Center for Hospice Care
choices to make the most of life

Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
April 19, 2017
7:30 a.m.

BOARD BRIEFING BOOK

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Center for Hospice Care
choices to make the most of life

CHAPTER ONE

AGENDA

Center for Hospice Care

BOARD OF DIRECTORS MEETING
Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
April 19, 2017
7:30 a.m.

A G E N D A

1. Approval of February 15, 2017 Minutes *(action)* – Wendell Walsh (2 minutes)

2. President's Report *(information)* - Mark Murray (12 minutes)

3. Finance Committee *(action)* – Lori Turner (14 minutes)
   a. 1st Quarter 2017 Financial Statements
   b. 2016 Audited Financial Statements
   c. The Mystery of the Beneficial Interest in the Hospice Foundation Explained

4. Professional Advisory Group meeting and QI Committee meetings *(action)* – Carol Walker (5 minutes)

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

6. Foundation Update *(information)* – Amy Kuhar Mauro (12 minutes)

7. Board Education *(information)* – "Why Would Anyone Want to Donate to Center for Hospice Care?" – Mark Murray, Mike Wargo (8 Minutes)

8. Chairman's Report *(information)* – Wendell Walsh (2 minutes)

Next meeting June 28, 2017 at 7:30 a.m.

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Center for Hospice Care
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CHAPTER TWO

MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
February 15, 2017

Members Present:	Amy Kuhar Mauro, Anna Milligan, Carol Walker, Jennifer Ewing, Jesse Hsieh, Lori Turner, Suzie Weirick, Tim Portolese, Wendell Walsh
Absent:	Ann Firth, Francis Ellert, Mary Newbold
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 12/21/16 meeting as presented. The motion was accepted unanimously.	T. Portolese motioned J. Hsieh seconded
3. President's Report	• LaPorte Office – Dave Haley met with the interim CEO of LaPorte Hospital. We asked for a GIP contract and it will be sent through the Community Health System corporate office. It might take three months to be approved, but then it would include their hospitals in Starke and Porter Counties as well. Mark M. and Mike W. met last week with the Mayor of LaPorte. She offered to help us and gave us some contacts in the city. They also looked at some rental properties. Our goal is to open an office by July 1st. We have been serving patients in LaPorte County since 1997. • The 2016 and 2017 CHC goals are in the board packet. They are tied to the Strategic Plan which was approved by the board a year ago this month. This is a three-year Strategic Plan and we will attempt to update the Board on it more frequently throughout the year. • ADC in January was 390. Our breakeven is 383. • We have recorded new TV spots which are in production. • Another palliative care center has opened in Osceola by our former hospice medical director, Dr. Amber Burger. • This is Amy Tribbett's, Director of Marketing and Access, last Board meeting. She is moving to Alaska. Her last date with us is 03/01. Her replacement, Craig Harrell starts on 02/20. He held the same position with Hospice of the Calumet Area in which serves northwest IN and parts of IL for the last 16 years, so we anticipate a smooth transition. • Milton Adult Day Services – We have finally met everything so we can submit claims to the VA and Medicaid.	

Topic	Discussion	Action
	• Medicare Market Share – We are still the largest hospice provider in our service area, but we are losing market share as more competitors come into our markets. In 2011 the top seven hospice providers accounted for 83% of our eight county market share. In 2015 they accounted for 70%. In St. Joseph County in 2011 five providers accounted for 94% of Medicare Hospice patients, and in 2015 eight providers accounted for 95% of the market share. In 2015 three for-profit hospices combined comprised 12.10% of the St. Joseph County market share. In 2011 those three didn't exist. There are now 32 hospices that serve our eight county service area. • We now have a new tool, Health*Pivots* that will provide data on any health care provider in our area. We will be able to find every hospice discharge by hospital and to which hospice provider. 28.3% of Memorial's hospice discharges went to five different out of state for-profit hospices and another 8% to "other" hospices. 27.2% of SJRMC's hospice referrals went to five different out of state for-profit and 10.4% to "other" hospices. 29.9% of EGH's hospice discharges went to five different out of state for-profit and 11.6% to "other" hospices. All of the hospital health systems have approached us about a Preferred Provider contract, but nothing has occurred yet. Even though the hospital management may say we work with CHC, it is not getting down to the case managers who choose whoever they have a relationship with. We will be sharing this information with our community liaisons to share with the hospitals. • Some of the board members said they would like talking points to use when asked why they should donated to CHC, where does the money go, why do they need my money if they are receiving payments from Medicare and insurance companies. Not everybody for a variety of reasons has health insurance. Our reimbursement has been cut going back to 2009. We provide many extra services for which there is no reimbursement. That is one thing we are addressing in the capital campaign. The Hospice Medicare Benefit requires that we use volunteers and provide survivors with 13 months of bereavement but they don't pay anything for it. We are also giving away more money in charity care than we receive in fundraising. At a future board meeting we will make this the board education piece and provide talking points for board members. • Year in Review 2016 – This was the third year in a row that we served over 2,100 patients. The ADC was 399 in 2016 and 2015. Cancer is now 34% of the diagnoses we serve, cardiovascular 28%, dementia 13%, and COPD/Respiratory 12%. That is	

Topic	Discussion	Action
	why we have our specialty programs of BreatheEasy and HeartWize. ALOS was 68 days, median 14 days, and the mode 2 days. Medicare Hospice LOS was 72.94 days, which is down 12% from a year ago. There were 180 DBAs or 7.42% of all referrals. ECF referrals have been going down. In 2016 9% of referrals were from ECFs compared to 11% in 2015. This is where the for-profit hospices are growing, because those patients have a longer length of stay. The Hospice Houses combined served 661 patients, an 11% increase. Occupancy was 68% and ALOS 5.3 days. GIP days in the hospital were up 9%. We served 127 patients and 50% of them died in the hospital. This was a reimbursement loss for CHC of $124,567. Bereavement had 1,774 deaths. We now offer bereavement services to DBA families. In 2016 that was 204 clients compared to 189 in 2015. • We have about 500 volunteers. Medicare hospice regulations require volunteer participation in direct patient care and hospice programming. There is no reimbursement for volunteers. We have three volunteer coordinators and a volunteer recruitment and training coordinator. There is also no reimbursement for bereavement. This is another reason why we raise money. We have to record the dollar amount and savings on an annual basis of the volunteer hours on the state survey. In 2016 volunteers worked 17,574 hours, a 6.4% increase from 2015. This is the equivalent of 8.4 FTEs. They drove 52,633 miles, an increase of 16.9% from a year ago. Volunteers provided $435,617 in savings to CHC in 2016, an increase of 9%.	
4. Finance Committee	• The finance committee met last week and approved the pre-audited December 2016 financial statements. Per diem days are the basis of what our reimbursement is based upon. The number of per diem days was up slightly from a year ago and down slightly on the budget. YTD operating revenue was $21.6MM, total revenue $23.7MM, total expenses $19MM, net gain $4.7MM, net without beneficial interest in Foundation $2.8MM. The combined net without investments of CHC and the Foundation was $3.5MM. The $4.7MM net gain was a record. • The YTD CHC net gain is up 37.6% from December 2015, the net without beneficial interest in the Foundation is down 22%, and net without investments was up 2.8% from December 2015. Our group health insurance is partially self-funded and was budgeted at $1.6MM and we came in at $1.3MM. It also helped that we made significant progress on our backlog of Accounts Receivable for the past three to four years. A/R is now the lowest since 2014. On the balance sheet we carry an allowance	

Topic	Discussion	Action
	for doubtful accounts, and because of the improvement in the A/R backlog we were able to adjust that down about $200,000. We have no significant liabilities other than the normal accrued payroll and vendor liabilities. • Milton Adult Day Services – We posted a net gain for 2016 of $8,100. • Part of the $4.7MM net gain is from the success of the capital campaign. Hospice Foundation expenses include fundraising expenses, Foundation staff salary and wages, and buildings depreciation. The Hospice Foundation also funds a portion of the Life Transition Center, Camp Evergreen, the art counseling program, discounted patient care, and construction of new facilities. As a not-for-profit we are required to break out expenses between the two entities. Program services are 83%, management & general 15%, fundraising expenses 2%. The benchmark for program services is about 65%. $1.1MM of the $1.8MM Hospice Foundation net gain was investment activity. We gave away $2.2MM in unreimbursed services in 2016, which is one of the reasons why we do fundraising. We should also promote why people should use CHC compared to our competitors. Give the board some selling points to share with others. For example, CHC and the Hospice Foundation also underwrites and sponsors various community events, which most of our competition does not. • A motion was made to accept the pre-audited December 2016 financial statements as presented. The motion was accepted unanimously.	J. Hsieh motioned S. Weirick seconded
5. Policies	• "Concurrent Care for Children Requirement" and "Medicaid Hospice Plan of Care for Curative Care Members 20 Years and Younger" – Hospice patients 20 years and younger usually have other services involved in their care such as home health or DME. Once hospice becomes involves we oversee all of that care. As a result, all of the agencies need to supply information to Medicaid to get reimbursed. We did not have policy before so this will help us not miss any communication with other agencies. We are also required to have a care plan or IDT meeting with other agencies to coordinate the care. • "Nursing Services – LPN Supervision" – The difference between an LPN and an RN is schooling. An RN has to have an associate, bachelor, or master's degree. An RN has to direct the care of the LPN. They can go to a home on their own, but they are working under the direction of an RN. We only have four LPN employees. We increased the role of LPNs from a clinical standpoint. They do not set up a CADD pump or adjust the meds. They just monitor the pump. We will be doing skills validation in April with all of the LPNs on all of the competencies including	

Topic	Discussion	Action
	documentation and assessment skills. The "LPN Skilled Nursing Duties Grid" lists what competencies the LPN can and cannot do. • "Medication Disposal" – The Conditions of Participation have changed so we are no longer required to record and destroy the meds in the home at the time of death. However, as a service to our patients and families we will still give them a medication disposal instruction card along with a baggie of kitty litter and tell them how to destroy the meds. Families used to have to sign a medication disposal form of what was destroyed, but that is no longer required. • A motion was made to accept the new and revised policies as presented. The motion was accepted unanimously.	A. Mauro motioned C. Walker seconded
6. Foundation Update	• The last seven years in a row we have seen an increase in fundraising to a total of $10MM. 2016 exceeded 2015. The capital campaign has raised over $7.5MM so far of its $10MM goal over five years. We are seeing more money coming in the area of endowments. This year we will be focusing on capital fundraising for the Mishawaka Campus. The breakdown is capital $2.1MM, endowment $1.2MM, annual giving $2.2MM, undesignated $40,000, and other undesignated $2MM for a total of $7.4MM.	
7. Chairman's Report	• Reminder to sign the Conflict of Interest form and return it to Becky K. This is annual requirement of our 990 report.	
8. Board Education	• Dan Reagan of D.G. Reagan & Associates, LLC gave an update on the "Cornerstones for Living: The Crossroads Campaign." The quiet phase of the five year campaign began in July 2014, and we are now getting ready to launch the public phase. The next issue of *Crossroads* will focus on the campaign. Once the campaign is more public, board members may be put in a position to answer those questions about why does CHC need $10MM. The campaign objectives are to raise $5MM in capital, $2MM for endowments, and $3MM annual giving.	
Adjournment	• The meeting adjourned at 9:00 a.m.	Next meeting 04/19

Prepared by Becky Kizer for approval by the Board of Directors on April 19, 2017.

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Carol Walker, Secretary Becky Kizer, Recording Secretary

Center for Hospice Care
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CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
Hospice Foundation
Milton Adult Day Services
Global Partners in Care

President / CEO Report
April 19, 2017

(Report posted to Secure Board Website April 13, 2017)

This meeting takes place in Conference Rooms A at the Mishawaka Campus at 7:30 AM.
This report includes event information from February 16 – April 19, 2017.
The Hospice Foundation Board meeting follows in the same room.

CENSUS

At the end of March 2017, year-to-date (YTD) referrals are running 2.3% higher than same time last year. The conversion rate – turning a referral into an admission – is 69% compared to 65% in 2016. Patients served at the end of March is up 4% and the original admissions are up 7% from same time 2016. Even with this wonderful progress comparison, the average daily census (ADC) is down 0.62% due primarily to very late referrals and ever increasing short lengths of stay. YTD March 2017 has 42% of all admissions dying in seven days or less, compared to 38% YTD March 2016. Compared to last year the South Bend Hospice House number of patients served is up 14% YTD through March. The Elkhart Hospice House number of patients served is up 4% YTD through March. However, the Elkhart occupancy is down 21% from same period last year due to the 24% decrease in average length of stay (ALOS). Yet the South Bend Hospice House ALOS is up 2%. The YTD ALOS difference between the South Bend and Elkhart Hospice Houses is a full day.

