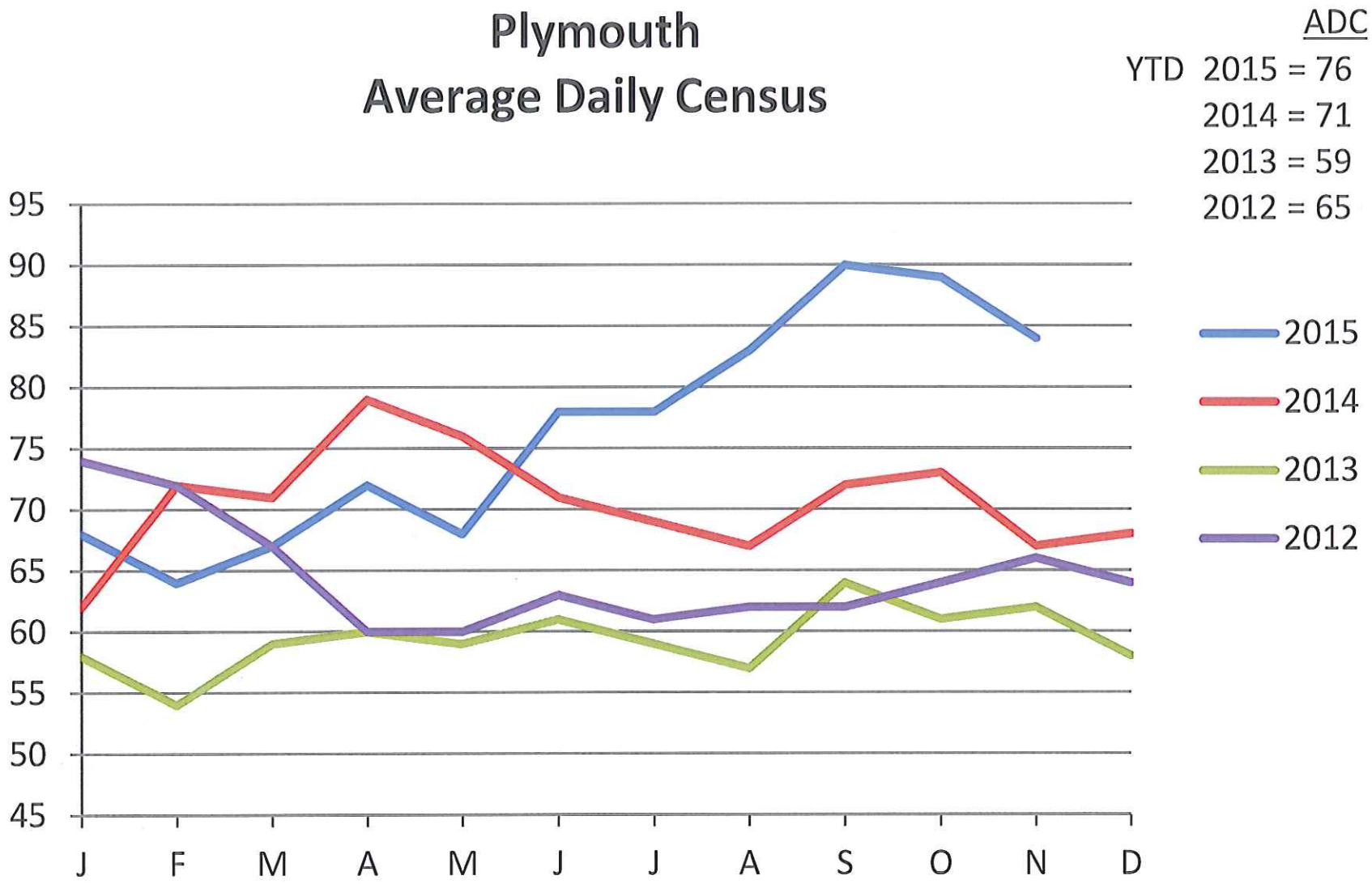
South Bend
Average Daily Census



Elkhart
Average Daily Census



Plymouth
Average Daily Census



Notre Dame alumna presents research at international conference in Kampala, Uganda

September 25, 2015

Brianna Wanlass, '15 MS, was invited to present her 2015 University of Notre Dame's Master of Science in Global Health Capstone Research Project, "Developing a Surveillance System to Support and Strengthen Palliative Care Services in Uganda", at the 6th Biennial Palliative Care Conference in Kampala, Uganda, on August 27-28, 2015. While at Notre Dame she worked under Professor Lacey Ahern, Associate Director of Global Health Training.

Wanlass conducted her capstone research project in Uganda with the Palliative Care Association of Uganda (PCAU). PCAU is a long-standing partnership with the University working on projects with the Eck Institute for Global Health's research programs and the Kellogg Institute for International Studies. Notre Dame's Professor Ahern has worked with PCAU since 2009 when the organization was brought to her attention by the Center for Hospice Care in Mishawaka. As part of Global Partners in Care (formerly FHSSA) Partnership Initiative, Center for Hospice Care (CHC) was linked with Palliative Care Association of Uganda (PCAU) in 2008. Her work has furthered the mission of the PCAU.

Working with CHC, Ahern helped organize internships in Uganda for Notre Dame students in palliative and spiritual care. With the support of the Kellogg Institute for International Studies and the Ford Family Program in Human Development Studies and Solidarity, Hanna O'Brien, a College of Science Pre-Professional Studies and Anthropology double major at Notre Dame, was the first palliative care student to study in Uganda the summer of 2010. She returned in the summer of 2011. The Eck Institute for Global Health also helped fund spiritual care internships for Notre Dame Master of Divinity students Ben and Mary Ann Wilson in 2011. Other students and faculty have contributed to additional projects.

In addition, Brianna Kunycky, working at Notre Dame's Geospatial Analysis Laboratory under the direction of Dr. Dilkushi Pitts, created a new palliative care map that depicts the current

geographic deployment of palliative care workers throughout Uganda. Her work helped to identify coverage gaps and aid in prioritizing those areas of the country that are most in need of certified palliative care workers.

In the summer of 2013, Master of Science in Global Health student, Gaby Austgen interned in Uganda with PCAU. Austgen helped lay the groundwork for regular monitoring and communication between palliative care providers and support organizations like PCAU. Austgen said of the experience, "I've been aware of the existence of inequities in healthcare for a long time; seeing these situations in person somehow made them much more real…We cannot allow the fact that a life can no longer be 'saved' to remove that life from our care and consideration. We owe it to our neighbors to help them die peacefully – without the burden of physical, mental, or spiritual anguish."

Uganda has made tremendous strides in the provision of palliative care services throughout the country, due largely to the efforts of PCAU particularly its advocacy efforts. PCAU is now mandated by the Ministry of Health with providing leadership and coordination for scale-up of palliative care services in Uganda. PCAU identified the need to regularly collect information to help strengthen and support palliative care services throughout Uganda and asked ND for help. Wanlass and PCAU piloted an mHealth platform to gather regular information from palliative care workers at facilities in four different regions of Uganda. The phones collected accurate GPS data, basic information on services offered and utilized, and patient data. This early pilot showed promising results for collecting and monitoring palliative care services throughout the community. Easily accessible information like this will allow the Ministry of Health, PCAU, health care facilities, and others to make evidence-based decisions on care they provide. Overall, the participants and PCAU enthusiastically accepted and appreciated the implementation of the mHealth surveillance system.

"In the field of global health there is a tendency to focus on preventative and curative measures. This leaves little attention paid to those facing life-limiting illnesses or those at the end-of-life," states Wanlass. "Palliative care aims to improve the lives of these individuals through offering holistic care to the patient."

At the conference, Wanlass had the opportunity to meet with the pilot implementation team and conduct follow-up trainings with them and with PCAU staff members. The project is continuing at the pilot sites and planning for scaling out to new facilities by next summer.

