Center for Hospice Care
choices to make the most of life

Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
February 15, 2017
7:30 a.m.

BOARD BRIEFING BOOK

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choices to make the most of life

CHAPTER ONE

AGENDA

Center for Hospice Care

BOARD OF DIRECTORS MEETING
Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
February 15, 2017
7:30 a.m.

A G E N D A

1. Approval of December 21, 2016 Minutes *(action)* – Wendell Walsh (2 minutes)

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

3. Finance Committee *(action)* – Lori Turner (10 minutes)
   (a) December 2016 Year End Pre-Audited Financial Statements *(action)*

4. Policies *(action)* – Sue Morgan (5 minutes)

5. Foundation Update *(information)* – Amy Kuhar Mauro (10 minutes)

6. Chairman's Report *(information)* – Wendell Walsh (3 minutes)

7. Board Education – Cornerstones for Living: the Crossroads Campaign Public Phase *(information)* – Dan Reagan (30 minutes and 10 minutes for Q&A)

Please note that this meeting will last until 9:00 a.m. for Dan Reagan's presentation on the Capital Campaign.

Next meeting April 19, 2017 at 7:30 a.m.

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Center for Hospice Care
choices to make the most of life

CHAPTER TWO

MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
December 21, 2016

Members Present:	Amy Kuhar Mauro, Ann Firth, Carol Walker, Corey Cressy, Jennifer Ewing, Jesse Hsieh, Mary Newbold, Wendell Walsh
Absent:	Anna Milligan, Francis Ellert, Lori Turner, Suzie Weirick, Tim Portolese
CHC Staff:	Mark Murray, Amy Tribbett, Dave Haley, Karl Holderman, Mike Wargo, Sue Morgan, Becky Kizer

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 7:30 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 10/19/16 meeting as presented. The motion was accepted unanimously.	J. Ewing motioned M. Newbold seconded
3. President's Report	• The ADC in November was back over 400 for the first time since August. YTD through yesterday is 399, which ties what we did in 2015. The ADC breakeven is 337. YTD the ADC is down 0.08% from last year. Earlier this year it was down as much as 5%. We've made a lot of efforts to increase the GIP level of care in Hospice House and as a result South Bend Hospice House (SBHH) had an increase of 7% in patients served but a 2% decrease in the occupancy rate. Elkhart Hospice House (EHH) had a 6% increase in patients served and an 11% decrease in the occupancy rate. The average length of stay at the SBHH decreased 8% and the EHH decreased 16% primarily due to late referrals from hospitals, which are shorter lengths of stay and the numbers of these are increasing • In the 2017 budget we are including opening an office in LaPorte by July 1, 2017. About six years ago marketing data showed LaPorte County as having the third highest number of patients not being served by hospice. We have served LaPorte County since 1997. In 2014 we served 19 patients, 23 in 2015, and so far have served 27 in 2016 for an ADC of around 5.5. Many years ago the former LaPorte Hospital purchased the VNA Home Health & Hospice. The a few years ago the hospital was purchased by I.U. Health System.. In March, Community Health Systems (CHS), a for-profit entity operating 158 hospitals in 22 states, mostly in middle market and rural hospitals across the county, purchased the hospital CHS purchased the hospital from I.U., they dropped the hospice program immediately but kept the home health. There are eleven different hospices including CHC that say they serve LaPorte County, but only one now has a physical presence there—	

Topic	Discussion	Action
	Franciscan Health System out of the hospital in Michigan City. We may also have opportunities from a foundation and trust to help fund a LaPorte office on a five year pilot program. We would like to open an office as close to the hospital as possible. We will add Porter County to our service area as well since it's close and contingent to LaPorte County. The people we have talked to including the LaPorte Hospital Foundation which received funds from the hospital sale are interested in us coming as a non-profit. They are revamping their mission because they won't be raising funds for the hospital any longer. Awareness about hospice services has increased. Our liaisons often hear doctors say not having a physical presence in LaPorte County is a problem, so having a store front presence will be a huge benefit for us. Our on call response time to that area now is not always optimum. We've also had problems getting volunteers to go there. • Service area – There is no cap or limit on where can go. We don't expand just for the sake of expanding. 94% of our patients are in St. Joseph, Elkhart and Marshall Counties. We could expand along the northern part of the state along the toll road, make alliances, work with managed care networks, etc. We are not interested in Michigan because they have a moratorium on new home health agencies, so we would have a different product in Michigan. There are some good hospice programs in Michigan that we work with. We also don't think we have done everything we can in Indiana. There are also licensing issues for professional staff in to have licenses in two states. • NHPCO has a new President/CEO who will begin on or before 02/01/17. This has not been released nationally yet, because he still needs to let his clients in the DC area know. He is very familiar with hospice and palliative care. Don Schumacher's last day was last Thursday. He leaves a terrific legacy. There have been several conversations on a national level about what the first 100 days of a Trump Presidency will look like. We're concerned about Medicaid and the new Administration wanting to do block grants and throw everything back to the states. There have been some Medicaid hospice problems in Indiana. We are out over $90,000 and have received no hospice in the state has received payments for a hospice general inpatient level of care since July 2015. The new head of CMS is from Indiana and helped start the Healthy Indiana plan under Mitch Daniels and HIP 2.0 under Pence. She has been invited to speak at the NHPCO conference. • The biennial board self-evaluation tool is included in the board packet, along with	

Topic	Discussion	Action
	a self-addressed stamped envelope. The results will be included in the February board packet. This is an evaluation of the effectiveness of the board by the board and we follow any trending. This is not an evaluation on the staff and management of CHC. The board manages itself. • MedPAC is recommending to Congress that it eliminate the legislatively mandated update for FY2018 hospice payments. Under current law, the hospice payment update for FY2018 is capped at 1% exclusive of the budget sequester. • The latest issue of the H&P (hospice and physician) newsletter focuses on our HeartWize and BreatheEasy specialty programs. Now that we have a year of data available, we can show how these programs help reduce the number of re-hospitalizations. Amy Tribbett will be creating a one-page sheet of the data that will be easier to read and distribute to physicians. Hospitals don't want readmissions, because they get penalized under certain diagnoses. They are receptive to us when we show the data, and now that we have a year's worth we can show the reality of it. We get more support from doctors like cardiologists, pulmonologists, etc. The case managers at the hospitals are aware of the programs, but we get more support from the doctors. Dave Haley has had conversation with his counterparts at the hospitals. We continue to educate the patient and family on who to call and what to do. The new CEO at St. Joseph Health System toured our facilities, and we also have an appointment with the new CEO of EGH to come and tour our offices. • The February CHC Board meeting will last a half-hour longer than normal, because Dan Reagan will be the special guest to talk about the public phase of the capital campaign. Reagan has been involved since the beginning of the campaign. He worked for a number of years at Notre Dame on their campaigns and has helped them to raise over $2 Billion on his last campaign before he left.. We will be unveiling the public phase of the campaign and what we intend to do. • One of our current nurse practitioner employees will be taking the hospice and palliative medicine exam on 12/29. Dr. Shelly Harkins will begin working here part-time as of 01/09/17. She is board certified in hospice and palliative medicine. She will be with us until the end of June and work three days a week. • The Veterans Memorial Dedication ceremony was held on 10/19/16. • The annual CHC Service of Remembrance was held on 11/27. 455 people participated in South Bend, Elkhart and Plymouth. Families who lost a loved one	

Topic	Discussion	Action
	this year were invited. • The annual employee Donuts with Santa was held on 12/03 at the Mishawaka office. 70-80 employees and their family members attended.	
4. Finance Committee	• Flex Spending Limit – The Finance Committee approved keeping the limit at $2,000 for 2017. The amount has worked well for staff. A motion was made to approve setting the flex spending limit at $2,000 for 2017. The motion was accepted unanimously. • Retirement Plan Audit – The Finance Committee reviewed the audit of our retirement plan. There were no deficiencies. The audit is an IRS requirement. Even though as a not-for-profit our plan is a 403b, with the change in 2010 audit requirements it now must mirror 401k plans and be audited. A motion was made to accept the Retirement Plan Audit as presented. The motion was accepted unanimously. • Financial Statements – October operating income was $1,735,084, beneficial interest in Foundation was a ($408,272) loss, total revenue $1,379,813, total expenses $1,679,017, net loss ($299,204), net without beneficial interest $109,068. October YTD operating income $17,864,568, interest & other income $165,659, beneficial interest in Foundation $219,849, total revenue $18,250,076, total expenses $15,849,777, net gain $2,400,299, net without beneficial interest $2,180,450. • November operating income $1,798,008, interest & other income $54,667, beneficial interest in Foundation $787,517, total revenue $2,640,192, total expenses $1,575,287, net gain $1,064,905, net without beneficial interest $277,388. November YTD operating income $19,662,574, interest & other income $220,326, beneficial interest in Foundation $1,007,366, total revenue $20,890,266, total expenses $17,425,064, net gain $3,465,202, net without beneficial interest $2,457,836. • A motion was made to accept the October and November 2016 financial statements as presented. The motion was accepted unanimously. • Center for Adult Day Services (CADS) was never intended to be a money maker. Historically REAL Services lost $2,000 a month. Now we have a $9,000 net gain during the first four months. We are keeping track of this. • 2017 Budget – The projections are tied closely to the ADC. It is a very prudent attempt to project what the ADC will be and how it will result in terms of income	A. Mauro motioned J. Ewing seconded A. Firth motioned M. Newbold seconded A. Mauro motioned C. Walker seconded

Topic	Discussion	Action
	for the organization. This year additional expenses for some personnel costs were built into the budget. The Finance Committee believes it is a prudent budget and recommends approval. We are projecting to serve 2,102 patients in 2016 and 2,131in 2017, a 1.4% increase. ADC at the end of the year should be just under 400, so we are projecting an ADC of 405 for 2017 which includes some additional patients in LaPorte County for the second half of 2017. Overall operating revenue projecting $22,004,415, total revenue $23,752,652, total expenses $21,621,601, net gain $2,131,050, net without beneficial interest $1,010,814. We will be adding some medical staff next year, plus staffing the office in LaPorte. • A motion was made to accept the 2017 budget as presented. The motion was accepted unanimously.	C. Walker motioned C. Cressy seconded
5. QI Committee Report	• Carol W. reported she continues to be amazed at the different quality indicators tracked within different departments in CHC. It is a very well run committee. The committee continues to review the percentage of live discharges. In 2014 the national average was 11-13%, and some states are as high as 25-37%. We were at 10% in 2014 and at 9% in 2015 and 2016. Live discharges includes transfers to other hospices, moved out of service area, revocations, no longer meets criteria, and discharge for cause. Staff was educated about live discharges in October, particularly revocations. We've noticed that the most frequent timeframe for revocations is within the first 25 days after admission, so staff was educated to be sensitive to that and make sure they are focusing on those patients, especially those with shortness of breath. • CMS developed the Hospice Item Set (HIS) which is an assessment and data collection set that is based on quality measures. These will be changing over time. We will examine our individual scores and benchmarks to prepare for public reporting in 2017. • We are working on improving documentation occurring in the home. Education and training is done on a regular basis. August training was on documentation do's and don'ts and regulatory requirements. We are also reviewing high risk/low volume services. The QAPI started with blood transfusions. Everything went smoothly with the most recent transfusion. • Patient safety – Falls continue to be a focus for all health care settings. There was a spike in October. More often it occurs in nursing homes. There were a couple of falls in the home, so we assessed the situation and provided commodes.	

Topic	Discussion	Action
	• Spiritual care introduced a quality indicator for spiritual care comprehensive assessments. They are also working on an assessment tool that will put us in line with other chaplaincies in health care, and on an education brochure. Social work is working on how new patients are presented at the IDT meetings. They are also looking at the scope of services and reviewing the plan of care, end of life decisions, advance directives, and any immediate goals of the family.	
6. Foundation Update	• Through November we are seeing a trend going back over the past four years of an increase in the amount of revenue generated in fundraising activities. Through the 29 months of our five year comprehensive fundraising campaign, Cornerstones for Living: The Crossroads Campaign, we have raised $7,271,563 in cash, pledges, and documented bequests. Much of that is in endowments and annual giving. In 2017-2018 we will turn our attention to raising capital funding for the new patient care staff building and Hospice House. We are receiving a $1,750,000 gift over five years from the Dwyer Trust. It consists of $250,000 to fund regional hospice and palliative care community education initiatives and $500,000 to fund the first five years of a seat in the IU School of Medicine's Hospice and Palliative Care Fellowship program. The remaining $1MM is in the form of a challenge grant that will provide funds to endow the Fellowship in perpetuity. This additional Fellowship seat in IU's program will be called the Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine. • We intend to identify physicians in our 8-county service area who are interested in using this opportunity to pursue an alternate career path in hospice and palliative medicine. We are working with the Fellowship program director, Dr. Lyle Fettig, to develop a recruitment strategy for our community. The total cost of supporting a seat in the Fellowship program is between $80,000 and $90,000 annually. The balance of the Dwyer Trust gift will be used to deliver continuing medical education to area physicians, principally focused on improving their ability to communicate bad news to their patients. Depending upon the experience level of the physicians going through each offering of the program, the course duration will be between one and three days with approximately twelve physicians in each cohort. Dr. Fettig and/or his colleagues will come here to deliver the course as well as hire professional actors for the role playing segments of the course. In addition to broad-based marketing efforts, we plan to proactively reach out to local health systems, residency programs, major medical practices and individual	