March 2017	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	519	836	806	30
Original Admissions	158	450	422	28
ADC Hospice	358.19	360.36	370.69	(10.33)
ADC Home Health	29.00	28.09	20.19	7.90
ADC CHC Total	387.19	388.45	390.88	(2.43)

February 2017	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	512	678	666	12
Original Admissions	143	291	282	9
ADC Hospice	361.86	361.49	372.22	(10.73)
ADC Home Health	26.57	27.61	19.72	7.89
ADC CHC Total	386.43	389.10	391.94	(2.84)

Monthly Average Daily Census by Office and Hospice Houses

	2017 Jan	**2017** Feb	**2017** Mar	**2017** Apr	**2017** May	**2017** June	**2017** July	**2017** Aug	**2016** Sept	**2016** Oct	**2016** Nov	**2016** Dec
S.B.:	224	227	223						222	217	219	220
Ply:	69	67	67						77	76	79	78
Elk:	87	86	87						90	94	99	96
SBH:	5	6	6						6	4	5	6
EKH:	4	3	4						3	3	2	4
Total:	390	388	387						398	394	405	404

HOSPICE HOUSES

March 2017	Current Month	Year to Date	Prior Year to Date	YTD Change
SB House Pts Served	42	99	87	12
SB House ALOS	4.45	5.14	5.06	0.08
SB House Occupancy	86.18%	80.79%	69.07%	11.72%
Elk House Pts Served	33	81	78	3
Elk House ALOS	3.91	4.20	5.56	(1.36)
Elk House Occupancy	59.45%	53.97%	68.13%	-14.16%

February 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 519 patients served in March, 159 resided in facilities. Of the 512 patients served in February, 144 resided in facilities. The average daily census of patients in skilled nursing homes, assisted living facilities, and group homes during March was 129; February was 127 and March YTD was 128.

FINANCES

Karl Holderman, CFO, reports the March 2017 Financials will be posted to the Board website on Friday morning, April 14th following Finance Committee approval. For information purposes, the unapproved February 2017 financials are presented below. 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.

February 2017 Financial Information

Center for Hospice Care *(1)*

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

February Overall Revenue	$	2,000,634	Year to Date Overall Revenue	$	4,016,631
February Total Expense	$	1,521,510	Year to Date Total Expense	$	3,097,321
February Net Gain	$	479,124	Year to Date Net Gain	$	919,310

Hospice Foundation

Feb Development Income	$	148,562	Year to Date Development Income	$	180,115
February Invest Gains (Loss)	$	400,122	Year to Date Investment Gains (Loss)	$	761,109
February Overall revenue	$	548,399	Year to Date Overall Revenue	$	934,734
Total February Expenses	$	221,388	Total Year to Date Expenses	$	445,110
November Overall Net	$	327,011	Year to Date Overall Net	$	498,624

Combined *(2)*

February Overall Revenue	$	2,222,022	Year to Date Overall Revenue	$	4,461,741
February Overall Net Gain	$	479,124	Year to Date Overall Net Gain	$	919,310

(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 February 2017, the combined YTD operating income was $3,434,660 down 0.4% from YTD February 2016. The YTD February overall combined net gain for CHC / HF was $919,310, up 407% from February 2016. At 2/28/17, CHC's YTD Net without the beneficial interest in the HF was $420,686 representing a 21% decrease from same time last year. The combined YTD net at 2/28/17 without counting investment gains/losses was $158,201 representing a decrease of 63% from YTD same time prior year. At the end of February 2017, the Hospice Foundation's Intermediate Investments totaled $4,468,365. Long Term Investments totaled

$18,214,544. CHC's assets on November 30, 2016, *including* its beneficial interest in the Hospice Foundation, totaled over $45.5MM. At the end of February 2017 HF's assets alone totaled $39.5MM 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 February 28, 2016 of just over $51.5MM.

CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

Gayle Waldenmaier, ACNP-BC, ACHPN, a nurse practitioner, started with us on April 10. She comes to us from Bronson Methodist Hospital in Kalamazoo, MI where she was employed as a Palliative Care Nurse Practitioner.

Amy Johnson, DO, a physician Fellow from the Indiana University School of Medicine Hospice and Palliative Medicine program, will be visiting CHC on April 13 and 14. She will observe rounds in both of our Hospice Houses and visit our Art Counseling and Bereavement programs.

Max Allen, DO, has obtained his Indiana licensure and has started conducting face-to-face visits on a fee for service arrangement with CHC.

George Drake, MD, of Edwardsburg, MI, will begin work two days a week as a Medical Director starting April 24. He is Board Certified in both Family Medicine and in Hospice and Palliative Medicine.

Shelly Harkins, M.D., MPH, formerly the Chief Medical Officer of Beacon Health Services, who joined CHC 30 hours per week last year, has accepted a position in Helena, MT. Her last day at CHC is scheduled for June 21.

Rodrigo Servelli, MDiv, will begin as a Spiritual Care Counselor on May 15. He comes to us from Bronson Methodist Hospital in Kalamazoo, MI. He is originally from Brazil and speaks Spanish and Portuguese.

We have transitioned to InHealth Ambulance as a preferred provider. Prompt Ambulance service, our previous preferred provider, has ceased operating in this area.

We continue to make excellent progress in reducing the number of delinquent billings and reducing our Account Receivables. At March 31, unbilled HMB receivables were at seven days and overall HMB receivables stood at 41 days, well below the National Hospice Executive Roundtable benchmark median of 56 days. Unbilled revenue is at $382,374. Due to being understaffed in the medical department, unbilled revenue "peaked" in September 2015 at $7,386,916 representing 132 days. This has been a monumental task in getting caught up this far and the medical staff are to be commended on their efforts in this tremendous achievement.

DIRECTOR OF NURSING UPDATE

Sue Morgan, DON, reports…

La Tonya Brooks RN BSN began as the Clinical Staff Educator on 2/20/17. She has revised the Nursing and CNA new employee orientation program. She is in the process of updating the Social Work and Spiritual Care orientation programs for new employees. A revised educational program on emergency management preparedness has been implemented as a portion of new employee orientation.

Tammy Huyvaert RN, BSN, MS is the new Assistant Director of Nursing; however, the effective date has not been determined. She has been with CHC for two years as the Admissions Coordinator and we are pleased to continue to provide opportunities for promotions from within.

CHC nurses attended an NHPCO education program "Documentation Compliant and Complete" by Jennifer Kennedy, RN, MA, BSN, CHC who is the Senior Director for Regulatory and Quality at NHPCO. Two educational programs were held on "Temporary Agreements for Patients Traveling outside of our Service Area" and "The Procedure for a Patient being admitted to Hospice House from Home" for symptom management.

CHC is due for a state and federal hospice survey sometime this fall. These surveys are unannounced. The investigations have been performed by the Indiana State Department of Health (ISDH), but we understand that since the new law went into effect that all hospices in the U.S. would be surveyed at least every three years (previously Indiana was shooting for once every eight years) that ISDH is understaffed and has contracted out these surveys to a CMS approved private consulting firm operating out of either West Virginia or Missouri. We have no idea what to expect. Presently Mock Surveys are being developed in-house and will begin occurring 2nd quarter 2017.

Saint Joseph Regional Medical Center has granted access for CHC Case Managers to their electronic medical record when we have General Inpatient Level (GIP) of care patients located in the hospital. This allows the nurse to have a complete perspective of the management of the patient. During these GIP days, CHC is responsible for the patients' care plans.

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

	2011	2012	2013	2014	2015	2016	2017
January	32,655.69	36,775.87	83,619.96	51,685.37	82,400.05	65,460.71	46,552.99

February	64,530.43	88,893.51	166,563.17	109,724.36	150,006.82	101,643.17	199,939.17
March	165,468.92	194,345.35	264,625.29	176,641,04	257,463.89	178,212.01	282,326.61
April	269,676.53	319,818.81	395,299.97	356,772.11	419,610.76	341,637.10	
May	332,141.44	416,792.85	446,125.49	427,057.81	635,004.26	579,888.08	
June	427,098.62	513,432.22	534,757.61	592,962.68	794,780.62	710,175.32	
July	487,325.01	579,801.36	604,696.88	679,253.96	956,351.88	1,072,579.84	
August	626,466.72	643,819.01	783,993.15	757,627.43	1,042,958.42	1,205,050.76	
September	724,782.28	736,557.59	864,352.82	935,826.45	1,267,659.12	1,297.009.78	
October	1,026,728.58	846,979.95	922,261.84	1,332,007.18	1,321,352.39	1,421,110.26	
November	1,091,575.65	895,164.28	969,395.17	1,376,246.01	1,469,386.01	1,494,702.09	
December	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)

	2011	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
January	32,110.69	32,309.58	83,380.18	51,685.37	57,971.60	52,156.98	31,552.99
February	30,644.74	43,783.64	82,943.21	43,038.99	67,572.77	36,182.46	35,125.58
March	99,796.42	102,351.84	98,212.12	66,916.68	107,457.07	73,667.84	79,387.44
April	97,332.61	123,998.46	130,674.68	180,156.07	162,146.87	163,425.09	
May	51,753.98	90,909.04	40,825.52	100,285.70	160,178.34	93,318.98	
June	90,718.18	92,036.89	65,815.51	97,258.66	159,776.36	127,315.24	
July	53,536.39	62,069.43	69,939.27	38,243.88	93,586.27	52,394.52	
August	83,202.86	64,017.65	92,732.69	79,015.87	86,606.54	97,470.92	
September	94,000.56	92,808.58	80,335.67	84,011.71	99,931.45	92,459.02	
October	47,779.09	65,904.80	56,439.02	55,208.68	53,693.27	71,323.54	
November	48,284.08	46,674.33	47,133.33	44,238.83	46,870.62	66,490.16	
December	133,617.73	111,236.77	130,277.99	193,065.45	161,519.80	138,328.11	
Total	**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 February and March 2017 focused on events to launch the public phase. Other activity was directed at scheduling donor meetings, investigating grant opportunities and following up with both existing and prospective major gift donors. Through 33 months of this 5-year campaign (7/1/14 thru 3/31/17) total cash, pledges and documented bequests total $7,686,661.

In February, we traveled to Naples, Florida to host our first donor event there. It took place at the Naples Sailing and Yacht Club on February 23. Denny and Janet Hartman hosted us and 1st Source Bank co-sponsored the event. Mike Wargo, Hospice Foundation Chief Development Officer, Chris Taelman, Crossroads Campaign Chair, Catherine Hiler, and I were pleased to be joined by 22 guests. We provided a brief presentation and updates about CHC/HF and introduced the group to the campaign. This meeting officially launched the public phase of The Crossroads Campaign. Our guests were attentive, engaged and some presented us with checks for donations, while others expressed an interest in supporting the campaign.

We hosted a press conference at the Mishawaka Campus on the afternoon of March 16, which generated television and newspaper coverage about the launch of the public phase of the campaign. Members of the media received information from Catherine Hiler, Mike Wargo and me and had the

opportunity to ask questions, view drawings of the new buildings and tour the campus. That evening a special Circle of Caring Dinner served as the backdrop to dedicate the Helping Hands Award Wall of Fame. Those attending this special event included former Helping Hands Award winners and surviving family members of deceased HHAD award winners.

Planned Giving

A gift of $108,260.60 from the estate of Bill and Mary Hartman that arrived in February is being directed to help meet a $1,000,000 matching grant provided to HF by the Vera Z. Dwyer Charitable Trust. The funds are being used to establish a hospice and palliative medicine fellowship named in honor of Vera Z. Dwyer. 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.

Annual Giving

The 2016 *Annual Appeal* continues to be successful. Through the end of March, 490 gifts from 403 donors have raised $95,667 as compared with $77,339 through this same time last year. The average gift is 21% higher as well - $195 as compared to $161 for last year's appeal.