"Sharing this research from my Notre Dame capstone project with the hundreds of conference attendees will allow participants from other countries to use a similar mHealth solution in their own work in palliative care throughout Sub-Saharan Africa," added Wanlass.

The Master of Science in Global Health program plans to continue working with CHC and PCAU by contributing student and faculty research support.

The Eck Institute for Global Health is a university-wide enterprise that recognizes health as a fundamental human right and endeavors to promote research, training, service to advance health standards for all people, especially people in low and middle-income countries, who are disproportionately impacted by preventable diseases. For more information about Notre Dame's Master of Science in Global Health degree program, visit: here.

PHOTO: Wanlass far left.

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Your Breaking News & Weather Authority

StormTeam 16 Alert... The National Weather Service has issued a High Wind Warning for Elkhart, Fulton, Kosciusko, La Porte, LaGrange, Marshall, Pulaski, St. Joseph and Starke and for Berrien and Cass until 10:00 PM Eastern Standard Time. ...Stay tuned to StormTeam 16

Holy Cross Village honors veterans with pinning ceremony

Updated: Wed 6:20 PM, Nov 11, 2015 *By: Yana Jones*

NOTRE DAME, Ind. - Veterans Day -- it's a time to honor and thank those who have served our country.

Special events were held all across the country, including several right here in Michiana.

Holy Cross Village partnered with the Center for Hospice Care to individually recognize the veterans that live in the community. More than 70 vets, who served in WWII, the Korean War, the Vietnam War and the Bosnian Conflict, now call Holy Cross Village home.

ND ROTC at Holy Cross Village

Notre Dame ROTC kicked off the first ceremony at 1:15 p.m. with a presentation of the colors. Attendees sung the National Anthem and recited the Pledge of Allegiance.

Some opening remarks were made, and then staff members individually recognized each veteran for their service with a pin, bracelet and certificate with their name and branch of military.

One of those veterans, Br. James Kumba, served in the Army National Guard for nine years before joining the brotherhood.

"I feel honored to be able to be here, and to experience this renewal... I look forward to it every year," Br. Kumba says.

Barb Cassady, Director of Life Enrichment at Holy Cross Village, explains, "Many of us have never lived through a war, and we really haven't been touched like they have... We want to just acknowledge and let them know how much we appreciate the sacrifices they made and especially their families."

Although Holy Cross Village has been honoring their veterans for years, Wednesday was the first time ND ROTC has joined in the ceremony.

"It's a huge privilege to be here, I mean we;re standing among veterans who have seen far worse and far more than we have, and it's just an honor to be around them and be able to help them while they're here and pay the respect that they deserve," says Cadet Emilie Vanneste of Notre Dame's ROTC.

A second ceremony was held at 3:15 p.m.

Veterans at Holy Cross Village honored for their service

By Eric Crouch, Multimedia Journalist CONNECT
Posted: Nov 11, 2015 5:09 PM EST

SOUTH BEND - Veterans of Four Wars living in Holy Cross Village were honored for their service today.

More than 70 residents of Holy Cross Village are veterans.

They were given pins for their service from the Center of Hospice Care.

Dorothy Leader is one of those veterans.

She worked as a nurse in World War Two.

"Well it brings back a lot of memories, both good and bad. I thank God that I'm up and around." Leader said.

Leader tells us one of the soldiers she treated during the war kept coming back around.

The two started dating and were eventually married until his death in 2006.

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WWII Veteran recounts D-Day, Nuremberg Trials

Once again, we can't thank you enough for your partnership with our school and in helping our young people overcome their losses. We serviced 10 students this year

Sincerely,

Maddi Watkins, The Rest of The Penn High School Counseling Center, and the Penn Families you serve

Sarah Hendricks Amanda Bates
Maria Cusick Andy Rowe Candace K. Keeler
John Watts Lynn Strayer
Amber Lawmaster

The high cost of dying

Michael Mazzeffi

Why are we using so many health care resources on dying patients?

OCTOBER 27, 2015, 12:43 PM

Although the Affordable Care Act should be applauded for increasing access to care, assisting small businesses with coverage and emphasizing preventive care, it falls short on cost containment, with health care costs still rising along with spending per individual case. And while it has provisions in place to fight fraud, it's not expected to make much of a dent in the $750 billion — or 30 percent of total health care spending — that the Institute of Medicine suggests is wasted annually on unnecessary services and excessive administrative fees.

Much of that "waste" may be attributed to aggressive care during the last year of life.

According to the Centers for Medicare and Medicaid Services, a quarter of Medicare spending is reserved for the 5 percent of beneficiaries who die each year. Using 30 years of Medicare data, researcher Gerald Riley showed a steady temporal increase in the number of repeat hospitalizations during a Medicare beneficiary's final year of life. Many patients die in the intensive care unit (ICU) — among the costliest types of hospitalization — and there is a trend toward more hospitalized patients dying in the ICU, according to a study by Brown University researcher Joan Teno, who published her work in the Journal of the American Medical Association.

As an ICU physician, I have seen that modern intensive care medicine can contribute to miraculous outcomes. ICUs now provide temporary artificial liver support, prolonged artificial circulation and perioperative care for solid organ transplantations of all kinds. However, my experiences in several major medical centers have also shown me that there is a problem with ICU spending in patients that are highly likely to die in the hospital.

Article continues below ↓

There are a number of possible underpinnings to this problem. American medical schools teach students to treat disease above all else; there is little to no emphasis on end of life care,

particularly in the ICU. Likewise there is no basic education in health economics or policy. Instead most physicians simply learn "on the job" about these issues, which is suboptimal.

Several policy initiatives could help to address these issues.

First, the American Council on Graduate Medical Education should mandate that medical schools include education about end of life issues. Alternatively, state medical boards could mandate graduate medical education pertaining to the topic. Mandatory topics should include enhanced communication, terminal pain management, advanced directives and economics of end of life care.

Hospitals should also pilot programs that have mandatory case review for patients who remain in the ICU longer than 30 days. The purpose of these reviews would not be to advocate for termination of supportive care, but instead to provide a regular forum for discussing the patient's condition with the patient's primary physician, intensive care physician, palliative care physician and other stakeholders. Formalization of the process would help to ensure that a patient's advanced directives are being followed and that physicians with different backgrounds and stakes communicate effectively.

Finally, physicians need enhanced education about how the legal system will treat them if they refuse to provide futile care. There is a perception among physicians that they must provide all care that is requested by a patient's family regardless of the probability of success. In fact, the AMA code of ethics states that physicians have an obligation to transition patients to palliative care when treatments have no reasonable chance of benefit. Also, some states (Texas, for example) have statutes protecting physicians from civil and criminal prosecution when they refuse to provide futile treatment. Other states should consider similar laws.

Curtailing the cost of dying in the ICU is a difficult subject, but it is inevitable if the United States plans to control health care spending.

Dr. Michael Mazzeffi (mmazzeffi@anes.umm.edu) is an assistant professor of anesthesiology at the University of Maryland School of Medicine; the views expressed her are his own and not affiliated with the university.