Topic	Discussion	Action
	physicians who have elected to do a residency rotation with CHC during the past few years. Carol W. suggested including advance practice nurses if seats are available as well. • We received a gift from the John H. Lloyd III family who pledged an additional $50,000 to the Linda Lloyd Mission Endowment for Camp Evergreen. Our goal is to raise $400,000 to endow that program and we already have $150,000 from one family. • The 2016 Annual Appeal hit mailboxes in November. It has been very successful so far and featured a story on CHC patient Wilbur Lewis, whom CHC arranged to take an Honor Flight to Washington, DC earlier this year as part of our We Honor Veterans program. • Bike Michiana for Hospice was held on 10/02. Ridership was down slightly, but the amount raised increased. Last year, the event netted $32,000 and this year it netted $42,000. • Okuyamba Fest was held on 10/12 and raised $4,600 for the Road to Hope program. • Due to a major event being held at the South Bend Museum of Art on 11/16, we decided to reschedule the Helping Hands Award Wall of Fame Dedication and After Images Art Show events. The Wall Dedication will now be held in conjunction with the Circle of Caring Dinner on March 16, and the "Journeys in Healing" art event will be held on June 14. We will also use the Circle of Caring Dinner to announce the public phase of our comprehensive fundraising campaign. • We continue to work with PCAU, the Eck Institute for Global Health and Uganda Martyrs University to establish the next phase of the mHealth initiative. This will be the third year of that project. Katie Anderson, a master's student in the Eck Institute recently completed her work on Phase 2, in which she worked closely with PCAU to expand the pilot program from four to 10 sites. Her recommendations for refining the process and the evaluation system will be incorporated into the next phase of the project. Lily Ramos Drale, a Uganda native and RN who is in the master's program at Notre Dame, will work closely with Lacey Ahern, the project's faculty advisor, to prepare for the scale up of the program. • Road to Hope now has 55 students enrolled, with just four currently unsponsored. The Road to Hope documentary continues to run in the film festival circuit. Each	

Topic	Discussion	Action
	screening represents yet another opportunity to expose audiences to the harsh realities of life for child caregivers and to the Road to Hope program and donor opportunities to support it. • We are in the process of creating several new education initiatives. The fourth offering of the Introduction to Hospice and Palliative Care Course that we teach to Notre Dame undergraduate students, in conjunction with the Ruth M. Hillebrand Center for Compassionate Care in Medicine, will be held on 02/25. We are also working with the Forever Learning Institute to offer a class on hospice and end of life planning, and continue collaborative opportunities with other area colleges and universities, including Holy Cross College, Indiana University South Bend and the IU School of Medicine – South Bend. • Construction Update – We will soon be receiving final numbers for construction of the patient care staff building. We met last week with the architects to review the Hospice House floor plans, and expect to have something to show the board at the February meeting. • New Market Tax Credits – The allocations were announced in November. The CDE that ranked our project as their number one funding priority, which is managed by the Indiana Housing Authority, did not receive an allocation. However, they did refer us onto a person connected with other CDEs across the country who have allocations but may not have enough projects in their pipeline to fully expend their allocations. He is in the process of facilitating meetings with them on our behalf. • LaPorte – Our goal is to open an office by 07/01/17. We are developing a 5-year pro forma based upon projected census growth and anticipated costs to ramp operations up to a breakeven point. The total losses we expect to incur during the ramp-up period will be the amount of gap funding we will seek in the form of grants and philanthropic support. We have already begun conversations with potential funders. We will use our track record and actual financial experience resulting from new office openings in Elkhart and Plymouth to determine the projected cost of opening a LaPorte office. Nafe Alick serves on the Crossroad Campaign cabinet. When looking for potential office space for his business in LaPorte last year, he identified a site that might work for us and we will be exploring it as a possibility along with others. Reimbursement under the Hospice Medicare Benefit has LaPorte as being at the highest rate in our service area. By	

Topic	Discussion	Action
	the end of 2017 we are projecting an ADC of nine patients. •	
7. Nominating Committee	• Anna Milligan, Tim Portolese, and Carol Walker are up for re-election to a second three-year term on the board of directors. • The slate of CHC board officers is as follows: Wendell Walsh, Chair; Mary Newbold, Vice Chair; Lori Turner, Treasurer; Carol Walker, Secretary; Amy Kuhar Mauro, Immediate Past Chair. • A motion was made to accept the re-election of Anna Milligan, Tim Portolese, and Carol Walker, and the slate of CHC board officers as presented. The motion was accepted unanimously.	J. Hsieh motioned J. Ewing seconded
8. Board Education	• Beginning January 1, 2017 Global Partners in Care will become an independent affiliate of the Hospice Foundation. There are 75 U.S. partners primarily in Africa. We have been partners since 2008 with PCAU and are widely recognized as the leading partner. We are number one in the amount of funds sent overseas. Only donor gifts that have been designated to be sent overseas are\sent overseas. At the June NHPCO Board meeting it was announced that they would like this important work to continue, but perhaps it should be done outside NHPCO. Mark expressed that we might be interested in helping. We did a long series of due diligence and then took the idea to the Hospice Foundation Board in October and they approved it. Then the NHPCO Board approved it. Last week the NHPCO executive committee changed the GPIC bylaws so the sole corporate owner would be the Hospice Foundation and removed NHPCO. We would add our board structure to the bylaws so the Hospice Foundation Board will also be the GPIC board. GPIC will remain an independent entity. We expect the transfer to be completed in January, but this will be a year of transition and we will be working very closely with the GPIC staff at NHPCO. • It is in our strategic plan to diversify our revenue stream and this is similar to the purchase of Milton Adult Day Services. We would keep the 10% fee of the money that flows through GPIC from the U.S. partners to the overseas partners. The 10% is used to manage the program and provide partner support. If we can continue to grow the program, we will be able to grow that non-hospice revenue stream for us. We would also apply for grants. GPIC has a history of obtaining them. There is a lot of interest in Notre Dame and other partners that we can work with. Eventually we will redomesticate GPIC the corporation from New York to Indiana.	

Topic	Discussion	Action
	• We have worked very closely with all the people operating GPIC for many years. Last week Cyndy Searfoss, Mike, Karl and Mark met with them for a day spread over two. We can facilitate partnerships easier and have face time with people that are interested in becoming partners. We are excited about this opportunity. There are four to five major programs in the country and we already know all the people that run them. The top five U.S. partners provide more than half of the GPIC support.	
9. Chairman's Report	• Reminder to complete the board self-evaluation and return it to Becky K. by the end of the year. It helps us become a better board. • Reminder that the 2017 board meeting dates are posted on the board website, so make sure the dates are on your calendars. • Amy Kuhar Mauro was recognized for serving as CHC Board Chair for the past two years. We appreciate her leadership, support input, and direction.	
Adjournment	• The meeting adjourned at 8:50 a.m.	Next meeting 02/15/17

Prepared by Becky Kizer for approval by the Board of Directors on 02/15/17.

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Mary Newbold, Secretary Becky Kizer, Recording Secretary

Center for Hospice Care
choices to make the most of life

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
Hospice Foundation
President / CEO Report
February 15, 2017

(*Report posted to Secure Board Website February 9, 2017)*
This meeting takes place in Conference Rooms A&B at the Mishawaka Campus at 7:30 AM and will last until 9 AM.
This report includes event information from December 22, 2016 – February 15, 2017.
The Hospice Foundation Board meeting follows in the same room.

CENSUS

January census information is below. Referrals in January were up slightly from January of 2016, but the number of admissions were down slightly. The number of admitted patients who died within seven days or less in January was 38%, lower than the calendar year 2016 percentage of 41%. Year-to-date (YTD) 2016 average length of stay (ALOS) for hospice patients dropped to 68 days from 74 in 2015. Median LOS stayed the same at 14 days. Referrals came in at 2,426, down from 2,507 in 2015. However, the conversation rate improved (turning a referral into an admission) to 71.27% from 70.16%. A 70% conversion rate is considered an optimal benchmark nationally. The percentage of referred patients who died before admission (d/b/a) increased to 7.42% in 2016 from 6.58%, even though we were responding faster than ever. Efforts on enhancing speed to care for referral sources was evidenced by the same and/or next day admits up to 52.9% of the referrals in 2016 versus 51.9% in 2015. Remember, after we receive a referral we must still convince the patient and family to agree. YTD Hospice House occupancy was 74.94%, an increase of 0.34%. Elkhart YTD occupancy was 69.51% for the year, down -8.46 compared to 2015. Both units had shorter lengths of stay in 2016 than 2015.

January 2017	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	535	535	546	(11)
Original Admissions	148	148	158	(10)
ADC Hospice	361.16	361.17	376.35	(15.19)
ADC Home Health	28.55	28.55	20.42	8.13
ADC CHC Total	389.71	389.71	396.77	(7.06)

December 2016	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	519	2,109	2,102	7
Original Admissions	155	1,721	1,734	(13)
ADC Hospice	376.74	376.26	375.73	0.53
ADC Home Health	27.29	22.63	22.84	(0.21)
ADC CHC Total	404.03	398.89	398.57	0.32

Monthly Average Daily Census by Office and Hospice Houses

	2017 Jan	**2017** Feb	**2017** Mar	**2017** Apr	**2017** May	**2016** June	**2016** July	**2016** Aug	**2016** Sept	**2016** Oct	**2016** Nov	**2016** Dec
S.B.:	224					243	226	226	222	217	219	220
Ply:	69					71	74	74	77	76	79	78
Elk:	87					91	95	94	90	94	99	96
SBH:	5					6	5	5	6	4	5	6
EKH:	4					4	5	5	3	3	2	4
Total:	390					414	404	404	398	394	405	404

HOSPICE HOUSES

January 2017	Current Month	Year to Date	Prior Year to Date	YTD Change
SB House Pts Served	35	35	32	3
SB House ALOS	4.49	4.49	4.25	0.24
SB House Occupancy	72.34%	72.34%	62.67%	9.68%
Elk House Pts Served	30	30	33	(3)
Elk House ALOS	4.13	4.13	5.12	(0.99)
Elk House Occupancy	57.14%	57.14%	77.88%	-20.74%

December 2016	Current Month	Year to Date	Prior Year to Date	YTD Change
SB House Pts Served	46	354	316	38
SB House ALOS	4.30	5.42	6.03	(0.61)
SB House Occupancy	91.26%	74.94%	74.60%	0.34%
Elk House Pts Served	37	307	282	25
Elk House ALOS	3.57	5.09	6.30	(1.21)
Elk House Occupancy	60.83%	61.05%	69.51%	-8.46%

PATIENTS IN FACILITIES

Of the 535 patients served in January, 164 resided in facilities. Of the 519 patients served in December 2016, 155 resided in facilities. The average daily census of patients in skilled nursing homes, assisted living facilities, and group homes during January was 130; December was 129 and December YTD 2016 was 142.

FINANCES

Karl Holderman, CFO, reports the December year-end 2016 Financials will be posted to the Board website on Friday morning, February 10th following Finance Committee approval. For information purposes, the approved November 2016 financials are presented below. Due to year-end closing, we only cover the December Financials at the first board meeting of the year in February. First quarter Finances for 2017 will be covered at the April board meeting, along with the 2016 audited financial statements from our independent audit firm, David Culp & Co., LLP.

November 2016 Financial Information

Center for Hospice Care *(1)*

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

November Overall Revenue	$	2,640,192	Year to Date Overall Revenue	$	20,890,266
November Total Expense	$	1,575,287	Year to Date Total Expense	$	17,425,064
November Net Gain	$	1,064,905	Year to Date Net Gain	$	3,465,202

Hospice Foundation

Nov Development Income	$	894,828	Year to Date Development Income	$	2,237,974
November Invest Gains (Loss)	$	85,018	Year to Date Investment Gains (Loss)	$	930,722
November Overall revenue	$	980,491	Year to Date Overall Revenue	$	3,218,298
Total November Expenses	$	192,793	Total Year to Date Expenses	$	2,210,932
November Overall Net	$	785,518	Year to Date Overall Net	$	1,007,366

Combined *(2)*

November Overall Revenue	$	2,833,165	Year to Date Overall Revenue	$	23,101,198
November Overall Net Gain	$	1,064,905	Year to Date Overall Net Gain	$	3,465,202

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

At the end of November 2016, the combined operating income was $19,662,574 down 2.40% from November 2015. The YTD November overall combined net gain for CHC / HF was $3,465,202, was up 6.68% from November 2015. At 11/30/16, CHC's YTD Net without the beneficial interest in the HF was $2,457,836 representing a 24.41% decrease from same time last year. The combined YTD net at 11/30/16 without counting investment gains/losses was $2,534,480 representing a decrease of 18.37% from YTD same time prior year. At the end of November 2016, the Hospice

Foundation's Intermediate Investments totaled $4,441,604. Long Term Investments totaled $17,248,879. CHC's assets on November 30, 2016, *including* its beneficial interest in the Hospice Foundation, totaled nearly $44MM. At the end of November 2016 HF's assets alone totaled $37.8MM 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 November 30, 2016 of just under $50MM. At November 30, 2016, CHC and HF combined are under budget on revenue by 0.006% and below budget on expenses by 6%. At 11/30/16, with investment gains removed, the combined organizations have an "all in" positive margin of 15%.

CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

Shelly Harkins, M.D., MPH, formerly the Chief Medical Officer of Beacon Health Services, started as an Independent Contractor working three days a week, beginning January 9, 2017. She is board certified in hospice and palliative medicine.

Max Allen, D.O., is obtaining his Indiana licensure and will be conducting face-to-face visits for us in the very near future. We also will be contracting with George Drake, M.D. of Edwardsburg, MI to work two days a week as a Medical Director. He is Board Certified in both family medicine and in hospice and palliative medicine.

We have another board certified in hospice and palliative medicine physician from Portland, OR who will be visiting us for an interview on March 6.

We continue to make good progress in reducing the number of delinquent billings and reducing our Account Receivables. Our days receivable for Medicare Hospice Benefit claims are now back down to the national benchmark.

The South Bend Hospice House has transitioned to a new linen supplier, United Hospital Services out of Indianapolis, after Beacon Health Services closed their laundry operation.

DIRECTOR OF NURSING UPDATE

Sue Morgan, DON, reports…

LaTonya Brooks RN, BSN will begin as the Clinical Staff Educator effective 2/17. She is relocating from Houston, TX. She has experience as an educator and over six years of hospice experience. As the Clinical Staff Educator, she will be responsible for CHC orientation for newly hired clinical staff, nursing, social work and spiritual care. She will focus on nursing staff education for CNA's, our BreatheEasy specialty program, the nurse preceptor program, and Cardiac Boot Camp which is the training piece for our HeartWize specialty program.

During December, a Skills Fair for nurses was held to maintain clinical competency for core skills. All nurses completed the program.

The Role of CHC's LPN's has been expanded for their clinical competencies. In March, they will attend an education program to increase their knowledge and clinical skills.

During January, a CMS all day education program was held via Webinar regarding the federal government's ever expanding "Hospice Quality Reporting Program." 15 staff attended. On the horizon are more quality metrics and public reporting of hospice quality scores. While participating is technically voluntary, hospices who choose not to report specific quality data to CMS face a 2% reduction in reimbursement following each year they do not submit their data.