Special Events & Projects

The 2017 Helping Hands Award Dinner is approaching fast and the team continues to prepare. This year's dinner will be held on Wednesday, May 3rd at the Hilton Garden Inn when we'll be honoring *First Responders* from our service area.

The memorial dedication at the Elkhart Campus *Gardens of Remembrance and Renewal* will be held on June 6, and the inaugural *Journeys in Healing* gallery showing/silent auction to support the *After Images* art counseling program will be Wednesday, June 14. Early preparations for Walk for Hospice (8/12) and Bike Michiana for Hospice (9/17) are also underway.

Global Partners in Care

The transition of the organization from the National Hospice and Palliative Care Organization (NHPCO) to the Hospice Foundation continues. Until the New York Secretary of State's office approves some of the documentation required for the transfer of ownership, however, we are unable to complete the transition. Once this paperwork is approved, GPIC's bank account will transfer – allowing us to initiate wire transfers on the partners' behalf, as well as set up a PayPal account to accept donations.

The Global Partners in Care website has been revised to reflect our address and contact information. The logo has been updated and other cosmetic changes have been made as well.

To help guide our efforts, we are relying closely on NHPCO's continued input as well as that of the GPIC advisory council, which is comprised of several of representatives of some of the larger and more active partnerships as well as other historical key supporters. In addition, the annual survey has gone out to partners on both sides of the Atlantic and results will be tabulated this month. We

have had several conference/Skype calls both in the US and in Africa, with more scheduled in the coming weeks.

We have had inquiries about expanding GPIC's partnership initiatives to include Lesotho, Ethiopia and Haiti. We are researching how best to advise those in the US who would like to partner in these countries by contacting those knowledgeable about NGO/healthcare policies and procedures in each country.

A former NHPCO employee who was part of the GPIC team, Jeremy Tagliari, is facilitating conversations with Hospices of Hope, a UK-based organization that supports hospice development in multiple Eastern European countries, including Romania, Moldova, and Serbia.

PCAU

PCAU's 7th Palliative Care Conference is being jointly presented by the United Cancer Institute and PCAU. The conference will be held August 23-25 in Kampala. CHC/HF will once again be a sponsor for the event, which is expected to bring together more than 400 international participants from Africa and other countries around the world. CHC staff will be invited to submit abstracts for consideration by the conference scientific committee. Those chosen will be part of this year's staff exchange.

Former staffer and now international volunteer, Roberta Spencer will be traveling to Uganda to volunteer at the *Road to Hope Children's Camp* in early May. She will be working with PCAU staff on other Road to Hope activities, as well as presenting spiritual care programs and engaging in training efforts. Now in its third year, this children's bereavement program is based upon our own *Camp Evergreen* and is expected to be attended by more than 50 children from villages across Uganda.

Lily Ramos, a Masters student at the Eck Institute for Global Health at Notre Dame, will also travel to Uganda in early May to work on the mHealth initiative. Lily is both a Uganda native and an RN. Her focus is to enhance the quality of the data being captured by each facility. 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. The local Asante Foundation which has supported our Crossroads Campaign is providing funding for the program's next scale-up, which will add 10 facilities to the program, now in its third year of implementation.

Road to Hope Program/Documentary

As noted previously, PCAU will be hosting Road to Hope students at camp during the month of May. Plans are being made to include a collaborative art project that will begin with Road to Hope students during their camp, then finish in June by children attending the teen Camp Evergreen. The resulting piece will be made available at this year's Okuyamba Fest.

The *Road to Hope* film was named Best Documentary at the United International Film Festival, received the Bronze Medal for Best Documentary Feature, as well as Best Documentary Screenplay at the Global Independent Film Awards. It has also been named an official selection of the New York Sun Fest and will screen later this month as one of five films nominated for Best Documentary

at the Cameroon International Film Festival. To date, Road to Hope has won 31 awards and has been an official selection and/or nominee in 67 film festival and award competition categories.

Education

The fourth edition of the Introduction to Hospice & Palliative Care course at the University of Notre Dame took place the week of February 20th. This year, students were required to log an additional three and a half hours of in-class time to meet the one-credit hour course requirement, so two weeknight sessions were offered to accommodate student schedules. More than 70 students took part in the course, most of whom were pre-professional undergraduate healthcare students. The class was offered in collaboration with the Ruth M. Hillebrand Center for Compassionate Care in Medicine.

Our first screening of the PBS FRONTLINE documentary, *Being Mortal*, took place on March 23rd and was attended by 53 people. Following the screening, attendees were invited to share their reactions to the film and ask questions of an expert panel. Panel members were Mark Murray, Dominic Vachon, director of the Hillebrand Center, Mark Sandock, MD, Physician Consultation at Saint Joseph Health System, and the CHC President/CEO. 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. The event was attended by a broad cross-section of the community, with varying ages and backgrounds, including clinicians. Post-event surveys indicated that those who attended felt the event was very helpful in understanding end-of-life issues. We received our first inquiry about our Hospice and Palliative Care Fellowship from a first-year resident at Saint Joseph Health Systems who was one of the two family medicine residents from Saint Joseph Health System who attended the *Being Mortal* event.

Our first class with the Forever Learning Institute, which covers hospice, palliative care and end-of-life planning, will wrap up in early April. The six-week course was attended by 10 students and will be offered again in the fall.

Mishawaka Campus

Work continues with new and planned construction projects on and around the Mishawaka Campus. We now have firm pricing from DJ Construction for the new clinical staff building. Helman Sechrist has completed the floorplan and exterior design for the new Hospice House and is now working on the next level of detail in an effort to secure construction cost estimates.

Residential Housing at the Mishawaka Campus

As previously reported 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 and we are now working to obtain a written appraisal to determine an appropriate asking price. We've begun networking within the local real estate community to generate interest in these new homes in advance of beginning construction.

Staffing

Peter Ashely has joined the Hospice Foundation as Director of Communications. He comes to HF from the Mendoza College of Business at the University of Notre Dame where he was Director of Marketing and Communications. Prior to that he was Director of Marketing and Communications at Georgia State University in Atlanta. Peter has a Masters in Communications from the University of North Carolina at Chapel Hill.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

Craig Harrell, Director of Marketing and Access, reports on marketing and access activities for February and March…

Referral, Professional, & Community Outreach

Our Professional Liaisons continue to contact doctor's offices, clinics, hospitals, group homes and extended care facilities in an effort to build relationships and generate referrals. In February and March our three fulltime Liaisons completed 771 visits to current and potential referral sources within our service area.

The Liaisons have been utilizing Playmaker as the software to track our Customer Relations Management (CRM) for approximately one year. We are going to address 'Best Practices' that will help the reps become more efficient in their daily calls, which should result in more referrals.

Barb King, Marketing and Access Assistant, continues to be involved in outreach to our diverse communities. She recently met with the Director of Diversity for the city of South Bend and participated in the first Women's Health Fair presented by the Greater St. John Missionary Church.

Volunteer Department

The Annual Report and Volunteer Recognition Luncheon is taking place on Tuesday, April 18th at The Brick. Our thanks again this year to HF board member and Brick owner Corey Cressy for donating the space. CHC Volunteer Kathy Fuchs will be awarded the Krueger Award with 150 of her peers in attendance.

Volunteer Training & Recruitment

Kristiana Donahue, Volunteer Recruitment Coordinator, interviewed 14 new volunteer candidates and had 25 new inquiries in February and March. She also completed training 11 new volunteers during that same time.

Kristiana continues to have struggles in recruiting volunteers in the Elkhart area. Her efforts have included doing marketing blitzes to area churches, colleges and businesses. She's also been added to the Elkhart Chamber of Commerce emails and distributed flyers about the upcoming Elkhart Volunteer Open House. This event encourages current volunteers to invite friends to ask about our services and expose them to ways they might contribute.

Access

For the Months of February and March, the Referral Specialist received 6,204 phone calls. This averaged to 105 phone calls per day and 35 calls per day per Specialist. Customer service training for our staff is an ongoing process, focusing on quickly identifying caller needs and scheduling a meeting with the patient and family. Sarah Lambert and I have been reviewing training materials that will help streamline the referral process while increasing consumer satisfaction.

Website

During the months of February and March, CHC's hosted 6,220 users, of which 71% were new users. Federated Digital Solutions (FDS) generated 3,062 new users through their use of Audience Targeting. This allows our ads to appear to people in need of our services at the proper time and in turn to our website to learn more about our services.

Social Media

Facebook (Center4Hospice)

Over the past months, we began "*Behind the scenes at Center for Hospice Care*" where we highlight a member of the CHC team with their position and how they came to work here. It not only helps educate followers to what we do, it also introduces them to who we are. Often these articles are shared with friends and family members of those who are featured. Posts in February and March reached a total of 107,578 Facebook members. Examples are below:

Digital Overview

The digital campaign generated 95 calls from February 1 – March 31.

LaPORTE OFFICE UPDATE

The owners of our first choice for locating an office in LaPorte which was directly across the street from the hospital have decided not to rent out the property after the library is done with it in May. They will keep it for themselves. We continue to look for appropriate space.

POLICIES ON THE AGENDA FOR APPROVAL

There are seven new or revised policies for approval in your board packet. They are:

1. Discharge Criteria
2. Suicide Ideation
3. Medication Review and Electronic Profiling (new)
4. Patients with Known or Discovered Infestations in Hospice House
5. Infection Control: Multi-Drug Resistant Organisms (new)
6. Hospital to Hospice House Admission (new)
7. Program Evaluation (new)

Existing policies have been updated to reflect regulatory changes, current practice, or to provide clarification. New policies are those that are needed due to new regulations, or because the need had previously not been noticed, or to provide a policy to explain and have an accountability mechanism available for new, identified procedures.

MedPAC RELEASES MARCH REPORT TO CONGRESS

The Medicare Payment Advisory Commission (MedPAC) released its annual March report to Congress on March 15. The report notes that more than 1.38 million Medicare beneficiaries received hospice care in 2015, an increase over 2014. MedPAC projects the aggregate hospice margin in 2017 to be 7.7 percent. In the report, the Commission recommends that ***"Congress should eliminate the update to the hospice payment rates for fiscal year 2018,"*** which is consistent with previous MedPAC recommendations. It is important to remember that Congress must act for a MedPAC recommendation to be implemented, which it has not done in recent years.

NEW GIP CLAIMS AUDIT

NHPCO issued a Regulatory Alert on 03/13/17 about a new General Inpatient Level of Care Claims Audit from CMS. CMS has contracted with StrategicHealthSolutions, LLC as a Supplemental Medical Review Contractor for a review of patient GIP stays. Approximately 65 hospices are a part of the audit. NHPCO reached out to CMS Center for Program Integrity and provides more details on the audit, the audit process, and the process for discussion and education of the audit findings.

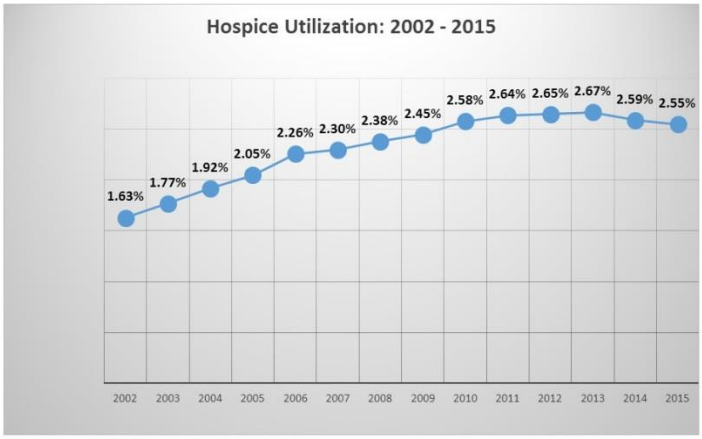
We do not believe that CHC has been caught up in this audit, however, we have received notice that about 25 patient claims are under scrutiny due to a "specific services" additional development request.

HOSPICE UTILIZATION: ANOTHER YEAR AND STILL NO BUSINESS

By Rich Chesney, Healthcare Market Resources

This is the second blog this month on utilization, so you might be wondering "why care?"! Utilization is the starting point in answering the question "How do I grow?" There are several choices – find new patients, take share away from competitors and increase the "order size". By benchmarking your agency's utilization against high levels of utilization, you can determine how much opportunity there is to find new patients.