This article is related to: Healthcare Providers, Healthcare Policies and Laws, Medical Research, Medicare, Brown University, Affordable Care Act (Obamacare)

Center for Hospice Care
Compliance Committee Meeting Minutes
October 22, 2015

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 3:00 p.m.	
2. Home Health Compliance Plan	• The Home Health Compliance Plan was reviewed. • Page 24, Verification of Physician Signature – Nan G. maintains the binders. Sue will follow up with Rebecca F. to see if we are doing quarterly random checks to confirm that physician signatures are authentic.	
3. Diagnosis Codes	• We are working on a system to determine which diagnoses contribute to the terminal illness and which ones do not. We are not anticipating this will be difficult to do.	
4. Health Literacy QAPI	• The group has met once and will be meeting again in a couple weeks.	
5. Home Health Mock Survey	• All of our home health patients no matter where they are had hospice verbiage in their documentation. SO we did some education with staff. We also identified what homebound meant under CMS regulations. It is very different under commercial insurance. We reminded staff that home health is a separate program from hospice. We found on home health prognosis nurses were putting six months or less, which is a hospice term. So we made some changes there. We also found if the prognosis is listed as poor, we need to identify the reasons why. Discharge plans sometimes had poor/six months, so we changed that. We also covered overall documentation and what to do when the surveyor comes. Sue made visits with Becky Swathwood in Plymouth, and she was phenomenal. The mock survey was very beneficial and everyone did what they were supposed to do. We reviewed documentation and data that the surveyor asks for upon entering a facility. We discovered that care plans are not always updated every 14 days. So Rebecca and Donna B. went through and made sure everything was updated at least for the past six months. • Employee health records – It is hard to determine the date of first patient contact, so we will get a card to add to the file that shows this information. Jan C. will change	

Topic	Discussion	Action
	those for us. • Infection Control – Education during orientation and ongoing needs to be more clearly validated and documented. We also ordered some disposable BP cuffs and stethoscopes to use with some patients. • Overall documentation was great and clearly stated goals. We will be starting more improvement initiatives and change some procedures based on the mock survey. It was also good training for Rebecca and Gail.	
6. Pharmacy Decision Making	• Reviewed article from the Hospice Compliance Letter on "Thoughtful Pharmacy Decision-Making Key to Compliance, Quality, Cost-Effectiveness." We are not in the process of watching pharmacy vendors. At every IDT we review what we pay and don't pay for. HospiScript has reports, including med reconciliation, that will we will get within five days of starting a medication. We feel we have good procedures in place to be compliant.	
Adjournment	• The meeting adjourned at 3:25 p.m.	Next meeting 03/10

Center for Hospice Care
choices to make the most of life

CHAPTER FOUR

QI Committee Report

Center for Hospice Care
QI Committee Meeting Minutes
November 17, 2015

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m.	
2. New Members	• Welcomed Karen Hudson, Elkhart Patient Care Coordinator, and Tammy Huyvaert, Admission Coordinator, to the committee. Terri Lawton, Plymouth Patient Care Coordinator, will also be added.	
3. Minutes	• The minutes of the 08/18/25 meeting were approved by consensus.	
4. Home Health Program	• OBQI (Outcome Based Quality Indicators) – We have two programs—hospice and home health. Home health is nursing, aides, social work and contracted therapies as needed. OASIS data is collected on home health patients and which goes on the OBQI report, so it is important for staff to know which program their patient is in. The OASIS data is collected at specific periods in time while the patient is on home health services—admission, change in condition, recertification, and discharge. If the patient goes to the hospital and services are put on hold, we have to do a resumption of care OASIS if they are readmitted. The data is transmitted to CMS. We are then compared to other home health agencies nationally and in Indiana. We can pull the report at any time and look for any trends and areas for improvement. Our program is unique to other home health agencies in that we only serve terminally ill patients. Home health is a small percentage of our ADC. We anticipate many of our home health patients transitioning to hospice. The data is transmitted to CMS when the event occurs and we have a specific window of time in which to transmit it. • Mock Survey – At the end of September we did a mock ISDH home health survey. We did Q&A with staff, reviewed policies, reviewed HR records, and reviewed the questions the surveyor would ask. Out of that we created a resource binder for each office. We reviewed the OBQI report which let us know some areas the surveyor may ask about. This was an excellent competency assessment for staff. Some of our	

Topic	Discussion	Action
	findings during the mock survey were inconsistency in identifying homebound status. Staff is inconsistent in checking the homebound box in the computer. Staff also uses hospice language in home health documentation, such as a prognosis of six months or less instead of poor or guarded. We created a new home health care plan SN028. We found that care plans were often not updated timely. Care plans are reviewed every 14 days. We found that changes were talked about at the IDT, but staff was inconsistent in physically updating the care plan to reflect what was discussed. We also noted care plans were not started for things like identifying the risk for falls or that a patient had fallen. In the employee health records we found that information could have been identified more clearly, so we put mechanisms in place to remedy that. We also found some training records that didn't belong in the health records, so those were moved. Infection control education is done during orientation and ongoing. We need to more clearly validate and document infection control education. We did find some great documentation in many records. Staff that participated in the mock survey felt confident. • On 11/06 the actual ISDH home health survey occurred. The surveyor was here on 11/06, 11/08 and 11/09. We had no deficiencies. We will continue to educate staff based on the results of the mock survey. The main take away was infection control practices, so we will be working on that.	
5. Infection Control	• In the third quarter TB validations were done and Alice W. was renewed as a TB instructor. Flu shots were given to all clinical staff. The QAPI proposes a new infection control plan for 2016 and revisions to the Vaccines form so the instructions on the form are clearer. The infection control program and plan for 2016 are the main things we will be working on as a result of the ISDH and mock surveys. We will review and update policies and procedures, do a lot of staff education, and solidify the program. See the QAPI Progress Report for more details. • The committee agreed by consensus to accept the planned improvements for 2016 and the revisions to the Vaccines form.	
6. HIPAA	• At all staff meetings throughout the year we presented HIPAA shorts on education and the proper use of PHI. In September we did our annual in-service on tracking potential violations and outcomes and IT did vulnerability testing. The admissions department did walking rounds, QA and the nursing department reviewed medical records for accuracy and access, and the social workers and spiritual care were	

Topic	Discussion	Action
	trained on encrypting emails.	
7. HIM Committee	• Health Information Management (HIM) is a new committee that came out of the performance improvement project which worked on the conversion to electronic medical records and other process changes. Some of the changes we have implemented are eliminating obsolete and paper documents, create new electronic forms, increase efficiency of the medical records process, and collaboration among all departments to increase efficiency and effectiveness in documentation. The QA department is creating new checklists. Included in the QI Committee packet is the scope and purpose of the HIM committee. We have gone into ECFs and looked at their medical records. The QA auditors have printers and can print off missing documents and place them in the ECF chart immediately. We are also working with admissions and billing to make sure the medical records get into the ECF charts timely.	
8. Live Discharges	• The QAPI looks at the percentage of revocations to an acute care facility, the percentage of live discharges with IDT input, and the number of revocations. Our organization is down compared to the national average in managing live discharges for patients not meeting the eligibility requirements The QAPI also looks at the number of non-revocation live discharges, percentage of attending physician notified of a live discharge, and percentage of revocations within 25 days of admission. Do we have an overall goal for each measure? We have added a lot of things to data collection, but we have never set a target so we can see whether we are successful in meeting our outcomes. We strive for 100%. We will look at the type of data we are collecting, its purpose, benchmark it against national percentages, see what CMS is looking at when talking about discharges within hospice programs, and collect data that is appropriate and meaningful. • It was suggested by Sue that this QAPI's work become a part of the HIM Committee instead of being a stand alone QAPI team. A QAPI is not supposed to last forever. Review of live discharges is important work, so it should probably be integrated into another format and data continue to be analyzed. The information would still be reported to the QI Committee. The QAPI reviews every live discharge and has added things over time like the results from the PEPPER Report, if the patient is in our BreatheEasy or HeartWize programs, was Hospice House offered, etc. We have a lot of data we could use in the HIM to help determine which direction would be best	