Our internal Health Information Management Committee will be able to initiate a totally paperless medical record by the end of 1st quarter 2017.

The Indiana State Department of Health Survey for CHC Hospice licensure and continued participation as a Medicare certified hospice is anticipated in the fall of 2017. Currently mock surveys are being developed and will begin occurring 2nd quarter 2017. We have heard recently due to the federal rules change making it mandatory that all hospices are surveyed at least every three years, (Indiana's previous target was once every eight years) that the state has had trouble keeping up and has hired a consulting company out of West Virginia that has been "approved" by CMS to perform the actual boots on the ground surveys for them. The states contract with CMS to perform the federal portion of the survey. The states can then contract out for the exercise.

HOSPICE FOUNDATION VP / COO UPDATE

Mike Wargo, VP/COO, for our separate 501(c)3 organization, Hospice Foundation (HF), presents this update for informational purposes to the CHC Board…

Fund Raising Comparative Summary

Through January 2017, the Development Department recorded the following calendar year cash gifts as compared with the same period during the previous seven years:

Year to Date Total Revenue (Cumulative)

	2010	2011	2012	2013	2014	2015	2016	2017
January	64,964.45	32,655.69	36,775.87	83,619.96	51,685.37	82,400.05	65,460.71	46,552.99
February	108,025.76	64,530.43	88,893.51	166,563.17	109,724.36	150,006.82	101,643.17	
March	231,949.73	165,468.92	194,345.35	264,625.29	176,641,04	257,463.89	178,212.01	
April	354,644.69	269,676.53	319,818.81	395,299.97	356,772.11	419,610.76	341,637.10	
May	389,785.41	332,141.44	416,792.85	446,125.49	427,057.81	635,004.26	579,888.08	
June	477,029.89	427,098.62	513,432.22	534,757.61	592,962.68	794,780.62	710,175.32	
July	532,913.52	487,325.01	579,801.36	604,696.88	679,253.96	956,351.88	1,072,579.84	
August	585,168.77	626,466.72	643,819.01	783,993.15	757,627.43	1,042,958.42	1,205,050.76	
September	671,103.04	724,782.28	736,557.59	864,352.82	935,826.45	1,267,659.12	1,297.009.78	
October	992,743.37	1,026,728.58	846,979.95	922,261.84	1,332,007.18	1,321,352.39	1,421,110.26	
November	1,043,750.46	1,091,575.65	895,164.28	969,395.17	1,376,246.01	1,469,386.01	1,494,702.09	
December	1,178,938.91	1,275,402.38	1,027,116.05	1,185,322.83	1,665,645.96	1,757,042.51	2,018,630.54	

Year to Date Monthly Revenue

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

	2010	2011	2012	2013	2014	2015	2016	2017
January	52,442.49	32,110.69	32,309.58	83,380.18	51,685.37	57,971.60	52,156.98	31,552.99
February	41,364.37	30,644.74	43,783.64	82,943.21	43,038.99	67,572.77	36,182.46	
March	65,886.51	99,796.42	102,351.84	98,212.12	66,916.68	107,457.07	73,667.84	
April	104,544.96	97,332.61	123,998.46	130,674.68	180,156.07	162,146.87	163,425.09	
May	33,768.72	51,753.98	90,909.04	40,825.52	100,285.70	160,178.34	93,318.98	
June	74,084.48	90,718.18	92,036.89	65,815.51	97,258.66	159,776.36	127,315.24	
July	55,278.63	53,536.39	62,069.43	69,939.27	38,243.88	93,586.27	52,394.52	
August	51,240.25	83,202.86	64,017.65	92,732.69	79,015.87	86,606.54	97,470.92	
September	85,629.27	94,000.56	92,808.58	80,335.67	84,011.71	99,931.45	92,459.02	
October	66,061.97	47,779.09	65,904.80	56,439.02	55,208.68	53,693.27	71,323.54	
November	49,247.09	48,284.08	46,674.33	47,133.33	44,238.83	46,870.62	66,490.16	
December	115,188.45	133,617.73	111,236.77	130,277.99	193,065.45	161,519.80	138,328.11	
Total	**794,737.19**	**862,777.33**	**928,101.01**	**978,709.19**	**1,033,125.99**	**1,257,310.96**	**1,064,532.86**	

Cornerstones for Living: The Crossroads Campaign

Campaign-related work in December 2016 and January 2017 included lead gift donor meetings, investigating grant opportunities and follow up with both existing and prospective donors. Through 31 months of this 5-year campaign (7/1/14 thru 1/31/17) total cash, pledges and documented bequests total $7,456,887.

In December, we received the remainder of the matching funds from the Asante Foundation, which represents completion of its payment of the $500,000 matching grant funds to underwrite the cost of the spiritual reflection room in the new hospice house.

Another goal reached in December involved hitting the $500,000 mark in pledges and payments dedicated to complete the matching grant awarded to us by the Judd Leighton Foundation. Based upon the required documentation submitted by us, the Leighton Foundation sent us the first $100,000 match payment in late December.

Planned Giving

Planned giving prospects that have been identified and contacted are provided information about various options to review and consider. These prospective planned gift donors are advised to consult legal counsel and financial advisors to determine the best course of action for their personal circumstances. Estate gifts received in December and January totaled $1,276.34.

Annual Giving

The 2016 Annual Appeal continues to be very successful so far. Through the end of January, it's raised $86,474. This compares to $77,339 during the same timeframe for the 2015 Annual Appeal. This year's average gift is significantly higher as well – $201 as compared to $161 for last year's appeal.

Special Events & Projects

With the beginning of the new year comes planning and preparation for the 2017 events cycle. In addition to our usual annual events, we will introduce the public phase of the Crossroads campaign with two Circle of Caring donor events. The first will take place at the Naples Sailing & Yacht Club in Naples, Florida on February 23rd. The second will be held on the Mishawaka Campus in conjunction with the Helping Hands Award Wall of Fame dedication on Thursday, March 16th. The festivities will begin at 5:30 with a cocktail reception, followed by the dedication of the wall, program and dinner.

Preparations for this year's Helping Hands Award Dinner, the next major event, are also underway. This year's dinner will be held on Wednesday, May 3rd at the Hilton Garden Inn. We'll be honoring first responders from our service area.

The memorial dedication at the Elkhart Campus "Gardens of Renewal and Remembrance" will be held on June 6th. Finally, the inaugural "Journeys in Healing" gallery showing/silent auction to support the After Images art counseling program will be Wednesday, June 14th.

Global Partners in Care

The transition of the organization from the National Hospice and Palliative Care Organization (NHPCO) to the Hospice Foundation began in January. A press release was sent by NHPCO on January 25th announcing that Global Partners in Care had a new home. This followed an announcement conference call to the organization's advisory council on January 23rd.

NHPCO also informed the African Palliative Care Association (APCA) of the transition. We will be working with APCA to define working relationships with national organizations in Africa as well as to establish protocols for vetting hospice organizations in Africa.

We are also speaking with some current and potential partners in the Midwest to either solidify relationships or initiate new ones. These include Susquehanna Hospice, Hospice of Kankakee Valley, Arbor Hospice and Hospice at Home.

PCAU

Preliminary work on the next phase of the mHealth initiative continues. This program represents the collaborative efforts of PCAU, CHC/HF, the Eck Institute for Global Health at Notre Dame, and Uganda Martyrs University to establish palliative care data collection and surveillance throughout the country. We are working with Lacey Ahern at Eck to finalize details for the next scale up, much of which will be funded by a $15,000 grant from the Asante Foundation.

Road to Hope Program/Documentary

Thanks to a growing relationship with the local organization "Feed the Hungry," we are now able to schedule shipments to Uganda either via staff traveling to the country or via shipping containers, which will make the transportation of refurbished laptop computers much more efficient than in the past. This also now allows us to send letters, photos and small items from Road to Hope sponsors to

their students more frequently. Denis has contacted sponsors to inform them of this; many of them are taking advantage of the first shipment.

The Road to Hope film continues to win awards on the film festival circuit. It received an Award of Excellence for Documentary Feature at the Impact DOCS Award, Best Documentary Feature of 2016 by the California Film Awards and Best Documentary Feature by the Festigious Los Angeles Film Competition.

Education

We are working with Dominic Vachon, PhD, Director of the Ruth Hillebrand Center for Compassionate Care in Medicine to offer the fourth edition of the Introduction to Hospice & Palliative Care course at Notre Dame on February 25th. The course is targeted at pre-professional undergraduate students.

Our first class with the Forever Learning Institute, which covers hospice and end-of-life planning, will begin March 6th.

We will host a screening of the PBS FRONTLINE documentary, *Being Mortal*, on March 23rd. This event is designed to bring together clinicians and community members to raise awareness of the importance of having conversations about end-of-life care and advance care planning. We are particularly interested in including clinicians who engage in these conversations.

A recruitment letter containing information about the IU School of Medicine Hospice and Palliative Care Fellowship was sent to residents who selected and participated in a rotation at CHC during the past two years. We will continue to look for opportunities to speak with residents and local physicians about the Fellowship.

Mishawaka Campus

Work continues with various new and planned construction projects on and around the Mishawaka Campus. DJ Construction is working with subcontractors to develop firm pricing for the new patient care staff building. Helman Sechrist has completed the floorplan and exterior design for the new hospice house.

Residential Housing

As part of our agreement with the City of Mishawaka, at the time we purchased city-owned property for the Mishawaka Campus, we've completed the design and now have cost estimates for construction of two new residential homes to be located at the corner of Comfort Place and Cedar Street. Lauren Dunbar, of Cressy & Everett, has completed a competitive market analysis to determine the appropriate price point. We will now begin networking within the real estate community to generate interest in these new homes in advance of beginning construction.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

Amy Tribbett, Director of Marketing and Access reports on December and January activities…

Referral, Professional, & Community Outreach:

In December and January, the liaisons completed 673 visits to doctor's offices, clinics, hospitals, group homes and extended care facilities.

CHC sponsored the LaGrange COA December lunch. We did an interactive version of Hospice 101. There were about 75 people in attendance.

We now have a blanket contract with Golden Living Fountainview in Mishawaka. Previously they were only accepting per-patient contracts. Golden Living owns AseraCare, one of our for-profit competitors.

The Administrator at Trailpoint Village (a for-profit American Senior Community facility) sent our contract to corporate. Currently they only contract with for-profit competitor Heart to Heart hospice. The Administrator would prefer to work with us and is pushing for the contract to be signed. We did recently admit a patient there under the per patient agreement.

New television creative was scripted and recorded at WSBT Studios for two new commercial spots for CHC. New spots should be completed by the end of February. They hit hard on the "choice" in hospice care providers. The spots were voiced by talent that had a very reasonable fee – FREE.

Barb King, Marketing Assistant, attended the "Building a Healthier Goshen" event in December at Goshen College.

Barb King and Amy attended the Hospice Veterans Partnership of Indiana meeting at the Roudebush VA Medical Center in Indianapolis. CHC will continue to be an active participant of this state-wide group.

CHC is hosting three "Conversation" events in conjunction with National Healthcare Decisions Day (week) in April. These events will take place April 18 – 20 in Mishawaka, Elkhart and Plymouth respectively.

Volunteer Department

On January 21, the Volunteer Coordinators hosted a Volunteer "Winter Warm-Up" Event and inservice at the Mishawaka Campus. Soup was served and volunteers enjoyed watching the film, Age of Champions.

Volunteer Training & Recruitment:

Volunteer Recruiter, Kristiana Donahue, interviewed nine new volunteer candidates and has 20 new inquiries. She has 14 RSVPs for February's New Volunteer Training. Many new volunteer applications are coming directly from the website, which means our digital and social marketing is driving website traffic.

Access

December Intake Stats
- 3286 phone calls
- Average 106 phone calls per day
- Average 35 calls per Referral Specialist per day
- Average 4 phone calls per hour

January Intake Stats
- 2,899 phone calls
- Average 93 phone calls per day
- Average 31 calls per Referral Specialist per day
- Average 4 phone calls per hour

Website

During the months of December and January, CHC's website traffic totaled 1,090 visits, with 2,136 total page views, and 677 total organic searches. In December and January, when customers saw our digital listing, the most common actions they took were:
- 148 of them visited our website
- 173 requested directions
- 53 called us

Social Media

Facebook (Center4Hospice):

Center for Hospice Care page has 3,283 fans. There were 7,146 engaged users for December & January and 197,938 page impressions. Center for Hospice Care's FB page has 3,200 fans.

Twitter (Center4Hospice)

Center for Hospice Care Twitter has 512 followers and a top reach of 1,565 and 218,000 Tweet Impressions.

NEW DIRECTOR OF MARKETING AND ACCESS STARTS THIS MONTH

As Amy Tribbett heads to new adventures in Alaska on March 1, I am pleased to announce that Craig Harrell will be the new Director of Marketing and Access. Craig comes to CHC from the Hospice of the Calumet Area which serves northwestern Indiana and parts of Illinois. He has been Director of Community Relations and Marketing there for nearly 17 years. During his tenure, he has implemented marketing strategies resulting in a 72% growth in patient census, created Community Education Campaigns highlighting the agency as the experts in end-of-life care resulting in a 68% increase of the public's top-of-mind identification in four years, and created campaigns that also identified the agency as the organization the public should contact for advice resulting in a 53% increase from pre-campaign levels. He holds a degree in Business Administration from Purdue University. I have known Craig for many years and am pleased he will

be joining our team. Amy has worked closely with him over the last eight years on various statewide hospice efforts -- particularly the Indiana We Honor Veterans chapter. He will be taking a week's vacation from his current employer the last week of February to shadow Amy during her last week at CHC. He will officially begin his position on February 20.

FEBRUARY 2017 BOARD MEETING TO BE SLIGHTLY LONGER

We are planning a special section of this board meeting to discuss the "going public" phase of the Hospice Foundation's capital campaign, *Cornerstones for Living: The Crossroads Campaign*. The board education section will begin as always at 8:20 AM, last 30 minutes, and then we will have ten minutes for Q&A. The meeting will end at 9 AM. Dan Reagan, Crossroads Campaign special consultant will be the guest presenter. Dan has been working with us on the Crossroads campaign since mid to late 2012. In April of 2012, Dan Reagan created the fundraising consulting firm of D.G. Reagan & Associates LLC. Reagan & Associates specializes in campaign development, fund raising department assessments and strategic planning for development programs. Prior to the formation of the firm, Reagan enjoyed a 28-year career in development at the University of Notre Dame. As Associate Vice President for University Relations at Notre Dame, Reagan directed the *Spirit of Notre Dame* campaign, at the time the largest fundraising effort in University history and in the history of Catholic higher education. With a goal of $1.5 billion, *Spirit* successfully concluded in June of 2011, raising $2.014 billion. Besides Hospice Foundation, some of his other current clients include Catholic Relief Services, Creighton University, Marquette University, and University of Virginia.