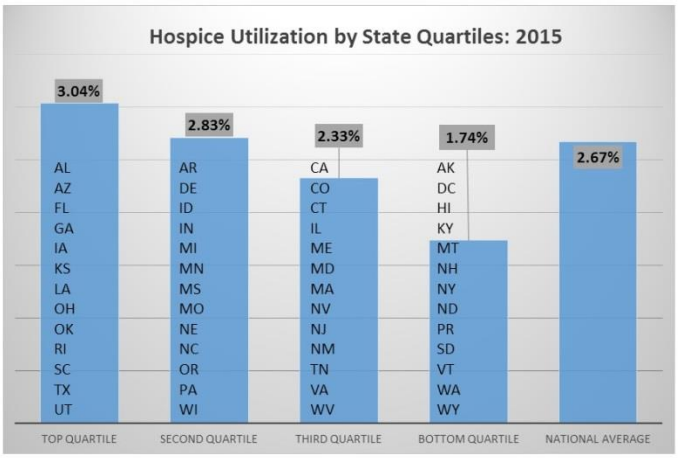
For 2015, we are seeing the continued leveling off of hospice utilization nationwide. It would be great if we could chalk this up to an aberration, but unfortunately as we look at utilization over the last decade, we see that hospice utilization has been leveling off for the last five or six years. The 2015 utilization rates are lower even than those of five years ago.



Utilization = Patients Served/Medicare Enrollees

When you consider that we measure hospice utilization by dividing the number of hospice patients served by the total Medicare eligible population for each state (this ensures that we capture live as well as expired discharges), we would expect hospice utilization to be somewhat stable, given the increasing awareness of hospice services, the ubiquitous availability of its services and favorable demographics.

Breaking hospice utilization into state quartiles shows a dramatic difference between the bottom quartile and the top one, as well as a pretty significant jump from the third quartile to the second one.



Utilization = Patients Served/Medicare Enrollees

Further, a state-by-state look between 2014 and 2015 shows very discouraging conditions:

- Just 11 states showed utilization growth from 2014 to 2015. Of those, 5 states had utilization growth of less than 1%. Of the remaining six states, only two (Arkansas and Maine) showed growth in excess of 2%.
- This is a significant decrease from last year in which 17 states experienced utilization growth, eight of which exceeded growth of 2%.
- Eleven states experienced declines in excess of 5%. Two of these (Wyoming and Alaska) experienced declines in excess of 11%.
- This is actually better than 2014 in which 14 states experienced declines of +5%, with four of those at +11% declines.

2017 and Beyond

With increased regulatory pressure and a new payment system which dis-incentivizes long term patients, hospice utilization looks to be on a continued decline. And yet, long term prospects could be strong given hospices' ability to help control end-of-life (EOL) costs, however this requires significant structural and attitudinal changes in the healthcare delivery system.

CHC PRES/CEO ELECTED NEW BOARD CHAIR OF THE INDIANA HOSPICE AND PALLIATIVE CARE ASSOCIATION

On April 4th, I was elected board chair of the Indiana Hospice and Palliative Care Association (IHPCO). This is my second time as chair. I was first elected 20 years ago, and served as board chair in 1998-99. I reluctantly agreed to serve after receiving assurances from the IHPCO Executive Director, Liz Carroll, that she would help with attempting to administratively, through the Indiana State Department of Health, or, legislatively through the state House and Senate, allow hospice inpatient units to care for palliative care patients who need pain and symptom control and who have not elected hospice. With the ongoing national decrease in General Inpatient Level of Care (GIP) days and increased scrutiny by CMS and the OIG on this level of care, I believe there is an opportunity for our inpatient units to effectively care for these types of patients at a significantly

lower cost than a hospital. I also believe managed care companies might pay us double the Medicare hospice GIP rate which would be about $1,400 a day rather than $3-4,000 a day to a hospital for pain and symptom management that could be performed in a significantly less expensive setting. Once symptoms are under control, these patients would return home or back to the residential facility where they live. While she has only been the IHPCO Executive Director for less than two years, Liz Carroll is also Executive Director of the Indiana Assisted Living Association, an attorney, and a former Deputy Commissioner of the Indiana State Department of Health and has many wonderful contacts.

OUT AND ABOUT

Along with at least ten other CHC staffers, we taught the one-credit course "Intro to Hospice and Palliative Care" at the University of Notre Dame 2/22, 2/23 and 2/25.

I attended and presented at the "Circle of Caring" Dinner and unveiling of the Helping Hands Award Wall of Fame on 3/16.

I was a co-presenter with Mark Sandock, MD, Physician Consultant for Saint Joseph Health System at the Indiana University School of Medicine "Mini Medical Series" on the evening of 3/22 at the IUSM at Notre Dame.

I was a panelist following the screening of "Being Mortal" here at the MC on 3/23 along with Mark Sandock, MD, and, Dominic Vachon, PhD, director of the Ruth Hillebrand Center for Compassionate Care at the University of Notre Dame.

Several CHC staff, including Karl Holderman, Dave Haley and Sue Morgan, attended IHPCO's annual Hospice Regulatory and Reimbursement Day meeting in Carmel on April 5th.

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

Dave Haley's Census Charts.

Front page South Bend Tribune story on the public announcement of the Crossroads Campaign

Links to television news coverage of the Crossroads Campaign Press Conference:
http://wsbt.com/news/local/mishawaka-center-for-the-hospice-reveal-plans-for-10-million-project
http://www.wndu.com/content/news/Center-For-Hospice-Care-unveils-expansion-plan-416398203.html

Page from the IU School of Medicine newsletter, and South Bend Tribune section describing the 21st Mini Medical Series which featured the CHC Pres/CEO

Thank you email from Riley High School for CHC's bereavement group for students there

Minutes of the QI Committee Meeting on 02/28/17

Minutes of the home health annual Professional Advisory Group meeting on 03/28/17

The most recent CHC Volunteer Newsletter via email publication

"Global Partners in Care has a New Home" article from NHPCO NewsLine

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

First quarter 2017 Financials

2016 Audited Financial Statements

PPS and FAST scale ID card

Most recent issue of CHOICES newsletter

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, June 28, 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 .

# # #

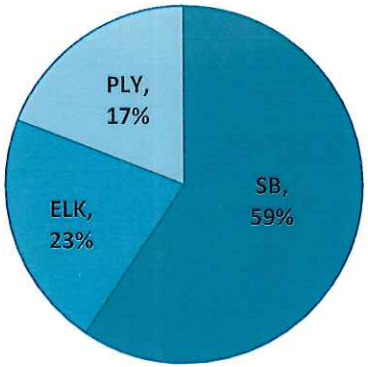
Center for Hospice Care

2017 YTD Average Daily Census (ADC)

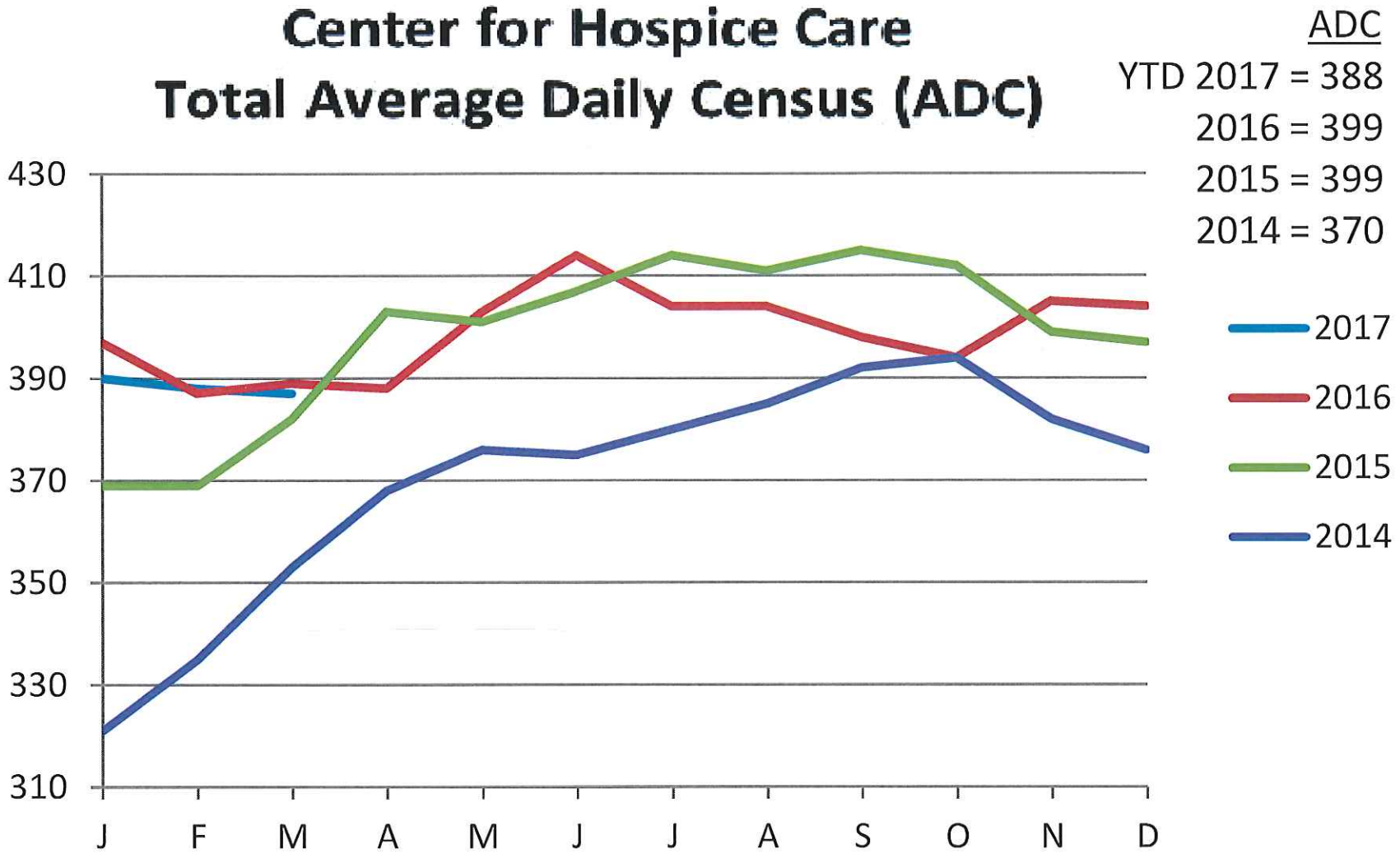
(includes Hospice House and Home Health)

	All	South Bend	Elkhart	Plymouth
J	390	229	91	69
F	388	233	89	67
M	387	229	91	67
A				
M				
J				
J				
A				
S				
O				
N				
D				
2017 YTD Totals	1165	691	271	203
2017 YTD ADC	**388**	**230**	**90**	**68**
2016 YTD ADC	391	224	95	72
YTD Change 2016 to 2017	-3	6	-5	-4
YTD % Change 2016 to 2017	**-0.7%**	**2.8%**	**-4.9%**	**-6.0%**