Topic	Discussion	Action
	going forward.	
9. Clinical Quality Measures	• We are starting a new plan for patients with trouble breathing. We will be using language off of the CAHPS survey. The QAPI also looks at bowel function and we are meeting the thresholds on that.	
10. Adverse Events	• In the third quarter there were no significant events. We had five incidents of FedEx either not making a delivery or packages were tampered with. With our change to HospiScript we will no longer be using FedEx. They did identify where their problem was coming out of. We talked to Alick's Home Medical to do an in-service at the January nurses meeting on oxygen and tubing. There was one med error in South Bend Hospice House. • Falls – We can control falls a little in the home and ECF. We continue to assess for any patient at risk for falls. We are now looking at repeats. In July there were 50 falls with seven patients with repeat falls. August had 34 falls with nine patients with repeat falls, and September had 55 falls with five patients with repeat falls. We will continue to track it that way. When we see an incident report for a repeat fall, Sue M. notifies the PCC and primary nurse. We reviewed falls at the October nurses meeting because of this. We also looked at care plans. There were no injuries as a result of these falls and no staff was present at the time of the fall. Another concern with ECFs is they have to report every fall to the state. We feel the fall risk assessment we use is pretty generic. In the IDT we will hear that a patient fell but we don't know if they are reporting all those falls through the IDT. So we are working on a way to make sure the IDT knows about every fall.	
11. Consumer Concerns	• This quarter there were 18 concerns compared to six last quarter. The group meets quarterly and looks for trends. We are trying to be proactive so if staff hears that a family is upset, we make a note of it. It doesn't mean there will be an incident report, but at least we have record of it. For example, we received a complaint letter from a family and when we investigated it we had already addressed their concern a few weeks ago.	
12. Health Care Literacy	• The QAPI is reviewing written materials for patients and families.	
13. QAPI Project Proposal	• We are streamlining processes and in the future, proposals for and new QAPI would come to the QI Committee for approval to make sure we are utilizing resources	

Topic	Discussion	Action
	appropriately. Tammy H. proposes a new QAPI to review the timeliness of entering medications. She pulled reports to see what time the nurse left the patient and what time the meds were entered. She set a time limit of 90 minutes after the visit and 74% didn't have the meds entered in that time. She is doing daily data collection. Staff was told they have enter the meds while in the home unless there is a good reason they cannot like bugs, hoarders, or any emergency visit they have to make. If so, the meds have to be entered within one hour of leaving the home. If not, they will receive a written warning. Tammy will continue to monitor over the next three months and should have more information to report at the February meeting on whether this has improved. It is extremely important that meds get entered in the home, because it goes to HospiScript as soon as the meds are entered in Cerner and they sync. There is also more chance of error if the meds are entered later. The new QAPI was approved by consensus. • With the change to HospiScript, meds only have to be entered once. HospiScript has a 7:00 PM cut off for next day delivery, so it is important to enter meds while in the home. Since we started monitoring this, we have seen great improvement. They also must sync their computer. Entering meds immediately is also helpful for triage and emergency visit nurses if they get a call from a new patient so they know what meds they are on. When nurses take new med orders, if they know the patient is waiting for them they should at least enter the meds and sync. Then they can complete the rest of the assessment later.	
14. Other	• Packets for Meetings – Since we have made some changes, does the committee want to continue having packets emailed in advance? If so, we will continue to make packets. If not, we would like to go totally to PowerPoint presentations. Send Sue M. an email and let her know. Greg G. said new forms should go out in advance, but the graphs and other reports could be on PowerPoint to expedite the information. We could send packet electronically for review and the rest be on screen. The committee agreed by consensus that the information could be sent electronically in advance and then reviewed at the meeting on PowerPoint. • Membership – Do we have the right members on the committee? The information is pertinent to all offices, so we will add the PCCs from Elkhart and Plymouth. They could participate via WebEx. So Karen Hudson and Terri Lawton will join the committee. Denise S. covers South Bend Hospice House and Karen H. covers	

Topic	Discussion	Action
	Elkhart Hospice House. Tammy H. covers admissions. What about someone from billing? The COPs talk about it not being exclusively clinical. If there are issues that impact finance, someone from billing could be included. • 2016 Meeting dates – 02/16, 05/17, 08/16, 11/15.	
Adjournment	• The meeting adjourned at 9:00 a.m.	Next meeting 02/16

Center for Hospice Care
choices to make the most of life

CHAPTER FIVE

POLICIES

HOSPICE

REVISED

PATIENT CARE

POLICIES

PURPOSE: To provide a verbal order of patient's terminal status at time of admission. Verbal orders will allow us two days to receive the written terminal status signed after period begins.

SCOPE OF PRACTICE: Registered Nurse.

~~PROCEDURE: When the R.N. receives the physician's order to admit to hospice services, the R.N. will verify the terminal status of the patient with the physician, mail out after the H&P is completed.~~

~~The R.N. will fill out the order with the patient's name, ID#, name of ordering physician, and the date order received.~~

~~The R.N. will note from whom the order was obtained, followed by his/her signature.~~

~~The yellow copy of the order will be placed on the chart, with the white copy being mailed to the physician for his signature per the Clinical Support Secretary.~~

RN will take all verbal orders for admission to hospice services. Verbal orders will be read back and verified with physician. Those orders can be stated as admit, consult, or certification of terminal illness. RN will ask that a written order be faxed to the admission department. Written orders will be uploaded to Cerner on the patient level.

Nurse Practitioners and Physician Assistants may not give written/verbal certifications..

Effective Date: 06/97	Revised Date: 10/15~~01~~/06	Board Approved: 01/17/06
Reviewed Date: 09/14		Signature Date: 01/17/06

Signature: President/CEO

Center for Hospice Care

REFERRAL INTAKE PROCESS~~INFORMATION SHEET~~

Section: Patient Care Policies Category: Hospice Page: 1 of 2

PURPOSE: To complete the Intake Information Sheet accurately and gather as much information as the caller will give.

POLICY: The Intake Information Sheet is completed for all referrals that are phoned or given to the agency. Information is immediately documented in the Electronic Medical Record (EMR) to start new patient chart. The Intake form is completed by the time the person is admitted and becomes a permanent part of the patient chart.

PROCEDURE: Complete an Intake Information Sheet and list all appropriate information regarding the patient as specified on the sheet.

1. ~~-~~Date and time referral was received.
2. Check off program that referral source recommended.
3. Patient's Social Security Number.
4. Patient name, age, date of birth.
5. Patient demographic information, i.e., address, county, phone number.
6. Who the caller is and relationship to the patient. Check off where the referral came from, i.e., home, ECF, family, physician, or other.
7. Situation prompting the referral, i.e., recent hospitalization, active symptoms, decline in functional or cognitive status.
8. If referral is for Home Health services, ask if patient has seen the physician within the last ninety (90) days. Initiate Face-to-Face encounter for Home Health patients IF the patient has Medicare.

~~1.~~9. Under Insurance, list the patient's Insurance Source. Medicare number if the patient has Medicare. For commercial insurance number, ~~l.~~ ~~L~~list Patient's ID #, Employer, phone number for private insurance. If Medicaid, list Medicaid number ~~and Medicaid~~.

~~2.~~10. List the patient's primary caregiver and relationship and list address and phone number if different from where the patient is being cared for. (This is important information which is very helpful for bereavement and follow-up.)

~~3.~~11. If referral diagnosis is given, write it under the referral diagnosis on the Intake Sheet.

12. When inputting~~giving~~ directions to a patient's home, be as specific as possible starting from the closest Agency office.
13. Document problems and other significant information regarding treatments, condition problems, etc., that may be expressed by caller.
14. Document any equipment that the patient may be needing~~s.~~ once assessed.
15. Identify if patient has been diagnosed with a life limiting illness is applicable and document any secondary diagnosis that is talked about during phone call.