POLICIES ON THE AGENDA FOR APPROVAL

There are four policies on the Agenda for the board meeting. They are:

1. Concurrent Care for Children Requirement, a needed policy due to changes in Medicaid under the ACA.
2. Medicaid Hospice Plan of Care for Curative Care Members 20 Years and Younger which is related to #1.
3. Nursing Services – LPN Supervision, a needed policy which we have not had previously.
4. Medication Disposal, which is being changed to reflect current practices.

MILTON ADULT DAY UPDATE

As we have mentioned previously, the Veteran's Administration contract has been transferred to CHC. Indiana Medicaid would not transfer the Waiver contract and we had to apply from scratch. That has been completed and we were accepted – finally. After many back and forth communications, we have also finally received verification from HP that CENTER FOR ADULT DAY SERVICES, LLC / dba MILTON ADULT DAY SERVICES has been enrolled. HP is the fiscal agent for Medicaid in Indiana and now we will be paid directly by Medicaid. I also signed the sublease agreement for the rental of the building on February 8th. I believe we are all set and everything has been taken care of. For MADS, the August thru December net gain for CHC was $8,103 -- an 8,103% return on investment.

LaPORTE OFFICE PLANNING UPDATE

Dave Haley went to La Porte Community Hospital on January 29 and met with their CEO and Chief Medical Officer to deliver an Agreement which would allow for a General Inpatient level of care arrangement. They were very receptive and are sending the Agreement for approval to their parent organization, Community Health Systems (CHS), located in Franklin, Tennessee. They indicated the review process would take about three months. However, when the contract is approved, it will be good with any of their hospitals in the area. They have the hospital in Kosciusko County and a larger one in Valparaiso. They were very supportive to learn we were going to open a new branch office in La Porte. We have also had some meetings with community leaders in the LaPorte area. Mike Wargo and I went to LaPorte on February 9 to meet with LaPorte Mayor Blair Milo and looked at some potential rental office space. We are planning on setting up a "get to know us" meeting with the former LaPorte Hospital Foundation that is reinventing itself into a "healthy LaPorte" foundation with the proceeds of the sale of the hospital to CHS. The topic will become an ongoing agenda item at our Administrative Team meetings. We continue to hope to have this office up and running by mid-2017.

2016 BEREAVEMENT STATISTICS

The Bereavement Department had 1,774 deaths with an average of 148 deaths per month, up 0.01% from 2016. Group and individual counseling sessions, client assessments, community presentations, mailings, other contacts, totaled 29,071 in 2016, down 6% from 2015. We had three concurrent Holiday Memorial Services with 455 attending. The total Death Before Admission (DBA) clients was 204, 6.6% of the total in 2016, up from 189 and 5.6% of the total in 2015. The 2016 "Movie and Meal" events attracted 330 people, up from 207 people during 2015. The Bereavement Department saw 3,001 clients during 2016 in one of the many types of counseling programs offered. 11% of the clients were from families where the patient expired prior to admission, or, DBA. We are not required to serve these people but strongly believe it's the right thing to do. 19% of the clients in 2016 had no prior family experience with CHC at all and came to us due to family dying by overdose, suicide, accidents, etc. The "Loss from Addictions" support group has been our fastest growing group and we've added additional groups due to the heroin epidemic in our local area.

2016 VOLUNTEER SERVICES STATISTICS

CHC has approximately 500+ volunteers who provide services such as Patient Care, Community Relations, Bereavement Support, Fundraising, Office Work, Veterans Programming, and on the Board of Directors and Board Committees. Our efforts to engage and re-engage our volunteers proved very successful as evidenced by the overall Volunteer Hours in 2016 totaling 17,573.76, an increase of 6.4% from 2015. CHC Volunteers drove 52,633 miles, an increase of 16.9% from 2015. We are required by Medicare to calculate the annual savings volunteers provided to CHC each year. During 2016 that totaled $435,617, an increase of 9% from 2015.

2016 GOALS UDPATE

Included in your packet is a copy of the final status for the 96 individual goals for 2016. Final status is broken down into four categories: "Met" means that the goal was achieved; "In Process" means the goal was started, but not yet completed during calendar year 2016 and likely carried over to 2017; "Not Doing" means after evaluating the goal we decided that for whatever reason we were not going to do the project; and "Not Met" means that we simply didn't get to that goal at all or external factors made the goal no longer realistic. Results for 2016 are as follows:

Total Number of Published Goals = 96

Met = 63 (66%)
In Process = 26 (27%)
Not Met = 4 (4%)
Not Doing = 3 (4%)

For 2016, % of the 93 of the 96 individual goals (93%) were either completed or were in the process of being completed at the end of the year. I am particularly pleased that we could do this during a time of unexpected opportunities that presented themselves. There were no goals during 2016 that included "Go into the Adult Day Services Business" or "Assume an International Partnership Program." We are delighted to answer specific questions on any of the goals and their status at the end of the year.

Please note, each year, all annual goals are tied to the current Strategic Plan and their status is shared with the board annually. The current Strategic Plan was approved by the board at the February 2016 board meeting.

2017 GOALS

Included in your packet are the 2017 Goals for Center for Hospice Care and the Hospice Foundation. Like we have done each year for the past 17 years, we have placed individual goals under the traditional headings which match the Strategic Plan. The four overarching goals are: Enhance Patient Care; Position for Future Growth; Maintain Economic Strength; and Continue Building Brand Identification. Annual Goal development begins at the Coordinator level of management and they work their way up through Directors and eventually to the Administrative Team for final approval. We always commence with ideas and concepts from what line staff and middle management staff believes we should accomplish as a leading hospice organization that will allow us to improve and enhance our organization and the care we deliver.

CONFLICT OF INTEREST POLICY STATEMENT

You will be asked to sign a conflict of interest policy statement for 2017. This is the same statement used in previous years. It is signed each year by every member of the board of directors to meet the requirements of our annual audit and answer specific questions on the IRS Form 990, the nonprofit "tax" return. The document is included as an attachment to this report for you to

review prior to Wednesday's meeting. We will have hard copies available for you to sign at the board meeting.

2016 CHC BOARD OF DIRECTORS SELF-EVALUATION

Attached to this report is the summary of scores, responses / comments to the open-ended questions for the 2016 Board of Directors Self-Evaluation along with comparative analysis from prior year surveys. This was distributed at the December meeting. This exercise is performed every other year and distributed at the last board meeting of the year. It is designed for the benefit of the board to raise its own awareness of itself and how members perceive their engagement and effectiveness. Results are reviewed by the CHC Executive Committee who may from time to time make recommendations to the full board based upon the survey results. As mentioned in December, the intent of this tool is for the board to evaluate its own performance. The exercise is not meant to be an evaluation of the staff or management of CHC. Board self-evaluations are not required by the IRS or any other entity, but are widely considered a "Best Practice" for non-profit boards to complete from time to time.

NHPCO ANNOUNCES NEW PRESIDENT / CEO

The National Hospice and Palliative Care Organization (NHPCO) has announced that its board of directors has selected Edo Banach, JD, as the organization's next president and chief executive officer, effective February 22, 2017. Banach will succeed J. Donald Schumacher, PsyD, who has led the organization since 2002. Banach, currently, is a partner in the firm of Gallagher, Evelius & Jones in Baltimore, MD. He previously was the Deputy Director of the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services and Associate General Counsel at the Visiting Nurse Service of New York. Prior to that, Banach was the General Counsel at the Medicare Rights Center. Banach holds a B.A. from Binghamton University and a J.D. from the University of Pennsylvania Law School. Prior to attending law school Banach worked for the New York City Department of Homeless Services and the New York City Mayor's Office of Operations under Rudy Giuliani.

NATIONAL HOSPICE EXECUTIVE ROUNDTABLE (NHERT) MET IN JANUARY

The NHERT met in Miami, FL January 8-10. Due to retirements of existing members, a new member Pres/CEO from Arkansas Hospice joined the group. Topics included Managed Care Relationship / Contract Audit / Analysis: how might we analyze and assess our managed care contracts? How might we use a template to do this analysis and share with each other if our markets don't overlap? How might this work "inform" our efforts down the road with Medicare Advantage Plans? Presentations from The Advisory Board Company included Eric Cragun on "The Election and What It Means for Healthcare," and, Bryan Miller on "Oncology Care Model Update / Advance Care Planning Update." We also heard details about the "strategic alliance" between NHERT member Empath Health / Suncoast Hospice in Clearwater, and, Stratum Health / Tidewell Hospice in Sarasota – two of the largest, independent non-profit programs in the country – who are coming together to form Pontus Health who will care for more than 16,000 patients a year. The NHERT is a collection of 12 non-competing non-profit CEOs from leading hospice organizations

located in various parts of the country who meet in-person three to four times per year to learn and share best practices. The NHERT will be meeting here at the Mishawaka Campus June 13 and 14 of this year. This will be the first time we have taken our "turn" to host since October 2011.

OUT AND ABOUT

I attended the NHERT Meetings in Miami, FL January 8 – 9.

I attended the Hospice Action Network and NHPCO Combined Board Issues Sessions in New Orleans, LA on January 17 and 18.

I was a guest speaker on February 9th for the "Innovations in Healthcare Transformation" MBA class at the Mendoza School of Business at the University of Notre Dame. The professor is CHC Board member Jesse Hsieh, MD.

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

Dave Haley's Census Charts.

Final Report on Status of 2016 Goals as tied to the Strategic Plan

2017 Agency Goals as related to the overall Strategic Plan

CHC advertisement in Spanish in the newspaper El Puente

List of CHC Committee Opportunities

Conflict of Interest Policy

Clinical Patient Care Policy Updates

2016 CHC Board of Directors Self-Evaluation Results

NHPCO Press Release regarding HF assuming Global Partners in Care

NHPCO Q&A sheet for Global Partners in Care U.S. partners

CHC ad in Spanish in the El Puente Hispanic Newspaper from Goshen, IN.

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

December 2016 Pre- Audit Financials

Conflict of Interest Policy for Board Member Signature

NEXT REGULAR BOARD MEETING

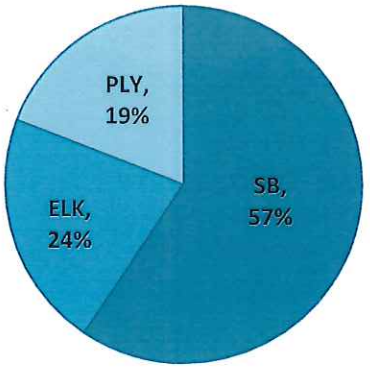
Our next regular Board Meeting will be **Wednesday, April 19, 2017 at 7:30 AM** in Conference Room A, first floor at the Mishawaka Campus, 501 Comfort Place, Mishawaka, IN 46545. In the meantime, if you have any questions, concerns, suggestions or comments, please contact me directly at 574-243-3117 or email mmurray@cfhcare.org.

# # #

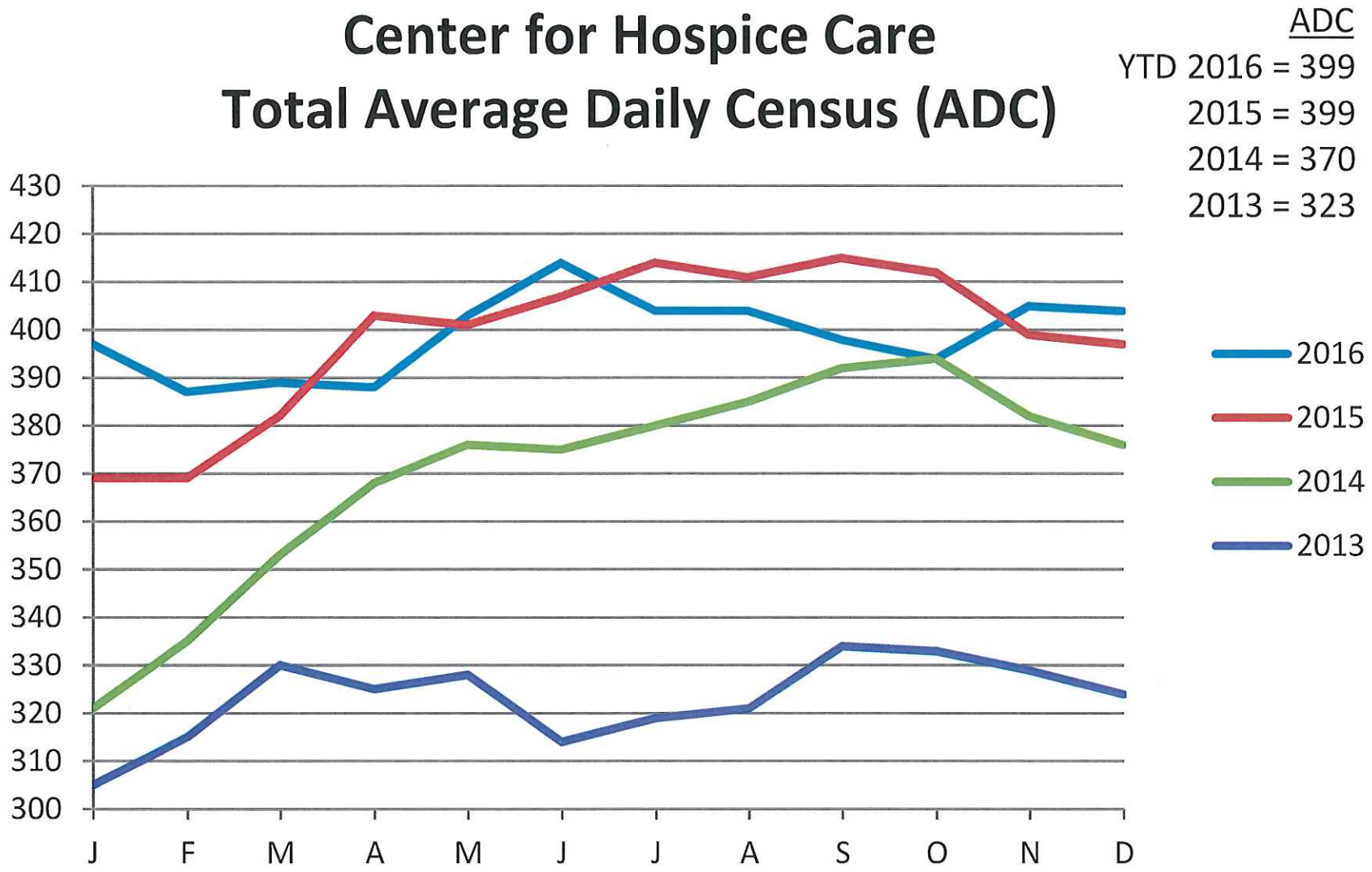
Center for Hospice Care
2016 YTD Average Daily Census (ADC)
(includes Hospice House and Home Health)