2017 YTD ADC by Branch

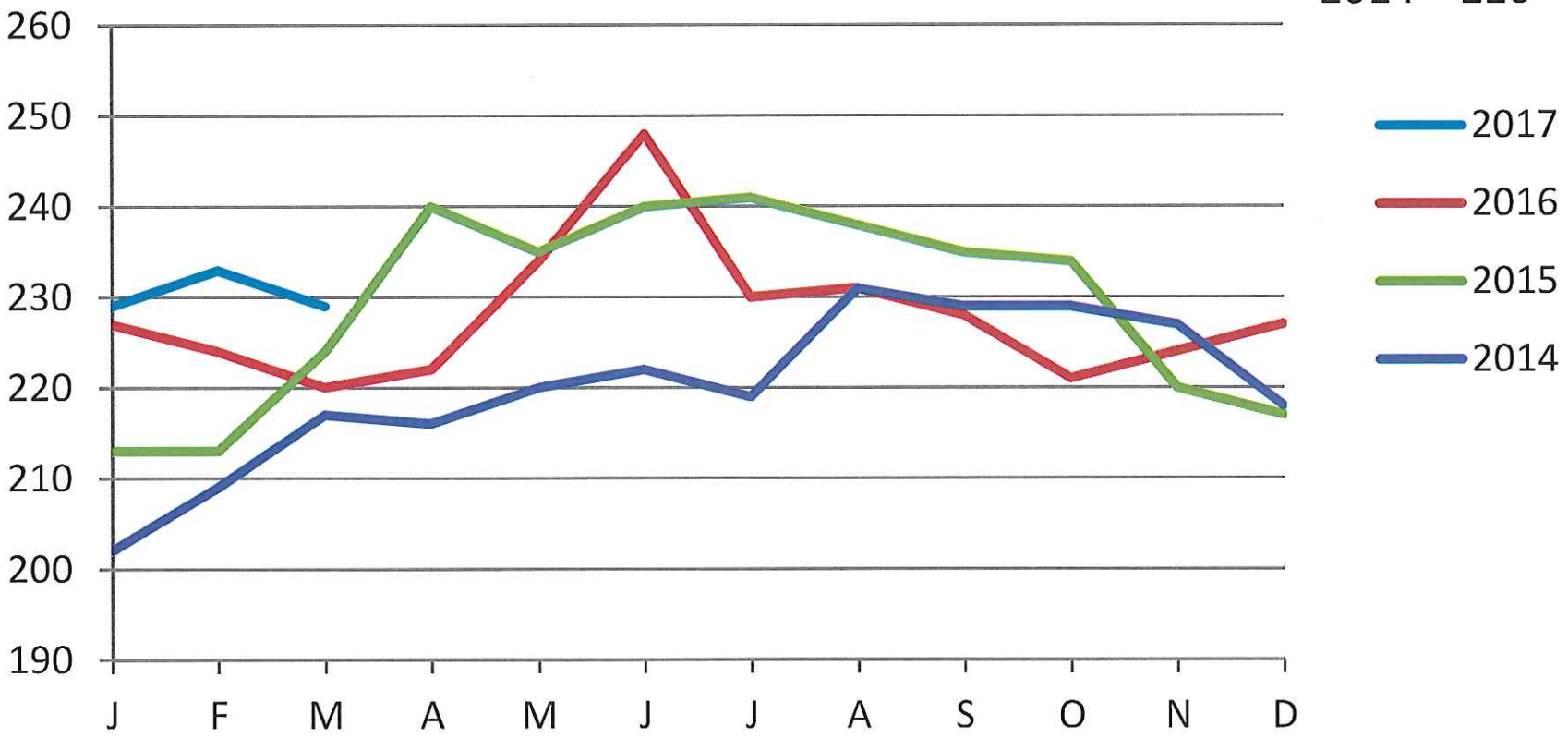


Center for Hospice Care
Total Average Daily Census (ADC)

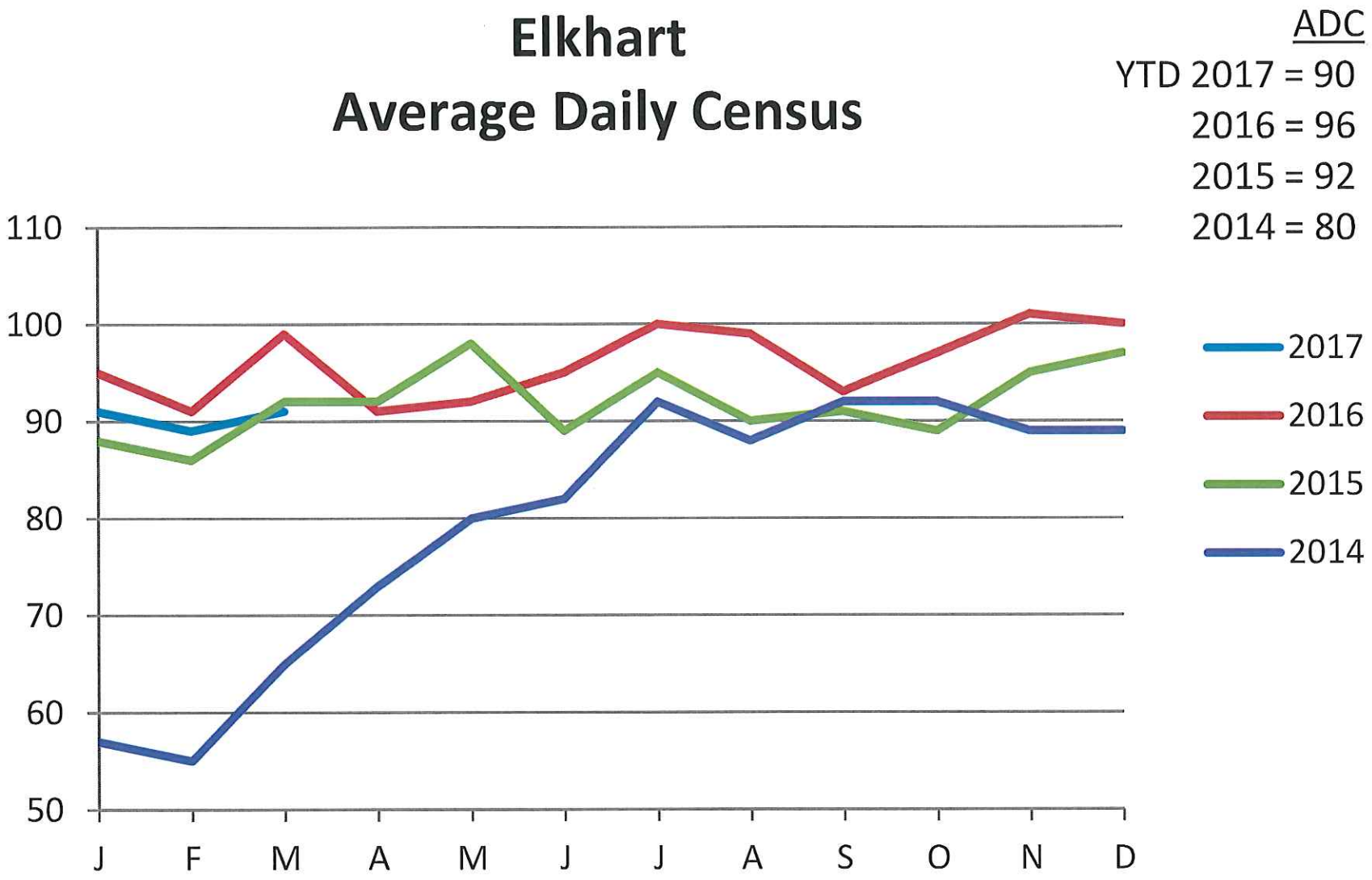


South Bend
Average Daily Census

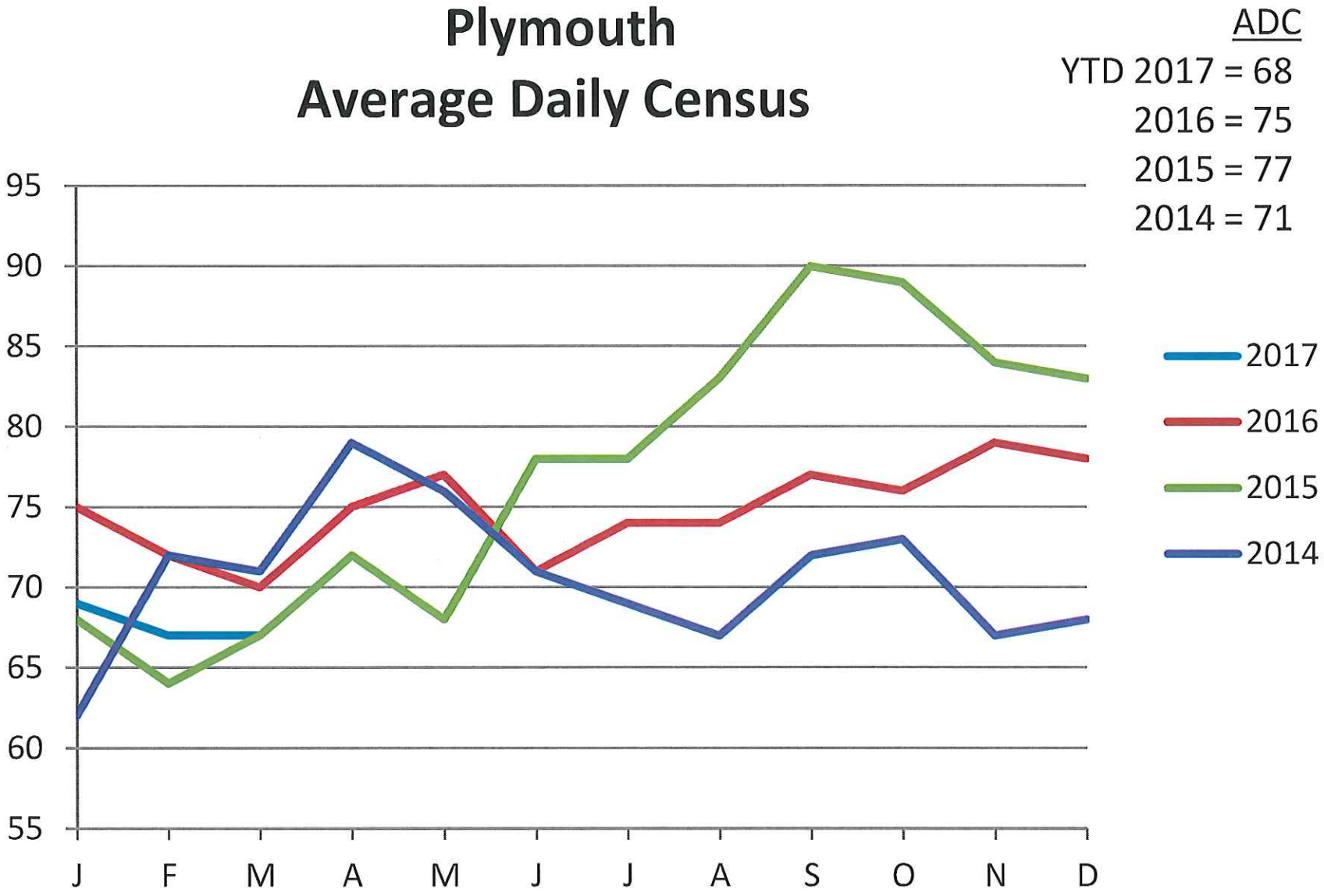
ADC
YTD 2017 = 230
2016 = 228
2015 = 229
2014 = 220

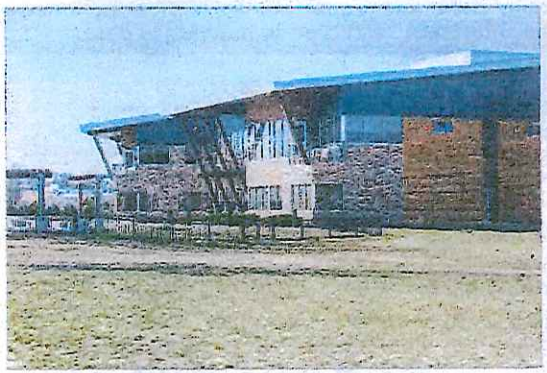


Elkhart
Average Daily Census



Plymouth
Average Daily Census





The nonprofit Center for Hospice Care is raising money to build a staff building next to its existing structure along the Riverwalk in Mishawaka, along with a 12-bed Hospice House. Tribune Photo/BECKY MALEWITZ

Drive to expand hospice campus

$10 million marked for buildings, programs, endowment

By Joseph Dits
South Bend Tribune

MISHAWAKA — The nonprofit Center for Hospice Care announced Thursday a $10 million campaign to build a 12-bed Hospice House at its campus near Central Park, along with a two-story building for the 100 staff who go into the community to care for dying patients.

The buildings would match the look — and even have the same architect — as its current structure, which opened along the city's Riverwalk in 2013, said Mike Wargo, chief operating officer for the center's foundation.

The campaign has already raised $7.6 million over the past 2½ years. The goal is to raise the remainder in the next 2½ years, said campaign chairwoman Catherine Hiler, of South Bend, whose husband, John, had served as the local U.S. congressman from 1981 to 1991.

The campaign has earmarked $5 million for the new buildings alone — of which $2.17 million has been

See HOSPICE, A6

FROM PAGE A1

Hospice

raised so far, said chief development officer Chris Taelman. Another $3 million in the campaign would go to programming and $2 million for an endowment, Wargo said.

CEO Mark Murray said the campus expansion will help to meet a rising demand for hospice care, which comforts people in their final days, most of them at home. In the 36 years that the center has been providing care, he said, a quarter of its 33,000 total patients have come in just the last four years.