~~• Identify if prognosis is known by patient and/or family and if available, what was told to the patient.~~

~~• The patient will be admitted on the recommendation of the Medical Director in~~

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~~consultation with, or with input from, the patient's attending physician. This must be done prior to admission. This will be documented on the back of the intake sheet if the patient has not had a pre-assessment. If a pre-assessment has been completed, documentation will be found on the back of the pre-assessment sheet.~~

- ~~The following will be considered in discussing the appropriateness of the patient for admission:~~
  ~~a. diagnosis of the terminal condition of the patient~~
  ~~b. other health conditions, whether related or unrelated to the terminal condition~~
  ~~c. current clinical relevant information supporting all diagnosis~~

- ~~Document the terminal diagnosis and other secondary illnesses.~~

- Person obtaining intake information shall sign at bottom where it is designated "Information Taken By".

- Document the name of the physician and date ~~after obtaining from him/her that the patient either has a terminal illness or has less than 6 months to live. Circle appropriate one.~~the physician was contacted to obtain an order for the appropriate program and verification that the physician will be the Attending Physician.

- ~~Date and signature/title shall be completed after the physician has given approval for patient to receive hospice services. If patient has not been admitted within seven days after intake, reconfirmation will be obtained by the person doing the pre-assessment and documented by adding another signature and date at designated area at bottom of page.~~

- H&P and any additional information confirming patient's terminal status will be found in MHIN or requested from the physician and date documented (labs pertaining to diagnosis, x-rays, especially chest x-rays).

- ~~Give Intake form to the Referral Secretary/Admissions Coordinator for follow-up making sure patient is placed in computer and recorded in the Admissions/Changes/ Discharges Email.~~

- Once all information is recorded on the intake sheet, the Referral Specialist will input all information in Cerner and pass on the intake sheet to the Admission Representative and/or RN to proceed with the assessment.

REGULATION: 42 CFR 418.54 – Initial and comprehensive assessment of the patient

PURPOSE: To assess the eligibility of patient and primary caregiver (PCG) for Agency care according to established criteria.

SCOPE OF PRACTICE: Registered Nurse, Admission Representative, or Social Worker.

POLICY: A patient/primary caregiver (PCG) assessment is made upon a referral of a potential patient. The pre-assessment is made by a qualified staff member.

The visit includes:

1. Explanation of hospice philosophy of care.

2. Determination as to whether or not the patient meets the criteria for admission, under either hospice or home health program~~.~~ (not a social work function).

3. Complete appropriate disease-specific LCD~~.~~ (not a social work function).

4. Explanation of hospice care under Licensed Home Care Program vs. Medicare Program, when appropriate. This includes information on all available services, financial responsibility for services and forms to be completed and signed.

5. Present applicable financial/billing information and confirm their understanding of information.

6. Assessment of the likelihood of the Agency to be able to meet the patient/PCG needs based on:
   - Availability and quality of a primary caregiver to meet the patient's needs
   - The ability of the PCG to meet the patient's needs with the support of the Agency.
   - The suitability of the home and environment (physical and interpersonal) for adequate care of patient and for the safety of agency personnel.
   - Other circumstances as determined on a case-by-case basis.

7. Identify the limits of hospice care.

8. Present the alternatives to hospice care if determined that patient/PCG does not meet qualifications for hospice care.

~~8.~~9. Present information regarding advanced directives.

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~~9.~~10. Update Referral source on status.

11. Fax request for attending and certification of terminal illness form to the requested physician on the Notice of Election Hospice Benefit form if the physician has not already indicated he/she will attend and certify the patient.

~~10.~~12. Contact IDT team members either in person or via phone to discuss patient eligibility and to discuss plan of care prior to admission.

13. Complete appropriate LCD according to the diagnosis given by the CHC Medical Director.

14. The RN signature must include full name and title on the LCD.

Center for Hospice Care

PRE-ASSESSMENT NOTE~~FORM~~

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

PURPOSE: To accurately complete the Pre-Assessment Form prior to formal Agency admission.

SCOPE OF PRACTICE: Registered Nurse, Admission Representative.

PROCEDURE:

1. Obtain the following information from the patient and objective assessment and document in the ~~-~~Pre-Assessment Note in Cerner~~form.~~:
   - (a) Where meeting was held
   - (b) Who referral was from
   - (c) Diagnosis and when diagnosed
   - (d) Past Medical History
   - (e) What prompted referral
   - (f) Objective and Subjective Data
   - (g) Current height and weight and past height and weight
   - (h) PPS now and three to six months ago
   - (i) What is patient able to do
   - (j) Intake past and present
   - (k) What can patient do now and three to six months ago
   - (l) Other agencies
   - (m) Wounds
   - (n) Veteran
   - (o) DME needs
   - (p) Consents signed/not signed
   - (q) Goals
   - (r) Appropriate/not appropriate
   - (s) Labs pertinent to diagnosis

~~2. The patient reference ID is obtained from the patient's referral form and/or computer. The patient ID number will be generated by the software at the time of the admission.~~

~~3. Complete all blanks as appropriate during the initial evaluation interview.~~

~~4. After the pre-assessment is completed, appropriately check off items at the bottom of the form.~~

~~5. Identify referral source.~~

~~6. Elaborate on statements and definitions of independence and quality of life, if needed.~~

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~~7. Document any other pertinent information.~~

~~8. Contact IDT team members either in person or via phone to discuss patient eligibility and to discuss plan of care prior to admission.~~

~~9. The RN signature must include full name and title.~~

Effective Date: 05/94	Revised Date: 10/15~~01/06~~	Board Approved: 01/17/06
Reviewed Date: 09/14		Signature Date: 01/17/06

Signature: President/CEO

Center for Hospice Care

INITIAL ASSESSMENT

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

REGULATION: 42 CFR 418.54(a) Initial and comprehensive assessment of the patient

PURPOSE: The ensure needs are met in a manner consistent with the symptoms and wishes of the patient and family.

POLICY: An initial assessment to determine the patient's immediate care and support needs will be conducted by a hospice Registered Nurse within 48 hours of the patient's election of hospice care.

PROCEDURE: 1. Within 48 hours of the patient's election of hospice care, the Admissions Patient Care Coordinator assigns a hospice Registered Nurse to conduct an initial assessment of the patient's immediate care support needs.

2. An initial assessment visit is made earlier than 48 hours if requested by the patient/family and/or if patient's needs warrant it.

3. The Agency RN completes the Start of Care tool and ensures that orders for treatment and services are obtained to meet the immediate needs of the patient.

4. Based on the patient's needs and findings from the initial assessment, the Agency RN coordinates disciplines that must participate in the comprehensive assessment of the patient within five (5) days of the patient's election of hospice care.

combined into
"Initial assessment of Patient, Family, Primary caregiver" policy →

Effective Date: 12/95 Revised Date: 12/08 Board Approved: 12/02/08
Reviewed Date: 09/14 Signature Date: 12/02/08

Signature: President/CEO

Center for Hospice Care

INITIAL ASSESSMENT OF PATIENT, FAMILY, PRIMARY CAREGIVER

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

REGULATION: 42 CFR 418.54 – Initial ~~and comprehensive~~ assessment of the patient, family and primary caregiver (PCG).

PURPOSE: ~~To assess the patient upon admission to the Agency~~ To ensure needs are met in a manner consistent with the symptoms and wishes of the patient and family.

SCOPE OF SERVICE: Registered Nurse

POLICY: ~~The Agency has the responsibility for assessment of the patient upon admission to the hospice program of care. A member of the interdisciplinary team will make this assessment visit.~~ An initial assessment is done to determine the critical information necessary to treat the patient/family's immediate care needs and will be conducted by a hospice Registered Nurse within 48 hours of the patient election of the hospice care benefit.