	All	South Bend	Elkhart	Plymouth
J	397	227	95	75
F	387	224	91	72
M	389	220	99	70
A	388	222	91	75
M	403	234	92	77
J	414	248	95	71
J	404	230	100	74
A	404	231	99	74
S	398	228	93	77
O	394	221	97	76
N	405	224	101	79
D	404	227	100	78
2016 YTD Totals	4787	2736	1153	898
2016 YTD ADC	**399**	**228**	**96**	**75**
2015 YTD ADC	399	229	92	77
YTD Change 2015 to 2016	0	-1	4	-2
YTD % Change 2015 to 2016	**0.0%**	**-0.4%**	**4.4%**	**-2.8%**

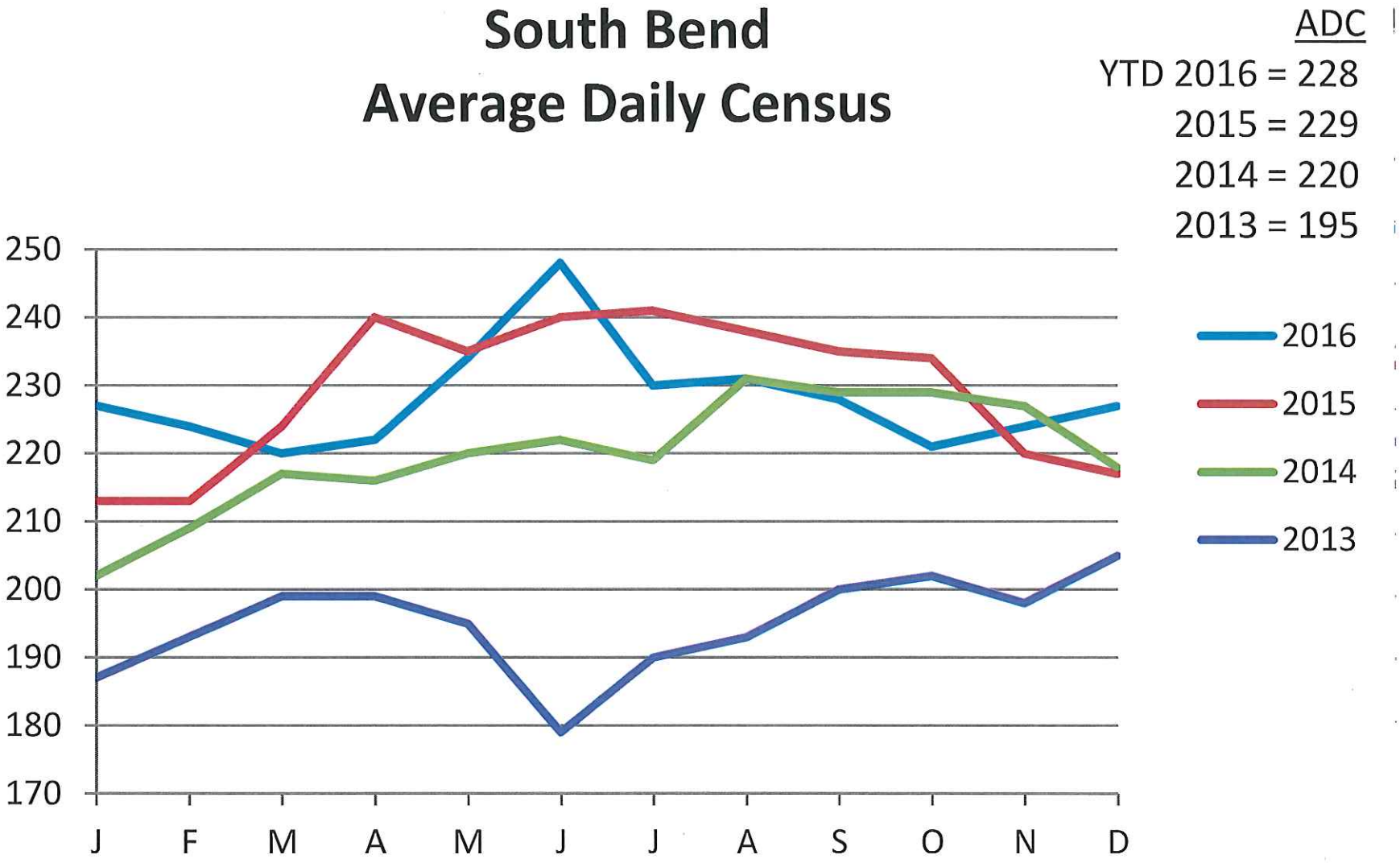
2016 YTD ADC by Branch



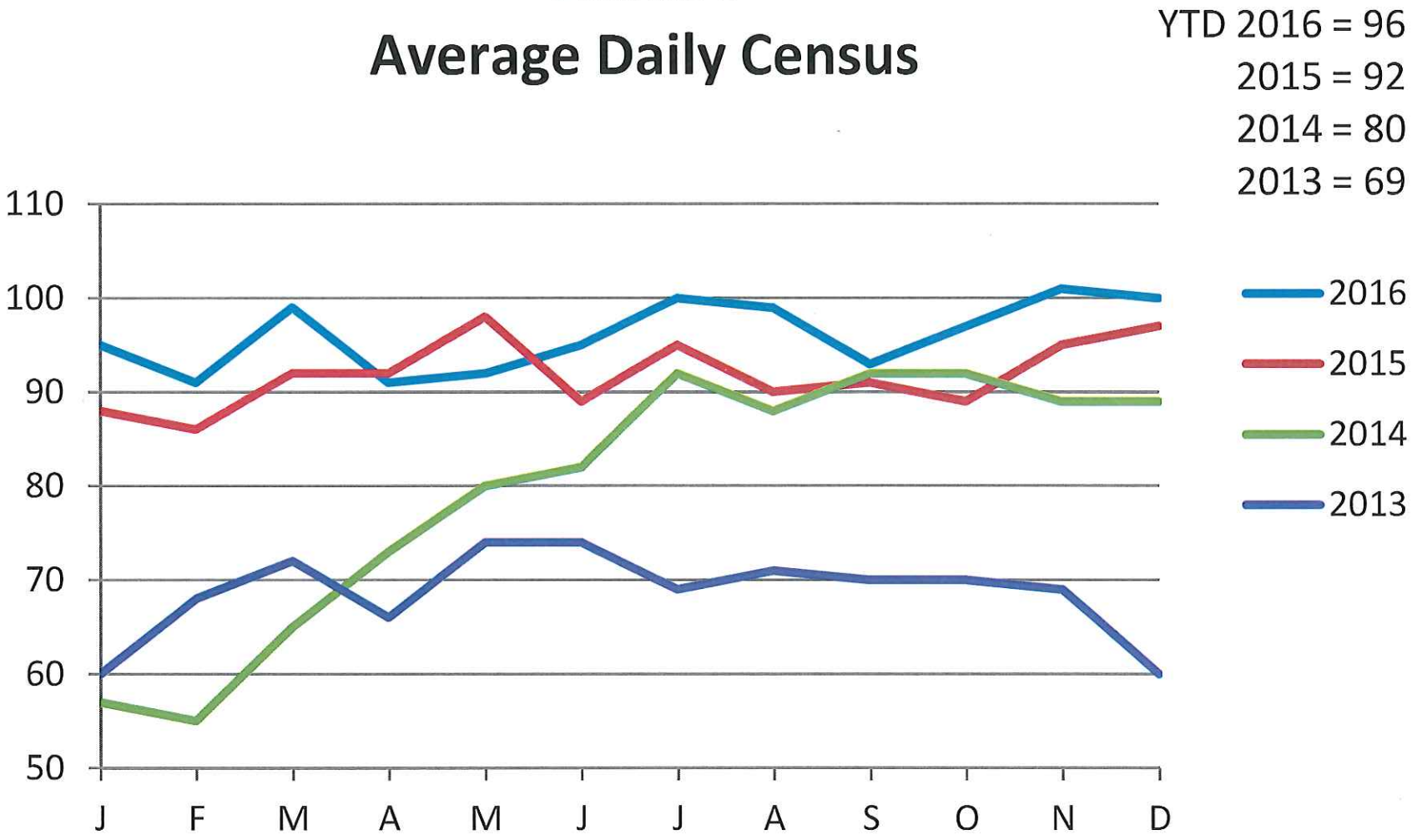
Center for Hospice Care
Total Average Daily Census (ADC)



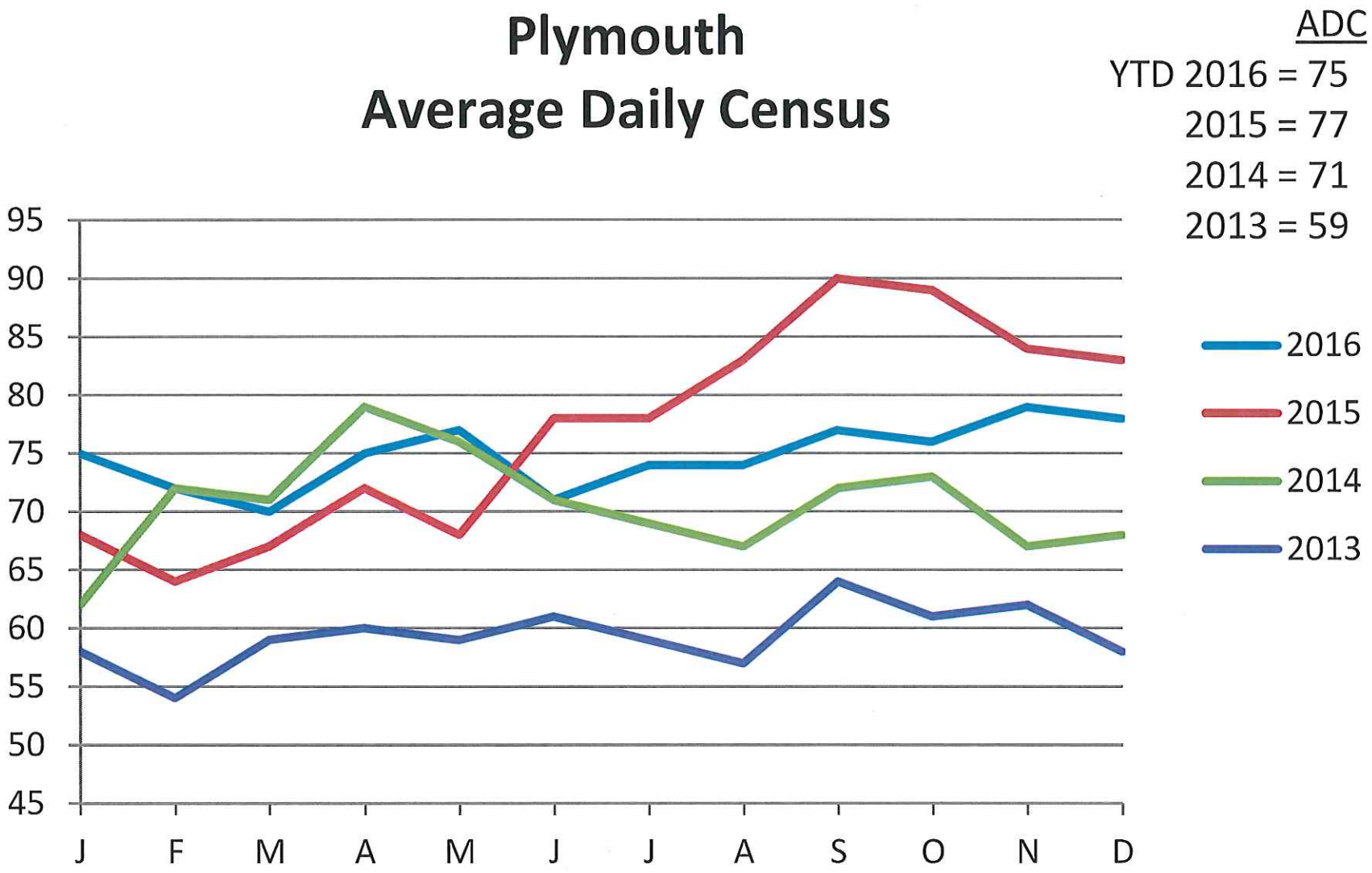
South Bend
Average Daily Census



Elkhart
Average Daily Census



Plymouth
Average Daily Census



Center for Hospice Care

Goals for Calendar Year 2016

Updated 02/07/17

Goal A: Enhance Patient Care

Category	Status	Goal
Administration	Met	1. Reboot Palliative Care programming with the Center for Palliative Care, promote availability of palliative care consults at the CPC, develop promotional materials for clinical indicators for referring a palliative care consultation and expand those into disease specific programs for Cardiac, COPD, Cancer, Dementia, and Neurological diseases with a strong emphasis on CHC's expertise in advance care planning, goals of care assistance, and education on end-of-life decision-making.
	In Process	2. Develop a specific pediatric palliative care program along with the marketing materials to support it with an emphasis on CHC clinical staff having been trained in the ELNEC Pediatric Palliative Care education modules.
	In Process	3. Begin the project for CHC to be the convener to design what end-of-life care looks like in our community.
	Not Met	4. Begin customization and implementation of the "Every Person. Every Time." Model of patient care.
	Not Met	5. Begin exploring and implementing new ways to engage front line staff into CHC.
	In Process	6. Begin designing a New Staff Orientation program.
Admissions	In Process	1. Increase same day referral/admissions to 33%.
	In Process	2. Begin process for tracking the percentage of Palliative Care Consults that convert to hospice admissions, as well as the location where the consultation took place, along with the number of days between consult and hospice admission.
	Met	3. Create a way to publish 2016 admission statistics for staff as they pertain to agency budgeted goals: daily, monthly, actual.
	Met	4. Make education a priority. Show webinars at every other admissions meeting (six in all) and hold staff accountable to review three other self-learning videos.
Volunteers	Met	1. Update volunteer section of the CHC website to include an electronic application packet, FAQ, and volunteer opportunities.
	In Process	2. Explore volunteer-to-volunteer program which utilizes current volunteers to mentor new volunteers at designated intervals.
	Met	3. Develop a ritual to remember volunteers that passed away.
	Met	4. Promote team building between staff and volunteers.
	In Process	5. Develop a skills validation process for level three volunteers.
	Met	6. Explore ways to make volunteer training more interactive.