It is one of 32 agencies that provides hospice care in its eight-county territory in northern Indiana, Murray said. Nationwide, 66 percent of hospice agencies are for-profit companies. Murray said the same is true here, though the Center for Hospice Care is nonprofit. It is also the largest provider of hospice care in Indiana, serving about 400 patients a day.

The center already runs a Hospice House with seven beds in Roseland and another with seven beds on the eastern end of Elkhart County. Wargo described them as places where patients "get their symptoms under control," often just after they've been discharged from a hospital and before they come home, though many die there.

Once the new, 12-bed Hospice House is built, he said, the Elkhart beds will remain. But the Roseland site, on Sunnybrook Court and behind the Pancake House, will be converted into the new home of Milton Adult Day Services, a place with activities for people with dementia that the center took over last year from the nonprofit Alzheimer's and Dementia Services of Northern Indiana.

Contractor bids have started rolling in for the 15,000-square-foot staff building, which would be the first of the two structures to be built, Wargo said. Hallways will link the existing building to it on an open, grassy area directly to the east.

Hospice House would be a separate one-story building just to the east and closer to the Riverwalk, where each patient's room will have a river view.

When asked how soon construction would begin, Wargo said, "the sooner the better," noting how bids seem to be rising each year, thanks to demand for contractors for several local building projects.

The current 25,000-square-foot building and campus, which cost just over $7.2 million, now houses administrative staff and bereavement work, among other functions, he said. Working with the city, the Center for Hospice Care opened it on a five-acre campus in 2013. Next to it, the city then completed a $4.9 million makeover of Central Park in 2015.

Apart from this campaign, Wargo said the Center for Hospice Care plans to build and sell two houses at the nearby corner of Comfort Place and Cedar Street — to meet a promise it had made to the city when the city helped it to acquire the land.

As the large baby boomer population ages, Murray said, "We expect a lot more growth over the next 15 to 20 years."

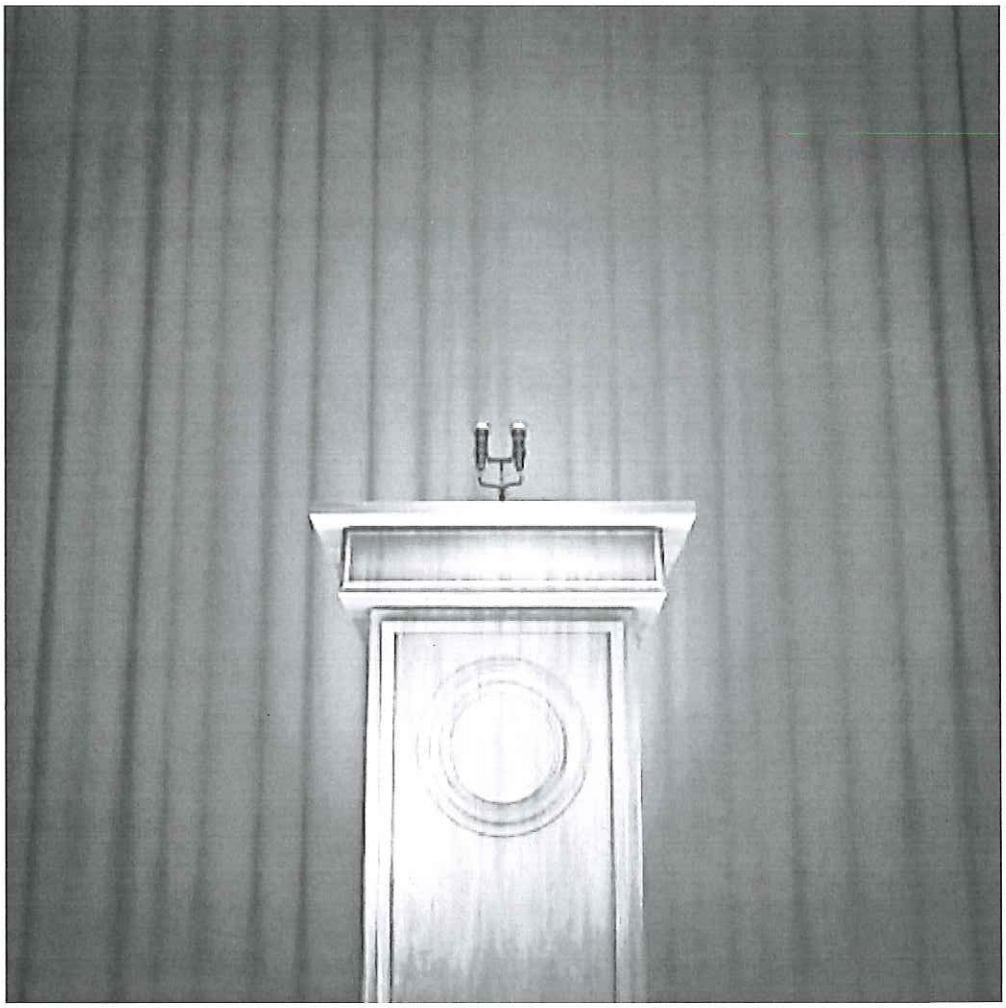
To donate

Call Mike Wargo at 574-243-2059. Or visit foundationforhospice.org.

http://www.southbendtribune.com/news/education/at-the-podium/article_e9f84ad3-e045-53f7-8fc3-91a45db2b41e.html

At the Podium

Mar 19, 2017 Updated 18 hrs ago



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File image

The following lectures are scheduled this week in the community. All events are free and open to the public:

• 5 p.m. Tuesday. **"Portals: Conversations About the Police, By the Policed,"** Vesla Weaver, professor of political science and African American studies and director of the Center for the Study of Inequality, Yale University. Room 3130, Eck Hall of Law, Notre Dame

• 12:30 p.m. Wednesday. **"On the Recent Delinking of Capitalism and Democracy,"** Stefano Zamagni, economics professor, University of Bologna. Room C-103, Hesburgh Center, Notre Dame

• 6:30 p.m. Wednesday. **"Facts Matter: A Guide to Critical Thinking,"** panel discussion featuring Cathy Borshuk, IU South Bend psychology professor; Louise Collins, IU South Bend philosophy professor; John Duffy, Notre Dame English professor; and Andrea Meluch, IU South Bend communications studies professor. St. Joseph County Public Library, 304 S. Main St., South Bend

• 6 p.m. Wednesday. **"Head Games: The Inside Story of Football's Concussion Crisis,"** Alan Schwarz, New York Times reporter. Auditorium, Mendoza College of Business, Notre Dame

• 7 p.m. Wednesday. **"Living Well: Quality of Life Considerations at Life's End,"** Mark Murray, president and CEO, Center for Hospice Care, and Mark Sandock, M.D., of St. Joseph Regional Medical Center and Michiana Life Wishes Coalition. Auditorium, IU School of Medicine-South Bend, 1234 N. Notre Dame Ave., South Bend

• 7 p.m. Wednesday. **"Sustainable Design Strategies,"** Greg Kil, of Kil Architecture and Planning. Room 1001, Wiekamp Hall, Indiana University South Bend

• 7 p.m. Wednesday. **"Toward a Moral Vision for a New Civil Rights Movement,"** the Rev. Bryan Massingale, theology and social ethics professor, Fordham University. Auditorium, Madeleva Hall, Saint Mary's College

• 7 p.m. Wednesday. **"What Makes You Beautiful: The Aesthetic Pedagogy of the Book of Exodus,"** Leonard DeLorenzo, theology professor. Auditorium, Eck Visitors Center, Notre Dame

2017 Mini Medical speakers are, clockwise from top left, Gary Fromm, MD; Joseph Kotva, PhD; Mark Murray; Anantha Shekhar, MD, PhD; Ebonee Davis, MD; Jose Bufill, MD.; Rafat Ansari, MD, and Mark Klaassen, MD.

21ST MINI MEDICAL SERIES BEGINS MARCH 15

One of the region's oldest and most established lecture series resumes March 15 with the first of six Mini Medical School discussions on health and health care at the IU School of Medicine-South Bend.

The series—the 21st annual—will touch on treatment advances, the future of medicine, and such chronic health issues as diabetes. Presentations take place on consecutive Wednesdays from 7 to 8:30 p.m. through April 19 in Raclin-Carmichael Hall, 1234 Notre Dame Ave, South Bend. They are sponsored by the Medical Education Foundation, the citizen's advisory group of the medical school South Bend center.

Topics, and their presenters, will cover a wide range of issues.

MARCH 15: Everything You Wanted to Know about Sleep (But Were too Tired to Ask), with **Gary Fromm, MD,** medical director, Memorial Sleep Disorder Center. He will discuss the medical barriers that impede a good night's sleep.

MARCH 22: Living Well: Quality of Life Considerations at Life's End. Panelists **Joseph Kotva, PhD,** a medical ethicist with IU School of Medicine-South Bend, and **Mark Murray,** president and CEO, Center for Hospice Care, will explore delicate end-of life decisions such as selecting an advocate and the optimal time to request hospice services.

MARCH 29: Indiana's Precision Health Initiative, with **Anantha Shekhar, MD, PhD,** of the IU School of Medicine-Indianapolis, on a statewide effort to advance personalized medicine therapies through collaboration among Indiana's business, medicine and higher education leaders.

APRIL 5: The Evolving Landscape of Joint Replacement. Elkhart orthopedic surgeon **Mark Klaassen, MD,** will discuss advances that have lessened the health impact of common joint replacements.

APRIL 12: The Future is Here: Emerging Trends in Cancer Therapy. **Rafat Ansari, MD,** and **Jose Bufill, MD,** of Michiana Hematology Oncology, Inc., will discuss the promise of personalized medicine and the complex commitment such therapies entail.

APRIL 19: Thriving with Diabetes. **Ebonee Davis, MD,** of the South Bend Clinic, will talk about the toll of diabetes, particularly for African Americans and Hispanics, and the personal and family commitments that make the disease livable.

Mark Murray

From: Mary Dunn <mdunn@sbcsc.k12.in.us>
Sent: Monday, April 10, 2017 9:38 AM
To: Mark Murray
Subject: Grief Group

Thank you so much for letting Annette DeGuch run a grief group at Riley High School. Each year she offers students a safe place to express their feelings of grief and learn coping mechanisms that help them move toward the acceptance of the death. Once again, I appreciate your generosity and hope that this valuable program continues for many years to come.

--
Mary Dunn L.C.S.W.
Riley High School
Social Worker

Mark Murray

From: Craig Harrell
Sent: Wednesday, March 29, 2017 7:23 AM
To: _All_CHC Staff
Subject: March 2017 Volunteer Newsletter

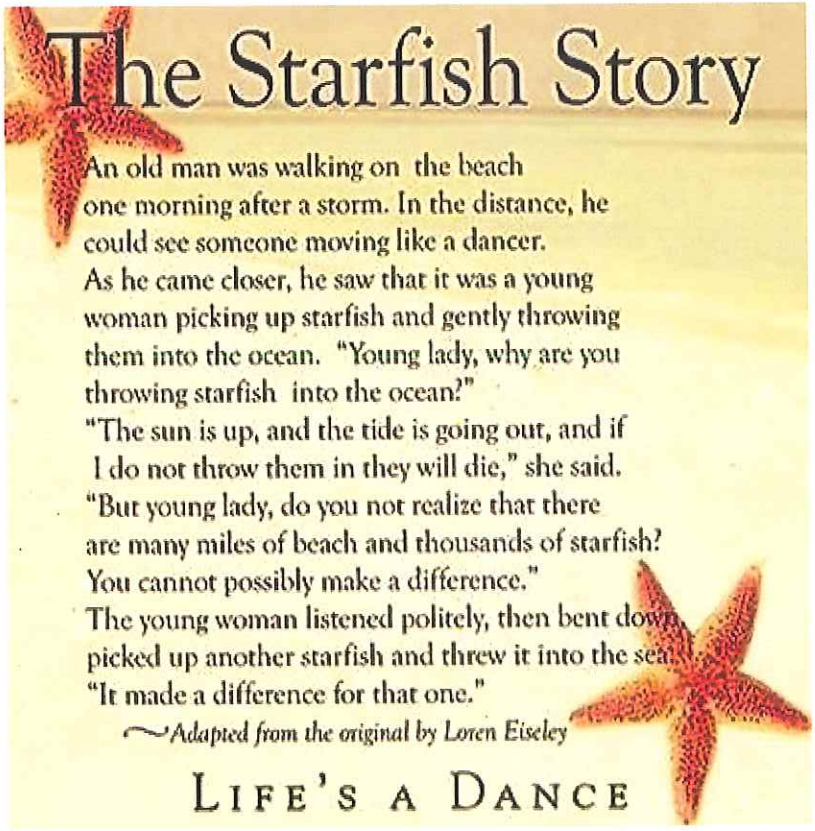
Importance: High

Center for Hospice Care

choices to make the most of life™

March 2017
Volunteer Newsletter

THIS ISSUE



Mark Your Calendar

» UPCOMING EVENTS

You Can Make a Difference
Learn how at our Open House!