The nurse will gather the following baseline data at the time of admission:

- Health history.
- Physical assessment of patient.
- Assessment of patient's pain and effectiveness of current pain management regimen.
- Consult with the ~~referring~~attending physician for orders to treat the patient's immediate physical, psychosocial, emotional, and spiritual status related to the terminal illness and related conditions. ~~in order to acquire adequate current information about the patient's health history, condition, medications, and treatment, and obtain a recent history and physical or discharge summary.~~
- Instruct in actions, side effects, contraindications, and efficacy of current regime, examine any additional medications (prescribed or over-the-counter) which the patient may be taking, and to report this information to the medical directors~~Agency~~ and/or attending physician.
- Based on the patient's needs and findings from the initial assessment, the primary nurse coordinates disciplines that must participate in the comprehensive assessment of the patient within five (5) days of the patient's election of hospice care.
  (1) The Social Worker is responsible for assessing the psychosocial needs of the patient/family/primary caregiver (PCG).

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(2) The Spiritual Care Counselor is responsible for assessing the patient's spiritual and emotional needs as well as resources available to the patient. Attention is also directed to the needs of the patient's family/ PCG.

Effective Date: 12/94	Revised Date: 10/1508/09	Board Approved: 08/19/09
Reviewed Date: 09/14		Signature Date: 08/19/09

Signature: President/CEO

PURPOSE: To ensure appropriate admission to hospice services.

SCOPE OF PRACTICE: Registered Nurse.

POLICY: Patients admitted to hospice services will be certified by their attending physician to have a limited life expectancy of six months or less if the disease follows its normal course.

PROCEDURE: Obtain completed patient folder.

Review the Pre-Assessment consents~~forms~~ to verify completion.

Review LCD and clinical data at time of referral to verify that patient is appropriate for services.

If the physician's approval to start service is more than seven (7) days old, the physician must be contacted again to obtain a current authorization.

The plan of care must be established by the Interdisciplinary Team (IDT), attending physician, and the Hospice Medical Director prior to providing care.

Coordinate with the patient/primary caregiver (PCG) to plan a visit.

Contact patient/primary caregiver to set appointment to complete the initial assessment and all other necessary information.

- Respond to any questions that may have arisen since pre-assessment
- Review information and literature given at the pre-assessment and discuss agency services

~~Obtain informed consent and necessary signatures.~~

Complete ~~a~~ an initial Nursing Assessment.

- ~~Complete all areas, including miscellaneous information~~ Verify all needed equipment has been delivered and no further needs.
- ~~Assess each body system~~ Education on hospice services, medications and DME.
- ~~Note health history prior to illness, diagnoses, labs, X-rays, etc.~~
- ~~Unusual family or home situations~~
- ~~Current available equipment and potential needs for other equipment~~

Make any necessary referrals.

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~~Obtain HMB order (if applicable).~~

~~Complete the Intake Information form.~~

Contact physician's office after initial nursing visit is completed

- Relay admission status
- Verify medications
- Review plan of care
- Record any changes made and/or contact with physician

Evaluate the need for a Hospice Aide/CNA and let the scheduler know of patient's needs.

- According to plan of care
- Per physician direction

If not already completed, ~~C~~complete the Plan of Care appropriate to the patient's payor~~insurance coverage~~. Listed below are additional forms needed for each insurance type.

1. Hospice Medicare Benefit ~~(HMB)~~
   - Fill in patient name and admission date on Physician Certification/ Recertification of Terminal Illness, QA form.
   - ~~HMB~~Hospice Medicare Benefit patients must have a written certification of terminal illness within two calendar days after the benefit period begins. If written certification cannot be obtained within two days, obtain a verbal certification and follow it with a written certification. This must be obtained prior to a claim being submitted for payment.
   - The initial certification of terminal illness must be obtained by both the Medical Director and the patient's attending physician. If these are one and the same, the physician will sign both places on the certification of terminal illness.
   - The Medical Director must sign all recertifications.
   - ~~Obtain HMB order (if applicable)~~
   - See ~~HMB/MHB: Certification of Terminal Illness~~ Hospice Medicare Benefit /Medicaid Hospice Benefit.

2. Medicaid Hospice Benefit (MHB)
   - Patient/PCG need to sign Medicaid Election form.
   - RN needs to complete the Nursing section of the Medicaid Plan of Care.

Support services will contact the patient/family within 48 hours of admission to offer services and to develop the Psychosocial and Spiritual plan of care

- Psychosocial and Spiritual Care assessments will be completed and placed in the patient folder within one week

- The visit(s) will be documented

Miscellaneous Forms:

- Place completed Volunteer Request Form in the Volunteer Coordinator's mailbox if appropriate. List as much information as possible to assist in appropriate volunteer placement.
- Provide a Pre-Poured Medication Profile for patients and/or primary caregivers who wish or require a written schedule of the medications.
- Use the Pre-Poured Medication Profile when pre-pouring patient medications.

Leave the Family/Facility Handbook~~admission folder~~ in the patient's home and inform the patient and family to keep all Agency-related information in it.

Email admission information to the appropriate team, triage, and the South Bend scheduler.

Consents to be Signed at Admission

Form	Hospice Medicare	Hospice Medicaid	Hospice Commercial Ins (includes VA)	Hoosier Connect	Hospice Self Pay
~~Explanation & Consent~~Receipt of Notice of Privacy Practices	X	X	X	X	X
~~Patient Bill of Rights~~General Consent and Release of Information	X	X	X	X	X
~~HMB~~ Election of Hospice Beneift	X		X	X	X
~~MHB~~ Medicaid Hospice Election		X		X	X
~~HMB Financial Explanation~~OASIS Privacy Statement	~~X~~				
~~Disclosure Statement~~Commercial Insurance Verification	~~X~~	~~X~~	X	X	~~X~~

DNR - offer to each patient at admission (patient choice to sign)

Center for Hospice Care

HOSPICE AIDE/HOME HEALTH AIDE REGISTRY

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

PROCEDURE: To be in compliance with the Indiana State Department of Health (ISDH) regulations regarding the Home Health Aide Registry.

POLICY: Hospice will abide by all ISDH regulations regarding the Home Health Aide Registry.

PROCEDURE: To comply with ISDH policies and rules, Hospice will ensure the following:

- Prior to employment, the Human Resources Director will check the ~~contact the nurse aide registry at 317-233-7612, or consult the~~ Access Indiana's Nurse Aide computerized registry to verify the hospice aide/CNA is in good standing.

- After the aide passes a competency evaluation, the Human Resources Director will register the hospice aide/CNA with the ISDH to be listed on the Home Health Aide Registry.

- ~~The Human Resources Director will notify the ISDH of the number of in-service training hours that each hospice aide/CNA completed in the previous calendar year on an annual basis.~~

- ~~The Human Resources Director will notify the ISDH when any hospice aide/CNA terminates employment~~

Effective Date: 05/02	Revised Date: 08/15 ~~01/06~~	Board Approved: 01/17/06
Reviewed Date: 09/14		Signature Date: 01/17/06

Signature: President/CEO

HOME HEALTH

REVISED

PATIENT CARE

POLICIES

PURPOSE: To accurately complete the Intake Information Sheet accurately and gather as much information as the caller will give.

POLICY: The Intake Information Sheet is completed for all referrals that are phoned or given to the agency. Information is immediately documented in the Electronic Medical Record (EMR) to start a new patient chart. The Intake form is completed by the time the person is admitted and becomes a permanent part of the patient chart.