Goals for Calendar Year 2016

Updated 02/07/17

Category	Status	Goal
	Not Doing	7. Create a Life Bio template.
	Met	8. Explore possible use of electronic volunteer time sheets.
	Met	9. Create an e-mail newsletter for current volunteers.
	Met	10. Create an e-mail volunteer recruiting newsletter.
Nursing	In Process	1. Integrate Elkhart and South Bend Hospice House for procedures, supplies, protocols, staff training and daily operations resulting in the same standard of nursing care and patient outcomes.
	Met	2. Establish scripting for triage and the admission departments to produce a fluent customer service standard across CHC (to be completed in collaboration with admissions and marketing).
	Met	3. Evaluate the educational needs of the RN's and LPN's across CHC. Establish an educational plan to meet the individual learning needs based on clinical competencies and didactic learning needs.
	Met	4. Establish a standard protocol for weekly IDT across CHC for all disciplines.
	Met	5. Review nursing staff competencies and offer cross training.
	In Process	6. Review supply consumption and usage of Medical Surgical supplies and establish par levels with McKesson for South Bend, Elkhart and Plymouth.
	In Process	7. Establish an Education Program and booklet for Admit GIP in the Hospital to outline responsibilities and role of the CHC Nurse in the continuum of care.
	Met	8. Establish a daily interdisciplinary report with Elkhart and South Bend Hospice Houses to identify family and patient needs with all disciplines by improving communication (in collaboration with Social Work and Spiritual Care).
Bereavement	Met	1. Improve the bereavement page of the CHC website by including grief education and links to bereavement resources.
	Met	2. Create a folder of information for Perinatal Referral Families in conjunction with the Admissions Department.
	Met	3. Improve the bereavement page of the CHC website once the new website is activated by including grief education and links to bereavement resources.
	Met	4. Continue to improve bereavement counseling support for Veterans by having all Bereavement Counselors complete Star Behavioral Health Providers Tier Two Veterans Training and for eligible counselors to continue with Tier 3 trainings.
	Met	5. Investigate and assess locations for Camp Evergreen within our eight county service area.
	Met	6. Explore possible outcome measures to utilize for children and teen counseling clients.
	Met	7. Partner with local hospital high risk pregnancy departments to provide staff education about the perinatal

Goals for Calendar Year 2016

Updated 02/07/17

Category	Status	Goal
		bereavement programming.
Social Work	Met	1. Assist with the development of the Center for Pediatric Palliative Care program and create a resource library for patients/families and staff.
	Met	2. Ensure each social worker views ten NHPCO webinars in the year.
	Met	3. Explore NASW CHP-SW credentialing and decide whether to pursue this option.
	Met	4. Develop a new format for the psychosocial assessment that aligns with the Medicare Conditions of Participation.
	In Process	5. Review and update the Respite Care policy as far as Social Worker's responsibilities and agency guidelines.
	Met	6. Review and update the Suicidal Intent Policy. Also, create a new assessment for suicide risk.
	Met	7. Update guidelines for each of the ways to discharge alive from the Hospice program.
Spiritual Care	Met	1. Organize 12 hospice educational presentations for local ministerial-type associations or faith communities.
	Met	2. Develop spiritual care information report (Spiritual Care needs/requests of patients and caregivers) which will be routinely placed on Daily Admission Report.
	Met	3. Investigate a process for using the Spiritual Comfort Measure in terms of measuring patient spiritual care outcomes.
	Met	4. Investigate additional MDiv internship affiliation opportunities.
Medical Directors	Met	1. Decrease the number of days delay in billing to less than the national average.
	Met	2. Assist in recruitment of one more NP and one more HPM physician.
	Met	3. Assist in recruitment of more physicians/NPs to offload face to face visits.
	Met	4. Open the Center for Palliative Care on the Mishawaka Campus.
	In Process	5. Begin prescribing controlled substances on iPads.
	Met	6. Apply alpha-numeric coding to the ICD-10 diagnoses to indicate which diagnoses are non-contributing to six month terminality, and why.

Goals for Calendar Year 2016

Updated 02/07/17

Goal B: Position for Future Growth

Category	Status	Goal
Administration	Met	1. Continue seeking The Advisory Board Company opportunities for CHC participation.
	Met	2. Update the 2012 Succession Planning Framework document.
Mishawaka Campus	Met	1. Complete design of Phase II new construction and revised Mishawaka Campus master plan.
	In Process	2. Design and construct new residential housing at northeast corner of Mishawaka Campus.
	Met	3. Continue to attempt to secure New Market Tax Credits.
Uganda	Met	1. Maximize exposure for Road to Hope documentary on international film festival circuit.
	Met	2. Develop strategies to use Road to Hope film as a tool to raise awareness of issues and challenges faced by child caregivers in Sub-Saharan Africa.
	Not Doing	3. Host at least one major fundraising event around the Road to Hope film.
	Met	4. Work with PCAU leadership and Ugandan Ministry of Health officials to implement an improved morphine supply chain strategy.
	Not Doing	5. In conjunction with the EMBA program at Notre Dame and PCAU leadership, update PCAU's strategic plan and succession strategy.
	In Process	6. Work with the University of Notre Dame's Initiative for Global Development to establish strategic global partnership opportunities to promote palliative care in Uganda.
	Met	7. Work with PCAU, Eck Institute for Global Health and Ugandan Martyr's University to expand testing and further development of new m-health platform.
	Met	8. Present at tri-annual APCA Conference.
	Met	9. Present "Road to Hope" session/workshop at NHPCO MLC along with Rose Kiwanuka and Torrey DeVitto.
	Met	10. Facilitate Rose Kiwanuka's 4th U.S. exchange visit to optimize exposure for work of PCAU
Education	In Process	1. Develop and launch Institute for Hospice/Advance Care Planning website.
	In Process	2. Develop comprehensive end-of-life planning curriculum, which can be delivered through local area professionals and faith communities.
	In Process	3. Work with local college(s) to develop programs to offer CEU awarding seminars for local area professionals about end-of-life issues relevant to their profession.
	Not Met	4. Develop initial online courses, e.g., how to choose a healthcare representative, how to effectively document

Category	Status	Goal
		advance directives, etc.
	Not Met	5. Develop online video education series about end-of-life planning matters using various local area professionals.
	Met	6. Review existing local college/university internship opportunities and initiate new domestic and international programs where possible.

Goal C: Maintain Economic Strength

Category	Status	Goal
Fund Raising and Stewardship	In Process	1. Develop and implement planned giving program and materials.
	In Process	2. Create Helping Hands Award Wall of Fame.
	Met	3. Secure Leighton Foundation match for palliative care initiative.
	Met	4. Secure Asante Foundation match for hospice house construction.
	Met	5. Complete design and fundraising efforts, and begin construction on Veteran's Memorial on the Mishawaka Campus.
	Met	6. Reach $6 million in total combined pledges and cash-in-hand for *Cornerstones for Living: The Crossroads Campaign* by 12/31/16.
	Met	7. Complete development of a Foundation graphic standards document.
	Met	8. Develop Foundation mailing policies document.
	In Process	9. Create and produce public phase campaign website and print materials.
	In Process	10. Finish creation and production of *Crossroads Campaign* video.
	Met	11. Hire new Director of Communications & Annual Giving.
	Met	12. Implement "Making Tracks: Fuel the Hospice Spirit" fundraising campaign.

Goals for Calendar Year 2016

Updated 02/07/17

Goal D: Continue Building Brand Identification

Category	Status	Goal
Marketing	Met	1. Roll out new CHC website.
	Met	2. Begin "score carding" by using explicit tools to create report cards between CHC and referral sources. Publish our pain and symptom scores. Promote CHC's QAPI data, FEHC scores, etc.
	In Process	3. Explore ways to promote our pediatric palliative care initiative.
	Met	4. Review and update existing referral source handouts, e.g., HeartWize, hospice triggers, etc.
	In Process	5. Post President's blog twice a month (24 blogs written and ready to post).
	In Process	6. Post Medical Director's blog twice a month (24 blogs written and ready to post).
	Met	7. Include "value propositions" in marketing materials to physicians and ECFs regarding both hospice and the rebooted palliative care program.
	Met	8. Begin utilizing Playmaker CRM to direct sales activities.
	In Process	9. With support of The Advisory Board Company materials and toolkits, increase ECF referrals by 5%.
	Met	10. Get the re-admission data from The Advisory Board Company's Post-Acute Care Mapping Tool by hospital for CHC and its competitors and use it with hospitals and discharge planners. Promote and use the data, for example, "If they use another hospice, patients are six times more likely to be readmitted to the hospital within 30 days."
	In Process	11. Establish an orientation program to introduce employees to CHC with continuity and emphasis on our Mission and Core Values (in collaboration with nursing and administration).

Center for Hospice Care

Goals for Calendar Year 2017

Updated 02/07/17

Goal A: Enhance Patient Care

Category	Status	Goal
Administration		1. Develop a specific pediatric palliative care program along with the marketing materials to support it with an emphasis on CHC clinical staff having been trained in the ELNEC Pediatric Palliative Care education modules. 2. Begin the project for CHC to be the convener to design what end-of-life care looks like in our community. 3. Begin customization and implementation of the "Every Person. Every Time." Model of patient care. 4. Begin exploring and implementing new ways to engage front line staff into CHC. 5. Begin the processes needed for opening an office in LaPorte County. 6. Begin designing a new staff orientation program. 7. Formally offer to bring an FTE in-house to coordinate the efforts of the Michiana Coalition on End-of-Life Wishes. 8. Adopt the PPS scale (or another approach to predictive analysis) to determine at admissions which patients have the greatest chances of expiring in seven days or less, and increase the immediate scheduling of the number of RN and social work visits to those patients. 9. Prepare for implementation and compliance of the new Emergency Preparedness CoP prior to 11/15/17. 10. Investigate and implement methods to reduce the use of "cut and paste" within the Cerner EMR across all clinical disciplines. 11. Quantify the number of incorrect, unnecessary, and inappropriate uses of "Revocation" during 2016 and reduce that number by at least 90% by the end of 2017 via staff education and accountability. 12. Reboot the new staff onboarding/orientation program to better promote an understanding of CHC—what it does and what it offers—to enhance staff engagement from the beginning. 13. Begin to quietly market the availability of private pay room and board residential care in Hospice House with a two week up front and refundable daily fee based upon the average area nursing home daily rate. 14. Increase ECF census by utilizing data from the HealthPivots tool.
Admissions		1. Increase same day referral/admissions to 33%. 2. Begin process for tracking the percentage of Palliative Care Consults that convert to hospice admissions, as well as the location where the consultation took place, along with the number of days between consult and hospice admission.

Goals for Calendar Year 2017

Updated 02/07/17

Category	Status	Goal
		3. Have 75% of admission nurses either have their CHPN or are working towards it. 4. Have 100% of admission nurses working on or completed ELNEC. 5. Increase PA to admission conversion rate to 85% for nurses. 6. Increase medication charting compliance to 95%. 7. Continue to find ways to improve the admission process and shorten the length of time it takes. 8. Have a completed, comprehensive Admission Nurse orientation program. 9. Have a completed, comprehensive Admission Representative orientation program. 10. Have a completed, comprehensive Referral Specialist orientation program. 11. Increase PA's to admission conversion rate to 85% for Admission Representatives. 12. Increase PA's to admission conversion rate to 85% for Admission Nurses.
Volunteers		1. Explore volunteer-to-volunteer program which utilizes current volunteers to mentor new volunteers at designated intervals. 2. Create a Volunteer Coordinator Procedure Manual. 3. Explore ideas for annual skills validation for volunteers. 4. Explore ways to utilize CHC staff to help train volunteers on patient care procedures. 5. Distribute updated Volunteer Training Manuals to all volunteers hired prior to 2016. 6. Investigate opportunities for online or phone-in volunteer time sheets. 7. Work with Hospice House staff to identify ways to increase volunteer and staff satisfaction. 8. Implement a New Patient Welcome Program where volunteers visit new patients within seven days with a small gift basket for patient and family. 9. Implement a Volunteer Care Call program where volunteers make calls to the caregiver(s) of new patients and other identified families who need additional support.
Nursing		1. Integrate Elkhart and South Bend Hospice Houses for procedures, supplies, protocols, staff training and daily operations resulting in the same standard of nursing care and patient outcomes. 2. Review supply consumption and usage of Medical Surgical supplies and establish par levels with McKesson for South Bend. 3. Establish an Education Program and booklet for GIPs to outline responsibilities and role of the CHC nurse in the

Goals for Calendar Year 2017

Updated 02/07/17

Category	Status	Goal
		continuum of care. 4. Establish a nursing, patient, and family medication education program to assure consistent information about medications. This will be accomplished in conjunction with Press Ganey patient satisfaction survey results, and will include consultation from DeliverCareRx and the medical staff. 5. Establish a CHC new employee orientation program including all departments. This is to be completed in conjunction with nursing, marketing, human resources, Foundation and administration. 6. Review nurse staffing practices related to schedules and on call to be consistent across CHC. This will be accomplished through changes in the present Human Resource policies and procedures. Ultimately increasing staff satisfaction.
Bereavement		1. Explore opportunities on the grief support page of the CHC website to update information periodically, as well as add documents written by CHC bereavement staff. 2. Continue to improve bereavement counseling support for Veterans by having bereavement counselors complete the Tier One, Tier Two, and Tier Three Star Behavioral Health Providers Trainings. 3. Investigate the potential process for including children and teen counseling clients in outcome measures. 4. Create a satisfaction survey and process for asking for feedback from individual and family counseling clients. 5. Explore doing a group family bereavement service directed at minor children and single parents or grandparents.
Social Work		1. Review and update the Respite Care policy as far as Social Worker's responsibilities and agency guidelines. 2. Ensure each social worker views NHPCO webinars or attends a Social Work NCHPP chat for a combined total of ten hospice education opportunities. 3. Explore possible risk stratification and assessment for patient problems related to caregiving. 4. Improve quality of care for Veterans by having all social workers who have been employed for at least one year (by 01/01/17) complete Star Behavioral Health Providers Tier One Veterans Training. This would include eight social workers including the social work coordinator.
Spiritual Care		1. Each SCC will organize and conduct at least two hospice educational presentations for local ministerial-type associations or faith communities. 2. Monitor the use and effectiveness of the new spiritual screening incorporated into the CHC Hospice Admission Outline, along with the new daily report for immediate spiritual needs. 3. Create new admission and routine visit forms for use in Cerner, with the help of IT, in order to reduce redundancy and to incorporate our Spiritual Comfort Measure, our Spiritual Health Assessment, and the FACT (an established spiritual history/assessment tool referring to Faith, Active, Coping, Treatment plan) into the

Category	Status	Goal
		documentation for each visit. 4. Investigate the possibility of a relationship between our spiritual care department and the Association for Clinical Pastoral Education.
Medical Directors		1. Begin prescribing controlled substances on iPads. 2. Enroll Dr. Cohen in the I.U. School of Medicine HPM Fellowship. 3. Complete original COTIs within seven calendar days. 4. Decrease the backlog of COTIs to less than three months.