Wednesday, April 12, 2017

Elkhart Prospective Volunteer Open House

Wednesday, April 12 2017
11:00am-1:00pm
22579 Old US 20 E
Elkhart, IN

Volunteer Recognition & Luncheon

Tuesday, April 18, 2017
11:30am-1:00pm
The Brick
South Bend, IN

NEW Volunteer Training

April 24 & 26, May 1, 2017
9:00am-12:00pm
May 3, 2017
9:00am-3:00pm
501 Comfort Place
Mishawaka, IN

Senior Wellness and Resource Fair

April 29, 2017
9:00am-3:00pm
Century Center
Downtown South Bend

NEW Volunteer Training

Saturday,
June 3 & 17, 2017
8:30am-5:00pm
501 Comfort Place
Mishawaka, IN

Annual Volunteer In-Service

Tuesday, June 6, 2017
*New Location
Bethel College
Mishawaka, IN

11:00am - 1:00pm

Center for Hospice Care Elkhart Campus
22579 Old US 20 E
Elkhart, IN 46516

We need YOU, our current volunteers, to help us spread the word and to invite your friends and family!
This Open House is designed for prospective volunteers who may have some questions about volunteering for CHC.

Your ticket to join?
Bring a prospective volunteer, or two, or four!

Remembering Edward Wilsberg

Caring for the hearts of others.

Center for Hospice Care lost one of our beloved Spiritual Care Counselors on February 20, 2017. Ed Wilsberg devoted his time at CHC to care for the spiritual needs of our patients and families. We are saddened by his loss and extend our love and condolences to his family.

One of the most difficult things in chaplaincy, and hospice care, is the need to set aside self in order to be fully present and supportive to patients and their families. Ed made this seem easy. He always made you feel as if you were the most important person to him at that particular moment. His encouragement of others was relentless, and he never had a negative or harsh word to say about anything. Ed willingly put others before himself, which is a perfect testimony to his own faith.
Larry Rice, M.A., M.Div.
Spiritual Care Coordinator

When I think of him, patient and gentle are two words that come to mind.
Trevor Foley, SCC
Spiritual Care Counselor

After I was hired by CHC, I was trained and "shown the ropes" by Ed. My two months of riding along with him are so valuable to me. I could tell

Happy Birthday

3/1
Cynthia Proffitt
3/1
Lev Suliandziga
3/2
Thomas Sharp
3/8
Gabrielle Mungcal
3/9
Bonnie Martin
3/11
Elizabeth Labuzienski
3/13
Sue Benak
3/15
Joan Fitt
3/15
Bernard Randall
3/15
Julie Shamo
3/16
Ann Bowers
3/16
Anita Shultz
3/19
William Bellairs
3/19
Erin Ryal
3/19
Fran Schuster
3/23
Joyce Carver
3/23
Anna Riblet
3/24
Brianna Bahe
3/24
Marie Weiss
3/25
Beverly Kyalwazi
3/25
Sandra Witkowski
3/26
Linda Burrell
3/26
Flora Lee Stone

he had a big heart for our patients and their families. He had a caring spirit and a genuine concern for people. About a week into our time together, he became a mentor, without him asking to be that for me. Our times together continued as we met twice a month over breakfast for support and encouragement. He is greatly missed by many.
Neil Davis MDiv
Spiritual Care Counselor

In the Spotlight

Sarah Wargo
South Bend Volunteer

What volunteer work do you do with CHC? How long have you been a CHC volunteer?

- I have been a volunteer for 3 years. I am a Patient Care volunteer. I work during the week, so I typically volunteer on Sundays. I usually sit with a patient so the caregiver can go to church or run errands. I also occasionally sit with Eleventh Hour patients and last year was my first year at Camp Evergreen.

Why do you volunteer with CHC?

- My Dad died of lung cancer in July of 2011. I think, like most volunteers, I was impressed with the level of care and compassion with which he, as well as my family, was treated . It's a great way to give back and spread some good. I've had the opportunity to meet some truly special people.

What do you like to do in your spare time?

- When the weather allows, I spend a lot of time walking my dog. We live in an area that has some great places to

3/27
Jennielea Vidrich

walk. Sometimes we head out to Potato Creek and hike. I also love to read. I love traveling to see my sister and my nephews and niece.

What is your favorite animal?

- My dog, Mya, is my favorite. She is my four-legged shadow. She loves car rides and going for walks and being tucked in bed. There is not a day that I come home and she isn't excited to see me, even if I've only been gone a few minutes.

Your help is needed!

Attention all Crocheters!

If you are a crocheter, we have a perfect volunteer opportunity for you!

We need a volunteer to spend some time with a ladies group at Miller's Merry Manor in Wakarusa. It starts at 10:30am and lasts about an hour. They meet once every other month.

Contact Marlane Huber if you're interested!

Patient Care Volunteers

We are ALWAYS looking for more Patient Care Volunteers. If you are a Level 3 trained volunteer and haven't been involved in this role, but would like to, let your Volunteer Coordinator know. If you haven't completed the Level 3 training, but are open to doing so, let your Volunteer Coordinator know. We have multiple training opportunities throughout the year. We can get you signed up.

Craig Harrell
(Director of Marketing and Access)

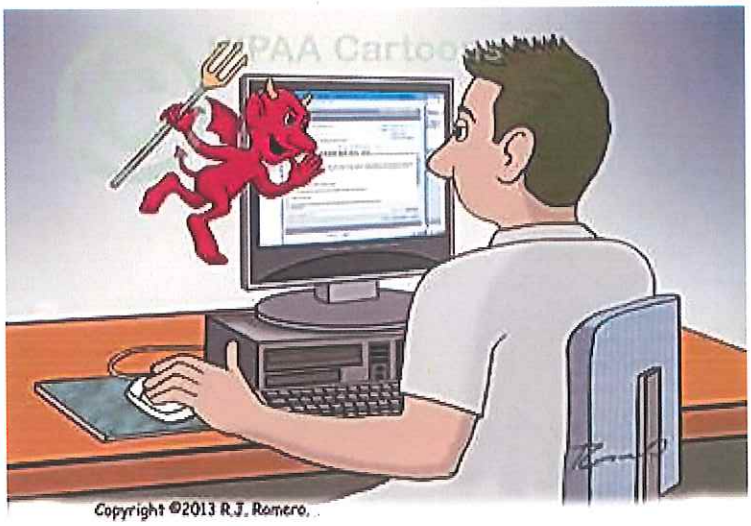
Peter Ashley
(Director of Communication and Annual Giving)

Shellie Cox
(Admission RN)

Bridget Rowland
(South Bend CNA)

Wanda Nelson
(HIM Support Specialist)

"You must remember this"



"Go on - email that confidential information with no encryption. What could go wrong?"

Don't listen to the little devil on the shoulder!

Unless you use encrypted email, **sending any patient information (name, address, anything) via email is a HIPPA violation**. The best way to relay patient information is face to face or call your Volunteer Coordinator. Just make sure you're not in the grocery store, at a party or surrounded by people when you call!

Follow us on Twitter: Like us on Facebook:

Kristiana Donahue
Volunteer Recruitment & Training Coordinator

Center for Hospice Care
choices to make the most of life

Center for Hospice Care
501 Comfort Place
Mishawaka, IN 46545

(574) 286.1198
(800) 413.9083 Toll Free
(574) 822.4876 Fax

Global Partners in Care Has a New Home

Mike Wargo, Hospice Foundation COO (back right), and Rose Kiwanuk, Palliative Care Association of Uganda Country Director (front row, third from left) are pictured with students that Hospice Foundation is currently sponsoring in the Diploma in Palliative Care Course at the Institute of Hospice and Palliative Care in Africa on the campus of Hospice Africa Uganda.

Earlier this year, NHPCO proudly announced 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, became 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 is in good hands and that the mission to increase access to hospice and palliative care where the need is great and resources few, lives 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.

Have questions about the transition? Please access our Q&A document (PDF).

Center for Hospice Care
QI Committee Meeting Minutes
February 28, 2017

Members Present:	Alice Wolff, Amy Knapp, Anna Milligan, Brett Maccani, Carol Walker, Craig Harrell, Dave Haley, Denise Wetzel, Greg Gifford, Holly Farmer, Jenelle Sloop, Karen Hudson, Larry Rice, Rebecca Fear, Sue Morgan, Tammy Huyvaert, Terri Lawton, Becky Kizer
Absent:	Jennifer Ewing, Mark Murray, Sarah Lambert

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m.	
2. Welcome	• New committee members Anna Milligan, CHC Board member, and Craig Harrell, Director of Marketing & Access, were welcomed to the committee.	
3. Minutes	• The minutes of the 11/15/16 meeting were approved by consensus.	
4. Committee Education	• We created a quality reporting calendar for 2017 to track when various items will be reported each quarter. We may not talk about everything each quarter, but we will be following them on the calendar. Some things may come up along the way that may be added as well.	
5. Quality Reporting	• Quality reporting includes the HIS (Hospice Item Set) and CAHPS (Consumer Assessment of Healthcare Providers Survey). 15 staff attended a HQRP (Hospice Quality Reporting Program) provider training. Public reporting will be coming in late summer 2017. We have been at 100% in the timeliness of submitting the HIS data. In 2017 there are two new final quality based measures. One is the number of hospice visits and by whom within three to seven days prior to death. The other is a hospice and palliative care composite process to measure the comprehensive assessment at admission. This is data we are already pulling. For the visits before the death, there is not an expectation of who visits the patient. CMS just wants to see if someone went, so this is in the data collection phase. • The public reports will show the HIS measures and results of the CAHPS surveys. There is an NHPCO webinar today about quality and regulatory topics. The primary HIS area we need to focus on is pain assessment, which was 52% in the fourth quarter 2016. The first screen asks if the patient has pain—yes/no. If yes, there are further	

Topic	Discussion	Action
	questions to find out more about the pain so it can be effectively treated. Rebecca F. and Tammy H. reviewed the data over a period of time to see how we are extracting the data and found we were not giving ourselves credit enough for the comprehensive assessment. The nurses are doing the comprehensive assessment, but not documenting it correctly on the HIS. There are seven areas for pain assessment documentation: location, severity, frequency, duration, character, relief measures, and effect on quality of living or function. CMS wants to see at least five of the seven elements documented. Tammy set up the format of the initial assessment so it matches the HIS. We will also check with IT if that could automatically populate, so the nurse doesn't have to enter it twice. Tammy educated the admission nurses on HIS last week and will also educate the Hospice House nurses. This has also been identified nationally as a trend with other hospices. We will continue to monitor it. • CAHPS – Most of our marks for help with symptoms and understanding side effects score in the 80's. Nurses were educated in January on the care kit medications. We also have a process in place to print education materials for patients/families. Rebecca has been trained by Press Ganey to create custom reports to drill down into the CAHPS data.	
6. Education & Training	• We offered a lot of education to staff in the fourth quarter on various topics. Congratulations to Kathy Eash, Nurse Practitioner, for completing her certification in hospice and palliative care nursing in December. NHPCO offers webinars twice a month. We also purchase the archived versions so they can be downloaded and viewed by other staff.	
7. Extubations in Hospice House	• We have seen an increase in the number of extubations in Hospice House. For the last five cases an IDT was held and all team members were present on all cases. Protocol documentation was checked and the admission orders and identification of an attending were done, all consents signed, education and expectations managed prior to admission, and all five cases had documentation present of the need for palliative extubations and family agreement and understanding prior to arrival to Hospice House. We also reviewed the documentation after the patients arrived at Hospice House. Two of the five were lacking in some portions of their documentation and those staffs were educated on the correct procedure. We will be creating standardized documentation expectations for palliative extubations in Hospice House and a checklist to help manage quality outcomes and documentation.	