PROCEDURE: Complete an Intake Information Sheet and list all appropriate information regarding the patient as specified on the sheet ~~(see example)~~

1. Date and time referral was received.
2. Check off program that referral source recommended.
3. Patient Social Security Number.
4. Patient name, age, date of birth.
5. Patient demographic information, i.e., address, county, phone number.
6. Who the caller is and relationship to the patient. Check off where the referral came from, i.e., home, ECF, family, physician, or other.
7. Situation prompting the referral, i.e., recent hospitalization, active symptoms, decline in functional or cognitive status.
8. If referral is for Home Health services, ask if patient has seen the doctor within the last ninety days. Initiate Face-to-Face encounter for Home Health patients IF patient has Medicare.
9. Under Insurance, list the patient's Insurance Source. Medicare number if the patient has Medicare. For commercial insurance, ~~–I~~List Patient's ID #, Employer, phone number for private insurance. If ~~and~~ Medicaid, list Medicaid number.
10. List the patient's primary caregiver and relationship and list address and phone number if different from where the patient is being cared for. (This is important information which is very helpful for bereavement and follow-up.)
11. If referral diagnosis is given, write it under the referral diagnosis on the Intake Sheet.
12. When ~~giving~~ inputting directions to a patient's home, be as specific as possible starting from the closest Agency office.
13. Document problems and other significant information regarding treatments, condition problems, etc., that may be expressed by caller.
14. ~~———~~Document any equipment that the patient ~~needs.~~mayy be needed once assessed.
15. Identify if ~~prognosis is known by patient and/or family and if available, what was told to the patient.~~ patient has been diagnosed with a life limiting illness is applicable, and document any secondary diagnosis that is talked about during the phone call.

~~—Document what terminal diagnosis is and other secondary illnesses.~~

Signature:  President/CEO

Person obtaining intake information shall sign at bottom where it's designated "Information Taken By".

Document the name of the physician and date ~~after obtaining from him/her that the patient either has a terminal illness or has less than 6 months to live. Circle appropriate one.~~the physician was contacted to obtain order for appropriate program and verification that the physician will be the Attending Physician.

~~Date and signature/title shall be completed after the physician has given approval for patient to receive services. If patient has not been admitted within seven days after intake, reconfirmation will be obtained by the person doing the pre-assessment and documented by adding another signature and date at designated area at bottom of page.~~

H&P and any additional information confirming patient's terminal status will be found in MHIN or requested from the physician and date documented (labs pertaining to diagnosis, x-rays, especially chest x-rays).

~~Give Intake form to the Referral Secretary/Admissions Coordinator for follow-up making sure patient is placed in computer and recorded in the Admissions/Changes/Discharges book on the Assistant Patient Care Coordinator's desk.~~

Once all information is recorded on intake sheet, the Referral Specialist will input all information in Cerner and pass on the intake sheet to the Admissions Representative and/or RN to proceed with the assessment.

PURPOSE: To assess the appropriateness of both patient and primary caregiver (PCG) for Agency care according to established criteria.

POLICY: A patient/PCG assessment is made upon a referral of a potential patient. The pre-assessment is made by ~~a qualified staff member~~ an RN, Admission Representative, or Social Worker.

The visit includes:

- Explanation of the Agency's philosophy of care.
- Determination as to whether or not the patient meets the criteria for admission, under the home health program.
- ~~Complete appropriate disease-specific LCD.~~
- Explanation of care under Licensed Home Care Program vs. Medicare Program, when appropriate. This includes information on all available services, financial responsibility for services and forms to be utilized and signed.
- Present applicable financial/billing information and confirm their understanding of information.
- Assessment of the likelihood of the Agency to be able to meet the patient/PCG needs based on:
  - availability and quality of a primary caregiver to meet the patient's needs
  - assess the ability of the PCG to meet the patient's needs with the support of the Agency.
  - determination of the suitability of the home and environment (physical and interpersonal) for adequate care of patient and for the safety of agency personnel.
  - other circumstances as determined on a case-by-case basis.
- Identify the limits of the Agency's care.
- Present the alternatives to care if determined that patient/PCG does not meet qualifications for the program.
- Present information regarding advanced directives.

Center for Hospice Care

PRE-ASSESSMENT FORM

Section: Patient Care Policies Category: Home Health Page: 1 of 1

PURPOSE: To accurately complete the Pre-Assessment Form prior to formal Agency admission.

~~EQUIPMENT:~~ ~~Obtain the Pre-Assessment form.~~

SCOPE OF PRACTICE: Admission Representative, Registered Nurse, or Social Workers.

~~The patient reference ID is obtained from the patient's referral form and/or computer. The patient ID number will be generated by the software at the time of the admission.~~

POLICY:

~~Complete all blanks as appropriate during the initial evaluation interview.~~ Confirm current insurance information confirming patient's name and correct spelling, insurance company address, phone numbers, effective dates and numbers, and any other secondary insurance information. Confirm who the insurance is with (patient or spouse). All cards must be seen for confirmation. Scan copy of insurance cards, including Medicare D, into Cerner.

~~After the pre-assessment is completed, appropriately check off items at the bottom of the form.~~

~~Identify referral source.~~
Confirm caregiver name, address, and phone number. Confirm the patient's address and phone number where care will be provided.

Request name of attending physician.

Elaborate on statements and definitions of independence and quality of life.

Document any other pertinent information, including homebound status and skilled need.

Document in RoadNotes all pertinent information under Pre-assessment note.

Obtain signature on all needed consents and insurance forms.

Contact IDT team members either in person or via phone to discuss patient appropriateness and to discuss plan of care prior to admission.

~~The RN signature must include full name and title.~~

Effective Date: 5/94	Revised Date: 10/15~~12/04~~	Board Approved: 12/07/04
Reviewed Date: 03/13		Signature Date: 12/07/04

Signature:  President/CEO

PURPOSE: ~~The initial assessment of a patient shall occur within 24 hours from time of intake. These time frames may differ according to the various settings, and types of services needed by patient/primary caregiver preference.~~ To assure timely admission of patients needing a skilled need through home health.

POLICY: The organization shall recognize a time frame beginning with the patient's intake, continuing with the pre-assessment through the initial assessment. It is the goal of Agency to complete this process within 24 hours. Failure to do so will be reflected in the documentation.

~~Staff is available for intakes, pre-assessments and initial assessments 24 hours per day, 7 days per week (including holidays and weekends).~~

The time span for this process will vary and is patient-specific with the following factors being considered:

From intake to pre-assessment:

- Waiting for the patient/family to allow ~~Agency~~ Representative to meet with them.
- Waiting for patient/family to coordinate a time to meet with other family/friends.

From pre-assessment to initial assessment:

- Waiting for the patient to be discharged from an inpatient facility to their home.
- Waiting for physician ~~approval~~ order and verification of attending.
- ~~Acceptance of the Agency program by the patient in allowing an admission into our program.~~
- Arrangement for billing and delivery of equipment/supplies ~~to be brought~~ into the home.

In actively pursuing to admit an Agency patient, if seven (7) days have lapsed from the initial contact for services by the physician, he/she will be contacted again to re-confirm their patient's appropriateness for admission. This shall be documented ~~at the bottom of the Intake Form~~ in Cerner with the name of the doctor, date, and time ~~signature of person~~ confirming this information.

PURPOSE: To assure appropriate continuity of care from entry into Agency services through discharge.

POLICY: The patient's needs, goals, and interventions are identified following the assessment visit. Appropriate referrals are made through the IDT team to provide for medical and supportive services. The IDT team is~~will be~~ responsible for the planning and management of services, continued assessment, patient/family education and management of information.

Continuity is assured through staff communication: cell phones, e-mail, IDT supervisory meetings, and patient-specific IDT meetings as needs arise.

Effective Date: 12/95	Revised Date: 10/15~~01/03~~	Board Approved: 01/21/03
Reviewed Date: 03/13		Signature Date: 01/21/03

Signature: President/CEO

PURPOSE: To assess the patient, family, and primary caregiver (PCG) upon admission to the Agency program of care.

POLICY: The Agency has the responsibility for assessment of the patient, upon admission. A member of the interdisciplinary team will make this assessment visit.

The nurse will gather at the time of the admission, the following baseline data:

- Health history.
- Physical assessment of patient.
- Assessment of patient's ~~pain and effectiveness of current pain management regimen.~~ skilled medical need and homebound status.
- Consult with the referring physician in order to acquire adequate current information about the patient's health history, condition, medications, and treatment, and obtain a recent history and physical or discharge summary.