Goal B: Position for Future Growth

Category	Status	Goal
Administration		1. Develop a dashboard for the CHC Board of Directors. 2. Review and revise Hospice Foundation Policies and Procedures Manual. 3. Secure a seat on the Michiana End-of-Life Wishes Coalition and chair the business development subcommittee.
Mishawaka Campus & Regional Expansion		1. Design and construct new residential housing at northeast corner of Mishawaka Campus. 2. Secure and build-out new LaPorte office.
Global Partners in Care		1. Successfully transition GPIC from NHPCO to Hospice Foundation. 2. Evaluate the viability of existing 75 international partnerships. 3. Work with APCA to establish framework for the identification and coordination of African GPIC partners. 4. Establish relationships with major international organizations engaged in hospice and palliative care initiatives, e.g., IAHPC, WHPCA, WHO, HCPA, IU/AMPATH, NASW, True Colors, various ND programs, etc. 5. Host the GPIC luncheon and create and staff an exhibitor booth at the NHPCO MLC.

Goals for Calendar Year 2017

Updated 02/07/17

Category	Status	Goal
Uganda		1. Work with the University of Notre Dame's Initiative for Global Development to establish strategic global partnership opportunities to promote palliative care in Uganda. 2. Work with Eck Institute for Global Health to ramp up third year of mHealth initiative. 3. Co-sponsor and facilitate two staff members to teach at the 6th Biennial PCAU conference. 4. Work with PCAU to explore possibility of establishing a PC diploma program at the Mulago School of Nursing.
Education		1. Develop and launch Institute for Hospice/Advance Care Planning website. 2. Develop comprehensive end-of-life planning curriculum, which can be delivered through local area professionals and faith communities. 3. Work with local college(s) to develop programs to offer CEU awarding seminars for local area professionals about end-of-life issues relevant to their profession. 4. Develop initial online courses, e.g., how to choose a healthcare representative, how to effectively document advance directives, etc. 5. Develop online video education series about end-of-life planning matters using various local area professionals. 6. Review existing local college/university internship opportunities and initiate new domestic and international programs where possible. 7. Establish Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine. 8. Offer the IU Talk program to local area physicians. 9. Establish educational program with Forever Learning Institute. 10. Establish Speaker's Bureau. 11. Explore the possibility of creating the "Life Lessons" television series or documentary film with WNIT as a means to raise awareness of the importance of making end-of-life wishes known to family and loved ones.

Goal C: Maintain Economic Strength

Category	Status	Goal
Fund Raising and Stewardship		1. Develop and implement planned giving program and materials. 2. Create Helping Hands Award Wall of Fame. 3. Create and produce public phase campaign website and print materials. 4. Finish creation and production of Crossroads Campaign video. 5. Initiate fundraising campaign to build the endowment at the Community Foundation of Elkhart County. 6. Initiate fundraising campaign to secure gap funding for costs of scaling up new LaPorte office.

Goal D: Continue Building Brand Identification

Category	Status	Goal
Marketing		1. Explore ways to promote our pediatric palliative care initiative. 2. Explore ways to promote our Center for Palliative Care. 3. Develop basic marketing tools for MADS. 4. Host National Healthcare Decision Day "Hello" events in Mishawaka, Elkhart and Plymouth. 5. Post monthly President's blog. 6. Post monthly Medical Director's blog. 7. With support of The Advisory Board Company materials and toolkits, increase ECF referrals by 5%. 8. Establish an orientation program to introduce employees to CHC with continuity and emphasis on our Mission and Core Values (in collaboration with nursing and administration). 9. Create new commercials for broadcast and digital advertising purposes.

Center for Hospice Care
Committees of the Board of Directors

The following committees of the CHC Board of Directors are currently available for board member participation. Contact the Chair of the Board if you are interested in joining one of these committees.

Bylaws Committee
The Bylaws Committee shall consist of the Executive Committee of the Corporation and other appointees by the Chair of the Board of Directors in such numbers as they deem necessary. It shall have the responsibility of reviewing the Corporation's Bylaws at least once every three years.

Nominating Committee
The Nominating Committee shall consist of the Executive Committee of the Corporation and other appointees by the Chair of the Board of Directors in such numbers as they deem necessary. It shall have the responsibility of nominating candidates for positions on the Board, as well as for officers of the Board of Directors. The committee generally meets two to three times a year.

Personnel Committee
The Personnel Committee shall consist of the Executive Committee and other appointees by the Chair of the Board of Directors, and be chaired by the Chair of the Board of Directors. This committee shall concern itself with the review and recommendations for approval of the Personnel Policies governing the staff of the Corporation. This committee meets at least biannually to review the Human Resources Manual and as needed. The committee will meet again in 2014.

Professional Advisory Group
This Committee shall advise the Corporation on professional clinical issues, participates 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. 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 health care services.
- At least one member of the group is neither an owner nor an employee of the Agency.

The chair shall be the Corporation's current Chief Medical Officer. Other members are appointed for one (1) year terms by the Chair of the Board of Directors and may be reappointed. The group meets annually in April.

Special Committees
Special committees may be appointed by the Chair of the Board of Directors as the need arises. Some of these committees include the Helping Hands Award Dinner Committee, the Bike Michiana for Hospice Committee, and the Walk for Hospice Committee.

Center for Hospice Care

Conflict of Interest Policy

Article 1

Purpose

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

Article II

Definitions

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

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

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

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

Article III

Procedures

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

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

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

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

Article IV
Records of Proceedings

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

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

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

Article VI

Annual Statements

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

Article VII

Periodic Reviews

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

Article VIII

Use of Outside Experts

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

_____ _____

Signature **Date**

_____

Print Name

2010

New

Center for Hospice Care

DRAFT

CONCURRENT CARE for CHILDREN REQUIREMENT

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

REGULATION: Affordable Care Act 2302 – Concurrent Care for Children

PURPOSE: To provide hospice services to children without forgoing any other service to which the child is entitled under Medicaid for treatment of a terminal condition.

POLICY: In compliance with the Affordable Care Act (ACA), the Indiana Health Coverage Programs (IHCP) covers hospice care for children 20 years of age and under, concurrently with all medically necessary curative treatment for the terminal illness. Members who need hospice care must be eligible for program services, have a prognosis of six months or less to live, and elect hospice services.

PROCEDURE:

1. When the member elects concurrent hospice and curative care benefits, the palliation and management of the terminal condition comes under the supervision of the hospice.

2. When a patient is on concurrent hospice and curative care services, a comprehensive plan of care coordinated with all providers will be developed.

3. The plan of care is prepared and agreed upon by the hospice interdisciplinary team (IDT) and the providers rendering the curative care. The plan of care must:
   (a) Provide an assessment of the member's needs.
   (b) Identify and delineate the hospice services and curative care services, including but not limited to:
      - The manner in which the services and assessments are coordinated.
      - The scope and frequency of the services.
      - The criteria for terminating curative care services.
   (c) Be reasonable and necessary for the palliation or management of the terminal illness and related conditions.
   (d) The plan of care must also be:
      - Reviewed and updated (as identified in the plan of care), including:
        (i) Verification that the member's needs are being met.
        (ii) Verification that Medicaid hospice benefits continue to be appropriate for the member.
      - Updated if the member's condition improves or deteriorates, or if the level of care changes.
      - Included, along with the advanced directive, in the hospice and curative care providers' medical charts.

Effective Date: 01/17	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

New

Center for Hospice Care

MEDICAID HOSPICE PLAN OF CARE FOR CURATIVE CARE MEMBERS 20 YEARS AND YOUNGER

DRAFT

REGULATION: Affordable Care Act 2302 – Concurrent Care for Children

PURPOSE: The Medicaid Hospice Plan of Care for Curative Care form (State Form 54896) is to be submitted to CHC and include information related to curative care services.

POLICY: The Plan of Care (POC) for each provider will allow CHC to work collaboratively to plan hours or visits of care to meet the patient's needs.

PROCEDURE:

Prior Authorization

- The Prior Authorization (PA) process remains unchanged.

Admission

- A blank POC will be sent to each agency involved in the care with a request to complete and return to CHC within five calendar days.
- A completed Medicaid Hospice Plan of Care for Curative Care Members 20 Years and Younger (MHCP) form, including the POC with proper signatures, will be submitted to the Billing Department within 24 hours of admission in order for Billing to submit within the five calendar days.
- Admission will notify the Patient Care Coordinator (PCC) of the patient's admission and the status of the POC.

Billing

- The Billing Department is responsible for submitting the MHCP to Indiana Health Coverage Programs (IHCP) in ten days.
- At each recert period Billing will submit the POC for all providers to IHCP.

Patient Care Coordinator

- The PCC will arrange for a care plan conference with all care providers within two weeks of admission to discuss the role of each provider and identify any changes in the POC.
- At each recert period, the PCC will request an updated MHCP be submitted.
- The PCC will submit the updated POC to Billing.
- At each recert period, the PCC will arrange a care plan conference for all providers.

Effective Date: 01/17	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

New

Center for Hospice Care

NURSING SERVICES – LPN SUPERVISION **DRAFT**

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

REGULATION: 42 CFR 418.64(b) – Core services

PURPOSE: To ensure that nursing care and services that are provided by a Licensed Practical Nurse (LPN) are under the supervision of a Registered Nurse (RN) in accordance with Hospice Conditions of Participation and Indiana Nurse Practice Act.

POLICY: All skilled nursing services provided by an LPN must be under the supervision and direction of an RN.

1. The LPN may provide direct patient care in accordance with the RN created plan of care and can include: observing and reporting changes in patient condition, teaching and training the patient and primary caregiver how to manage their treatment regime, and performing specific skilled nursing duties/tasks.

2. The LPN provides care in accordance with the patient plan of care and may update the plan of care as appropriate under the direction of an RN.

3. The role of a Supervising RN may include: RN Case Manager, Triage RN, and RNs fulfilling administrative leadership roles within the Agency.

4. Supervision of an LPN's practice may include, but is not limited to, the following: assignment of intermittent visits in accordance with the written plan of care by the Patient Care Coordinator or Case Manager, review of the LPN's assessments and provision of care by the Case Manager, dispatch to emergency visits and coordination of patient care by the Triage Nurse.

5. Documentation of supervision and care coordination with the RN can include, but is not limited to, the following: Concurrence with assessment notation by the Case Manager, Triage RN reviewing care plan adherence in the EMR, documented participation in IDT by both the LPN and RN, and any other documented collaborative communication by the RN and LPN.

6. LPN role responsibilities and expectations are in accordance with Agency's LPN job description.

7. Allowable LPN duties and tasks within the Agency are outlined in the attached "LPN Skilled Nursing Duties Grid."

Effective Date: 12/16	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

Signature: President/CEO

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

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

POLICY: Prescription medications no longer needed by the patient **may** be disposed of in accordance with state and federal drug disposal guidelines.

Medications are the property of the patient and are not the property of the Agency. Agency nurses may only educate the POA/responsible party on proper handling and disposal of medications. Agency staff shall not perform medication destruction and disposal. ~~No medication will be disposed of without the written consent of the patient or the patient's representative.~~

Education regarding proper ~~M~~medications disposal will be documented in the medical record by Agency staff, ~~utilizing the Agency Medication Disposal form,~~ in compliance with state and federal requirements. ~~All medication disposals will be done in the presence of the patient or patient's representative.~~

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

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

2. ~~No m~~Medications, scheduled, unscheduled or over the counter **will not** be removed from the home under any circumstance by the Agency staff. The patient's POA/responsible party take control of the disposal of medication.

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

4. Instruct the POA/responsible party on how to perform the following for proper medication disposal:~~The U.S. Food and Drug Administration (FDA) and the White~~

Signature: President/CEO

~~House Office of National Drug Control Policy issued the following guidelines in 2007 for the proper disposal of prescription medications:~~

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

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

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

~~d.~~c. Remove any patient identification labels, or completely mark through patient identification information on medication bottles/containers.

~~e.~~d. Educate on ~~Take advantage of~~ community drug take-back programs that allow the public to bring unused drugs to a central location for proper disposal. Call your city or county government or~~'s~~ household trash and recycling services ~~(see the blue pages in a phone book)~~ to determine when~~if a~~ take-back program are~~is~~ available. ~~in your community.~~ Many states including Indiana no longer recommend flushing medications.

~~5. As part of the aforementioned policy, the government recommends the following drugs be flushed down the toilet instead of thrown in the trash. The goal is to reduce the danger of unintentional use or overdose and illegal abuse.~~

- ~~Actig (fentanyl citrate)~~
- ~~Avinza Capsules (morphine sulfate)~~
- ~~Baraclude Tablets (entecavir)~~
- ~~Daytrana Transdermal Patch (methlyphenidate)~~
- ~~Duragesic Transdermal System (fentanyl)~~
- ~~Fentora (fentanyl buccal tablet)~~
- ~~Meperidine HCI Tablets~~
- ~~OxyContin Tablets (oxycodone)~~
- ~~Percocet (Oxycodone and Acetaminophen)~~
- ~~Reyataz Capsules (atazanavir sulfate)~~
- ~~Tequin Tablets (gatifloxacin)~~
- ~~Xyrem (Sodium Oxybate)~~

Signature: President/CEO

~~6.~~5. **HOSPICE HOUSE**: When any medications are disposed of in Hospice House, it will be disposed ~~of~~ with the witness of two staff members. The Medication/ Disposal form will be completed and made available to QA to scan into the EMR. ~~filed in the patient's chart.~~

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

8. **INFUSION CASSETTES:** Drain the cassette into an undesirable substance such as kitty litter or used coffee grounds. Remove the labels from the cassette or black out any identifying information with a Sharpie. Dispose of in a trash receptacle.

~~8.~~9. The Agency will comply with the Drug Enforcement Administration and adjust the policy as required to ensure total compliance with state and federal regulations. Failure to comply with this policy may result in disciplinary action.

~~9.~~10. Patients and families may locate an authorized collection receptacle by calling the DEA Office of Diversion Control's Registration Call Center at 1-800-882-9539 or Indiana state site https://secure.in.gov/idem/recycle/2343.htm.

Center for Hospice Care

BOARD OF DIRECTORS SELF-EVALUATION

2016 Survey Results

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

9 out of 13 people responded. Number of Responses for each rating is listed in the box along with Average Score.

#	Question	Very Good	Good	Average	Fair	Avg. Score 2016	Avg. Score 2014	Avg. Score 2012
1	Board has full and common understanding of the roles and responsibilities of a Board.	6	3			**4.7**	**4.3**	**4.7**
2	Board members understand the organization's mission and its products / programs.	7	2			**4.8**	**4.8**	**4.7**
3	Structural pattern is clear (Board, officers, committees, administrative team, staff).	6	3			**4.7**	**4.6**	**4.7**
4	Board has clear goals and actions resulting from relevant and realistic strategic planning.	4	3	2		**4.2**	**4.5**	**4.5**
5	Board attends to policy-related decisions, which effectively guide operational activities of staff.	6	3			**4.7**	**4.7**	**4.7**
6	Board receives regular reports on finances, budgets, products, program performance, and other important matters.	9				**5.0**	**5.0**	**4.9**
7	Board effectively represents the organization to the community.	6	3			**4.7**	**4.5**	**4.6**
8	Board meetings facilitate focus and progress on important organizational matters.	8			1	**4.7**	**4.6**	**4.7**
9	Board regularly monitors and evaluates progress toward strategic goals and products / program performance.	6	1	2		**4.4**	**4.5**	**4.7**

#	Question	Very Good	Good	Average	Fair	Avg. Score 2016	Avg. Score 2014	Avg. Score 2012
10	Each member of the Board feels involved and interested in the Board's work.	3	5	1		**4.2**	**4.3**	**4.2**
11	All necessary skills, stakeholders, and diversity are represented on the Board.	3	5	1		**4.2**	**4.3**	**4.6**

Ratings by percent of responses:

Rating	2016	2014	2012
Very Good	65%	66%	64%
Good	28%	29%	31%
Average	6%	5%	5%
Fair	1%	0	0

Participation Rate

2016	69%
2014	60%
2012	57%

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

1. Representing the organization in the community as an advocate for services and fundraising for activities/programs.
2. Knowing the positives and negatives of daily operations so we can handle inquiries and complaints. This will be especially challenging as some of the comments come from at home services, including social workers.
3. Long term planning for staff.
4. Too much "show and tell" that is not substantive/strategic.
5. Need to look/project further into the future. 5-8 years out.
6. Would like to see a better understanding of threats and risk issues.
7. A 5-10 year long-term strategic plan around emerging trends and end of life care.
8. Partnering with physicians, hospitals, and post-acute providers. Keep up good work here!
9. Continuing to improve strength of board through new board members.
10. Participation on committees.
11. Continued understanding of hospice care and delivering that message to our community.
12. Be a sounding board for Mark and his team and where appropriate, share our expertise and assist with networking and connections in the community.

13. Recruit new members for committees/board.
14. Identify future board leaders.
15. Encourage participation in CHC/HF events.
16. Understanding of organization's 5-10 year strategic plan.
17. Help with financial plan that may affect organization by next federal shifts in elected officials and their policies.
18. Help advance marketing plan to better differentiate CHC from other hospice organizations.
19. Wise use of funding. Not a criticism, just an observation from community about funding.
20. Continued high quality of care. We are at the top and want to stay there.
21. Even larger market share.
22. Marketing to hospitals and extended care facilities.
23. Sharing of the vast knowledge of hospice to other less fortunate communities.
24. Growth related to Palliative Care Services.
25. Continued focus on legislative effects on reimbursement and strategic plans.
26. Strategic assessment of growth needs outside of current service area.

How would you improve the Board's effectiveness?

1. This is tough as I honestly feel this is the best organization I've attempted to serve. Mark runs the organization VERY well. Everything appears to be so smooth and thought out. It's almost a wonderful complaint to have to feel like a rubber stamp. However, I have been confronted by complaints that are from volunteers as well as family members/caregivers. As a board member, I've referred them back to the organization and asked if there was something specific they desired. Usually the answer is no, because they don't know how to make the situation better or prevent in the future. So one thing we can look at is absolute perfection and 100% satisfaction on all ends. How? Well maybe that is the challenge. Are there measures we can help install to identify less than 100%? How can we implement without being accusatory? Where are the breakdowns? I think we need to strive for perfection, but in so many ways I think it's impossible to obtain. That's not exactly right, but the point is we need to seek perfection or else we will lose what we have worked for. We can't let up. We really need 100% satisfaction in all facets.

2. Make the board briefing information that is emailed out to board members before each meeting less than 12-15 pages. I am not sure such long materials get read.

3. Continued education on hospice care and continued invitations to participate on committees or at events.

4. I have nothing concrete to recommend at this time.

5. Only speaking for myself, I cannot not seem to get involved. I understand I was gone last winter, but I am home this winter except for short visits to my children.

6. Encourage active board involvement in committees and CHC community and Foundation activities.

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

1. Attendance.

2. I hope to see increased involvement by board members who are not members of the executive committee. The board is diverse as to gender, skills and experience. I'm proud of past efforts to recruit African-American and/or Hispanic members. I've learned that such candidates are in high demand in our community, and we are competing with other organizations. The search goes on.

3. It is such a well-run organization…hard to make recommendations.

4. I would probably be a better board member if the board meeting times could be modified. A 7:30 meeting with an hour drive is tough to manage. I enjoy serving on this board and will continue to work on improving my attendance.

Global Partners in Care Has a New Home

For Immediate Release:
January 26, 2017

National Hospice and Palliative Care Organization affiliate Global Partners in Care will become an affiliate of Hospice Foundation.

(Alexandria, Va) – The National Hospice and Palliative Care Organization is proud to announce that its affiliate, Global Partners in Care, a non-profit organization consisting of partnerships committed to supporting hospice and palliative care organizations in developing countries, will become an affiliate of the Hospice Foundation, headquartered in South Bend, Indiana. The Hospice Foundation is the supporting foundation for Center for Hospice Care. CHC is one of Global Partners in Care's most successful partner programs; they have worked with the Palliative Care Association of Uganda since 2008.

"This is a bittersweet transition because although we are sad to see Global Partners in Care leave the NHPCO family, we are thrilled to hand the baton to Hospice Foundation," says Executive Director John Mastrojohn III. "We know the program will be in good hands and that the mission to increase access to hospice and palliative care where the need is great and resources few, will live on."

Global Partners in Care was once known as the Foundation for Hospices in Sub-Saharan Africa. FHSSA was founded in 1999 to mobilize a response to the sub-Saharan HIV/AIDS pandemic and support Africa's hospice and palliative care programs' ability to provide compassionate care. In 2004, FHSSA became an affiliate of NHPCO. In 2014, NHPCO recognized the need to expand the mission beyond Africa and rebranded FHSSA to Global Partners in Care.

Today, the partnership network extends to several African countries, India, and Nepal. Since 2004, over $4.5 million has been sent to hospice and palliative care organizations. Through the course of Global Partners in Care's history, more than 80 U.S.-based hospices have partnered with similar care providers in 18 countries creating not only constructive partnerships but friendships between nations, communities and individuals.

"We are very excited to take on this new challenge," commented Hospice Foundation Chief Operating Officer Mike Wargo. "We've been actively engaged in supporting CHC's partnership with PCAU for nine years. During that time we've seen substantial evidence of the impact the Global Partners in Care model can have on organizations on both sides of the equation. When properly executed, these partnerships are a win-win for both the U.S. and international organization. Ultimately these partnerships improve the quality of living for patients and their families in underserved areas of the world."

Global Partners in Care provides partnership opportunities for U.S. hospice and palliative care organizations to make a commitment to support a hospice and palliative care organization in a developing country. Partners engage in capacity-building, strategic planning, education, fundraising, and technical assistance to expand and improve services for those in need.

To learn more about international partnership opportunities and other ways to support the organization, visit the Global Partners in Care website.

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About National Hospice and Palliative Care Organization

NHPCO is the oldest and largest nonprofit membership organization representing hospice and palliative care programs and professionals in the United States. The organization is committed to improving end-of-life care and expanding access to hospice care with the goal of profoundly enhancing quality of life for people dying in America and their loved ones.

Have questions about the transition? Please access our Q&A document now.

Contact:
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Mike Wargo
Hospice Foundation
Chief Operating Officer
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574-243-2059

Global Partners in Care has a new home with Hospice Foundation but we want to assure you that our mission and vision remain the same. The following information will help answer questions we have received about the transition.

- Is Hospice Foundation a non-profit organization?
  - Yes.
- Is Hospice Foundation a US organization? Have they been involved in international relationships previously?
  - Yes, to both questions. The Hospice Foundation a US organization involved in international partnerships.
- Will the financial commitment be the same? Will US partners continue to wire funds to their international partners through Global Partners in Care? Will the 10% retention percentage be the same?
  - Yes, to all three questions. There are no plans to make any changes to the current wiring or financial arrangements in the foreseeable future.
- Is the assumption that all of the partnerships continue to operate as they have in the past?
  - Yes, every partnership will continue to operate under the Global Partners in Care umbrella.
- Will the advisory council still continue its work? What will the staffing look like?
  - Hospice Foundation plans to work closely with the established advisory council, which has knowledge about the history of the program and experience in working with a variety of international partners. The Hospice Foundation's chief operating officer has been a member of the council since its inception.
  - As part of their duties, a total of six Hospice Foundation staff members will work on various aspects of Global Partners in Care. Additional staff will be available to assist on an as-needed basis.
- Will the nursing and social work scholarship programs continue?
  - Yes, we anticipate the application and award processes will remain the same.
- Will the Global Partnership Award remain the same?
  - The application process will remain the same. The 2017 award will be presented at the Global Partners in Care Luncheon at MLC (see details below).
- How will new American partners be recruited?
  - Global Partners in Care will have a presence at NHPCO's Management and Leadership Conferences (MLC). The next conference is May 1-3, 2017 and plans are already underway to organize 2017's annual Global Partners in Care Luncheon, to which all current and prospective partners will be invited.
  - Global Partners in Care will have an exhibitor booth at this year's MLC.
  - Prospects will be identified through the Hospice Foundation's work with various hospice programs across the country and through its affiliation with Center for Hospice Care.
  - Hospice Foundation has well-established collaborations with various well-respected institutions working to address hospice and palliative care issues in developing countries, including the University of Notre Dame, Indiana University School of Medicine, Eck Institute for Global Health and Holy Cross College, to name a few.
  - Potential partners will also be recruited through screenings of the Hospice Foundation's documentaries, "Okuyamba" and "Road to Hope."

Viviendo con la enfermedad de Crohn y colitis

Indiana News Service

Se le llama la "enfermedad invisible", pero las miles de personas que padecen de Crohn o colitis en Maryland manifiestan que se trata de todo lo contrario. Estas enfermedades se describen como enfermedades de inflamación del intestino que causan dolor, pérdida de peso, agotamiento y otros síntomas que no se curan.

Jordan Sorrells padece Crohn desde hace 20 años y asegura que no siempre es fácil educar a aquellos a su alrededor sobre la enfermedad, ya que da vergüenza referirse a algunos de los síntomas. "Definitivamente es una de esas enfermedades de las que la gente no quiere hablar", afirma y agrega: "No es buen tema de charla durante la cena. Yo he tenido que lidiar durante años con fatiga, pérdida de peso, que dependen de mi nivel de estrés y todo lo que pasa a mi alrededor".

Recientemente fue la Semana para la Concientización sobre Crohn y Colitis. Las causas que las provocan no están bien comprendidas, pero se sabe que la dieta y el estrés pueden agravar los síntomas, que incluyen diarrea persistente, sangrado rectal, cólicos abdominales, fiebre, pérdida de peso y sudores nocturnos.

Christina Humble, directora ejecutiva de Crohn's and Colitis Foundation of America, asegura que es probable que conozcamos a alguien con enfermedad intestinal inflamatoria y que ni siquiera lo sepamos. "Creo que hay que cuidar lo que uno dice, porque hay cosas que no les gusta escuchar, como '¿tienes un trastorno alimenticio?'. O mucha gente cree que no te ves enfermo, pero en realidad lo estás, ya que esto es interno, no externo", asevera.

Según Sorrells, si alguien cree tener los síntomas de IBD, es importante consultar a su médico, ya que los tratamientos le pueden ayudar a vivir con la enfermedad.

"La enfermedad de C
colitis tienen síntomas tan va
a menudo cambian de persona
Es tan individualizado que si
tener síntomas relacionados
pérdida de peso, diarrea, est
tener que ir corriendo al baño
el estómago, vaya con su méd

Cortesía de Jeffers

Récords Den

El récord dental,
documento oficial de la
y todas las comunicaci
la oficina dental. Las
determinan como se ma
tener acceso a la inforr
cuidado para el paciente
Si usted algún día
y correctos contienen su
dentista tratarlo en una
dentistas están haciend
mantener los records den
tienen gran calidad y s
alguna pregunta acerca