Instruct in actions, side effects, contraindications, and efficacy of current regime, examine any additional medications (prescribed or over-the-counter) which the patient may be taking, and to report this information to the Agency and/or attending physician.

The Social Worker is responsible for assessing the psychosocial needs of the patient, family, and primary caregiver (PCG).

The Spiritual Care Counselor is responsible for assessing the patient's spiritual and emotional needs. Attention is also directed to the needs of the patient's family/ PCG. Resources available to the family are likewise explored.

PURPOSE: To ensure appropriate admission to Agency services.

POLICY: Patients admitted to agency services will be certified by their attending physician to have an intermittent skilled need and homebound status. ~~limited life expectancy of six months or less if the disease follows its normal course.~~

PROCEDURE: ~~Obtain completed patient folder~~.

Review the Pre-Assessment notes and Interdisciplinary Team (IDT) ~~forms~~ to verify completion. .

~~Review LCD and clinical data at time of referral to verify that patient is appropriate for services.~~

If the physician's approval to start service is more than seven (7) days old, the physician must be contacted again to obtain a current authorization.

The plan of care must be established by the IDT, attending physician, and the Medical Director prior to providing care.

Coordinate with the patient/primary caregiver (PCG) to plan a visit.

Contact patient/PCG to set appointment to complete the assessment and all other necessary information.

- Respond to any questions that may have arisen since the pre-assessment.
- Review information and literature given at the pre-assessment and discuss agency services.

If not already obtained, o~~O~~btain informed consent and necessary signatures.

Explanation of previous 90 day face-to-face or need for patient to see attending physician within 30 days of admission.

Complete a Nursing Assessment.

- Complete all areas ~~including miscellaneous information~~of Medicare and Medicaid Oasis or Commercial Skilled Nursing Admission Evaluation in Cerner.
- Quality Assurance to review above before locking..
- Assess each body system.
- Note health history prior to illness, diagnoses, labs, x-rays, etc.
- Note u~~U~~nusual family or home situations.
- Note c~~C~~urrent available equipment and potential needs for other equipment.

Make any necessary referrals.

~~Complete the Intake Information form.~~

Signature: President/CEO

Contact physician's office after initial nursing visit is completed:

- Relay admission status
- Verify medications
- Review plan of treatment
- Record any changes made and/or contact with physician.

Evaluate the need for a Home Health Aide and let scheduler know of patient's needs.

- According to plan of treatment
- Per physician direction

~~Complete the Plan of Care appropriate to the patient's insurance coverage. Listed below are additional forms needed for each insurance type.~~

~~(a) Home Health Medicare (HHM)~~

- ~~Private (PVT), no insurance (Self-Pay), and Medicaid (CAID) require no additional forms.~~

Support services will contact the patient/family within 48 hours of admission to offer services and to develop the Psychosocial and Spiritual Care Plans.

- The psychosocial and spiritual care assessments will be completed and placed in the patient folder within one week. The visit(s) will be documented.

Miscellaneous Forms:

- Provide a Pre-poured Medication Profile for patients and/or primary caregivers who wish or require a written schedule of the medications.

- Use the Pre-Poured Medication Profile when pre-pouring patient medications.

Leave Family Handbook~~admission folder~~ in the patient's home and inform the patient and family to keep all Agency-related information in it.

Email admission information to appropriate team and the scheduler.

Consents to be Signed at Admission

Form	Medicare	Medicaid	Commercial Ins
Explanation & Consent	X	X	X
Patient Bill of Rights	X	X	X
OASIS Privacy Statement	X	X	~~X~~
Commercial Insurance Verification			X
Medicaid Home Health Admission Prior Authorization		X	

DNR – offer to each patient at admission (patient choice to sign)

Center for Hospice Care

INFORMED CONSENT

Section: Compliance, Patient Care Category: Home Health, Compliance Page: 1 of 1

PURPOSE: To insure the patient or legal representative will be informed of the type of care or services that will be provided.

POLICY: Informed consent for care is obtained from the patient or designated representative and documented in the clinical record.

PROCEDURE:

1. Prior to admission, all patients are given a complete description of the palliative nature of care and the services provided by the Agency.

2. All patients and/or their legal representative(s) are required to acknowledge that they have been given a complete understanding of the services to be provided by the Agency.

3. Patients and/or their legal representative(s) are informed of the eligibility requirements for services, and that the goal of care is directed toward relief of symptoms rather than the cure of the underlying disease.

4. A signed "General ~~Release of Information~~ Consent and Release of Information" form, ~~and electronic form, if applicable,~~ serves as confirmation of informed consent and is obtained from each patient and included in the patient's clinical record.

5. Care is not provided unless and until a signed "General ~~Release of Information~~ Consent and Release of Information" and applicable election form is received.

6. If a patient has been adjudged incompetent, the person appointed pursuant to state law to act on the patient's behalf signs the form.

7. Regular clinical record audits ensure that the "General ~~Release of Information~~ Consent and Release of Information" and election form has been signed and received from every patient prior to the start of care.

Effective Date: 09/00	Revised Date: 10/15	Board Approved: 08/17/11
Reviewed Date: 03/13		Signature Date: 08/17/11

Signature: President/CEO

Center for Hospice Care

FAXED CONSENTS

Section: Patient Care Policies Category: Home Health Page: 1 of 1

PURPOSE: To obtain a legal consent from a responsible party who is out of the local area.

PROCEDURE: Fax all needed consents to the Power of Attorney (POA), indicating where to sign and date.

~~Instruct POA via the telephone to sign, date, and fax back to Agency.~~ All consents will have an explanation and note where to sign and date for the POA. The POA has the opportunity via telephone prior to signing the consents and faxing to the Agency

Once consents are faxed, the POA will need to mail the signed consents to Agency, as we must have an original signature on our chart.

~~When consents with the original signature arrive at Agency, stamp with date received and staple to corresponding faxed copy and place in patient's chart~~ Signed faxed copies are uploaded to the admission level of Cerner.

Please note, if these are consents for an admission, we may not proceed with the admission until we have received the faxed copy.

Effective Date: 02/02	Revised Date: 10/15	Board Approved: 02/19/02
Reviewed Date: 03/13		Signature Date: 02/19/02

Signature: President/CEO

Center for Hospice Care

DRAFT

HOME HEALTH CERTIFICATION

Patient Name: _____ Date: _____

Thank you for allowing us to serve you. Because Center for Hospice Care is governed by Medicare rules and regulations, we need to make sure we are following guidelines so we can continue to care for you without interruption.

In order to qualify for home health care, Medicare guidelines state that you must have seen a physician who is willing to attest to your need for home health care within the last 90 days.

Please complete the following for our records:

The date you last saw the physician who is ordering your home health care was:

Date: _____

Physician's Name: _____

If you have not seen a physician who is willing to sign your need for home health care within the last 90 days, you will need to see a physician or non-physician practitioner within the next 30 days. This doctor may not be associated with Center for Hospice Care. Failing to do so could change your status to Self-Pay or even cause you to be discharged from services.

In order to keep this from happening, please see your physician by: _____

Thank you.

Center for Hospice Care

White Copy – Chart *Yellow Copy - Patient*

Revised 10/15
Billing/Home Health Certification

1-800-HOSPICE

111 Sunnybrook Court
South Bend, IN 46637
(574) 243-3100
Fax: (574) 243-3134

112 South Center Street, Suite C
Plymouth, IN 46563
(574) 935-4511
Fax: (574) 935-4589

22579 Old US 20 East
Elkhart, IN 46516
(574) 264-3321
Fax: (574) 264-5892

Life Transition Center
501 Comfort Place
Mishawaka, IN 46545
(574) 277-4100
Fax: (574) 255-1452