Topic	Discussion	Action
8. HIM Committee Report	• We are close to being able to eliminate the hard charts and having a full electronic medical record. We have created a binder for each office of hard copies of emergency forms and documents for use during a major power outage. The LCDs and communicable disease screening forms for entry into Hospice House are now electronic. The live discharge data is now collected and reviewed concurrently by QA staff instead of retrospectively. All hospice patient care policies were reviewed and updated in 2016. The patient family handbook, notice of election form, and general consents were revised to match the OIG compliance recommendations. Closed chart turnaround time improved from a backlog of three months in 2015 to less than two weeks in 2016. Paper forms and documents are now housed in a centralized electronic repository in QA and forms are now housed in file cabinets instead of on shelves. • In 2017 we will be working on creating custom reports for Hospice House admissions, symptom management, and levels of care. We are also working on cleaning up the files on the staff website and aaa.common drive. We continue to examine the HQRP/Public Reporting data for and "just do it" projects such as HIS data collection, live discharges, and family satisfaction. We are also working on performance improvement projects for home health QAPI data.	
9. Specialty Programs Committee	• The number of patients in the HeartWize program averages in the 80's and BreatheEasy averages in the 50's-70's. The goal is to keep patients out of going to the ER and being admitted to the hospital. Overall we are doing very well in keeping these patients where they want to be - at home.	
10. Home Health Program	• Will be tabled until the next meeting.	
11. Infection Control	• We do a number of projects related to infection control. In 2016 we did the annual staff education on Bloodborne pathogens. All of the infection control policies and the exposure control plan were reviewed and updated. We continue to review different styles of nursing bags. Every October we now hold a trunk fair to monitor the medical supplies and equipment stored in the nurses' vehicles and nursing bags. • In 2017 we will continue to educate and implement the infection control policies approved in 2016. We will be doing a mock hospice survey in anticipation of our survey later this year. We will update the infection control education presented during new employee orientation. We will update the annual Bloodborne pathogens staff education and competency validation. We will also work on identifying patients with	

Topic	Discussion	Action
	an MDRO and implement a new infection control policy for MDRO.	
12. Caregiver Information	• All staff has been educated on the importance of obtaining complete and accurate caregiver information such as name and address. Out of 50 admissions, only one had a missing address of the caregiver. From 12/06/16-02/23/17 there were 405 admissions and of those, 23 had incomplete caregiver information or 5.7%. Before we began the QAPI it was 41%. After a death, Laura Lord gets the caregiver information and verifies the spelling of names, addresses, etc. From 12/06/16-02/23/17 there were 264 bereaved clients and only five had no address. We discovered a couple of those had no bereaved, so we need to develop a way to communicate that information to the team. Admission sends an email to bereavement to notify them there is no bereaved. We need to find a way to put that in the system and not just an email.	
13. Medication Timeliness	• We ended 2016 with an 82% overall compliance rate of documenting medications in the home, so the threshold for 2017 will remain at 85%. We started at 74% and are now in the 80's. We just started this requirement in 2016. If the nurse cannot document while in the home, they need to email Tammy why not.	
14. Patient Safety	• There were no adverse event trends noted and no serious injuries related to adverse events. 18 falls occurred in December where the patient left their walker somewhere else in the house. There has also been an increase in falls in ECFs. Alice W. is working on this. Most of time the case manager has already identified a trend. There was one fall at home that resulted in a fractured hip not related to the terminal diagnosis. Medication errors – we discharged one patient for cause for repeated abuse of drugs. We tried several ways to get this to work, and Dr. Gifford reviewed the record, but there was nothing more we could have done in this case. • The Consumer Concerns Committee held its quarterly meeting and no trends or concerns were identified.	
15. Spiritual Care	• In 2016 we created quality indicators for spiritual care based on the CoPs and the health care chaplaincy network. We created a spiritual screening to be used on admission and a daily admission report for spiritual care that provides pertinent information regarding immediate needs or concerns. We also created a spiritual care brochure. IT created a custom report for use within Cerner that will incorporate an established spiritual assessment tool and our own Spiritual Comfort Measures for patients and Spiritual Health Assessment for caregivers.	

Topic	Discussion	Action
16. Social Work	• This quarter we focused on social work care planning and the content of the comprehensive assessment. We have two "just do it" projects going on for care planning. One goal is to have a care plan for each specialty program (HeartWize, BreatheEasy). For comprehensive assessments, we want to make we are including all of the elements of the social work CoPs. We also want to incorporate the dementia and veteran questionnaires so that information is all in one plan. • The social workers were also trained on doing peer reviews. We educated them on what we are looking for in a social work IDT note based on CHC's documentation standards. We will continue to review these at future social work meetings so staff can learn from each other.	
17. Nursing Care Plans	• Per the CoPs the care plan needs to be reviewed and updated when there is a condition change and at least every 15 days. We review care plans every 14 days and as conditions change. We set a threshold of 90%. We discovered a trend that the LPNs, triage nurses, and visit nurses were not updating the care plan when they identified a condition change and initiated interventions, so that may have contributed to some of the misses we are seeing. Those nurses will be trained on updating the plan of care in March and April. The patient care coordinators also addressed noncompliance with individual nurses. Going forward we will look at the care plans and make sure they are not too cumbersome.	
Adjournment	• The meeting adjourned at 9:00 a.m.	Next meeting 05/23

Center for Hospice Care
Professional Advisory Group Meeting Minutes
March 28, 2017

Members Present:	Carol Walker, Dave Haley, Donna Bailey, Greg Gifford, Mark Murray, Rebecca Fear, Sue Morgan, Becky Kizer
Absent:	Amy Knapp, Anna Wasierski, Judy Jourdan, Vick Gnoth

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 03/29/16 meeting as presented. The motion was accepted unanimously.	S. Morgan motioned R. Fear seconded
3. Home Health Administrative Review	• The home health census in 2016 began with 20 and ended with 27. We had a total of 103 unduplicated admissions, 107 total admissions, and 86 unduplicated discharges. 52 of the 86 discharges were to hospice care. The majority of the referrals came from physicians and Michiana Hematology Oncology. The primary referral diagnosis was cancer. 58 of the admissions were Home Health Medicare, 41 commercial insurance, and 8 self-pay.	
4. QI Summary	• Home health quality and performance improvement projects are reported at the quarterly Quality Improvement Committee meetings. Program quality and adherence to federal and state regulations was a focus in 2016 to ensure compliance. QA works closely with Admissions to insure we are consistent and meeting timelines for the completion of documentation. We implemented a new monitoring tool and a new home health admission procedure last fall. The OASIS Admission for Stare of Care is reviewed by QA. The assessments are not locked until they are reviewed by Donna B., and then they are locked and submitted.	
5. Home Health Records Review	• One of our ongoing quality measures is making sure the OASIS start of care/resumption of care match the end of care OASIS. If the assessment falls outside of the prescribed CMS timelines, it is considered not quality. The federal threshold is 80% and will be increasing to 90% in the next reporting period. We were at 96.8% compliance. The quality measure reporting is based on the OASIS data collection and is compiled into a quality report. We can create performance improvement projects based upon our scores. OASIS is only submitted on Medicare and Medicaid patients. If the sample size is too small to be of any value, sometimes the elements are not included in the reports.	

Topic	Discussion	Action
6. Probe & Educate Audit	• CMS conducted a Probe and Educate Audit on all home health providers in 2016. This consisted of five chart reviews for every agency. The main focus was on compliance with documentation on the face-to-face requirement. Two of our five audited claims were denied, which may necessitate a repeat probe review with a new sample of five claims. As a result, we reviewed all patients admitted to home health since the audit findings, and have implemented admission criteria guidelines to make sure all compliance elements are in place.	
7. Policy Review	• All of our home health policies were recently reviewed. We found some of the language in them was mirroring the hospice policies, so those were changed to meet the home health regulations. The new Home Health Conditions of Participation have been finalized and go into effect 07/01/17, but the interpretive guidelines have not been published yet. Once we have those, there may be additional changes to these policies. A motion was made to accept the revised home health policies as presented. The motion was accepted unanimously. • New Policy – Another agenda item was added to review a new policy, "Program Evaluation." Per the Home Health CoPs, the Professional Advisory Group will annually review the agency's policies including the policy on program evaluation, which we never had in writing. • A motion was made to accept the Program Evaluation policy as presented. The motion was accepted unanimously.	G. Gifford motioned D. Haley seconded M. Murray motioned G. Gifford seconded
Adjournment	• The meeting adjourned at 8:25 a.m.	Next meeting March 2018

Center for Hospice Care
choices to make the most of life

CHAPTER FOUR

POLICIES

Center for Hospice Care

DISCHARGE CRITERIA

Section: Patient Care Policies Category: Home Health

REGULATION: 42 CFR 484.48 – Clinical Record

PURPOSE: To ensure appropriate discharge from Agency services.

POLICY: The patient/primary caregiver (PCG) will be notified 15~~five (5)~~ days in advance, unless the following conditions exist:

- The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient.
- The patient refuses the home health agency's services.
- The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge.
- The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.

A home health agency must continue, in good faith, to attempt to provide services during the 15~~five (5)~~ day period. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented.

After the decision is made for discharge, the patient/PCG will be notified. At the time of discharge, ~~an IDT note and~~ a CHC Discharge Note~~Summary~~ is completed, and if applicable, a Discharge OASIS~~.~~ ~~Complete a Discharge Summary under Patient Note in the computer. Begin note by stating it is a discharge summary. If deceased, information in the note will include:~~

- ~~Date and time of death~~
- ~~Who was present at death and reaction~~
- ~~What doctor was notified, who will sign death certificate~~
- ~~What funeral home was contacted~~
- ~~Pharmacy notified~~
- ~~DME/IV provider notified~~
- ~~Offer to dispose of narcotics~~
- ~~Family aware of bereavement services~~
- ~~Complete discharge OASIS (if applicable)~~

~~If discharged for reason other than death, complete discharge summary stating reason for discharge.~~ For Medicare patients who no longer qualify under Home Health Medicare, see policy, "Discharge: Termination and Expedited Appeals Notice Requirements.

Effective Date: 02/97	Revised Date: 02/17 ~~03/09~~	Board Approved: 04/15/09
Reviewed Date: 04/14		Signature Date: 04/15/09

Signature: President/CEO

PURPOSE: To provide guidelines consistent with the National Hospice and Palliative Care Organization's (NHPCO) policy for individuals who express the intent to commit suicide.

PROCEDURE: When an individual declares the intent to commit suicide, staff will follow these guidelines and document all communications in the chart:

Hospice Patient/Caregiver

- Inform the individual that the hospice philosophy and Agency policy is to value life and staff will respond seriously to any expressed intent to harm oneself.
- Inform the individual~~patient~~ that information regarding the intent to harm self and/or hasten death cannot be held in confidence.
- Communication must be made as soon as possible to a supervisor and licensed health clinician ~~social worker~~ for assistance in intervention.
- Request a licensed mental health clinician~~social worker~~ do a risk assessment.
- If during the risk assessment there is a risk of clear and imminent danger identified/found for the individual, ~~family, or staff,~~ the police should be notified by calling 911.
- Notify the Power of Attorney/Health Care Representative/Primary Caregiver and attending physician of individual's suicidal ideation and gather information and recommendations.~~Share information with the family members and attending physician.~~
- ~~Follow any recommendations made by the physician.~~

Mandatory Interdisciplinary Team (IDT) Meeting is Held:

- ~~Call an IDT meeting to p~~Present the information gathered, including recommendations from the attending physician.
- Care team will ~~and~~ decide upon a plan of care, which might include further exploration of the issue, treatment of underlying symptoms, increased support by staff and/or volunteers, attention to precipitating factors, or referral to a mental health agency.
- Select a member of the IDT ~~team~~ to provide regular follow-up with patient/ family.

Signature: President/CEO

- Care team will decide which staff will ~~D~~document the IDT meeting.~~all circumstances surrounding the situation.~~

Bereavement Client

- Bereaved client or parent/guardian of a minor is informed on intake of confidentiality and the limits, including serious threat of harm to self.
- Inform the individual that the hospice philosophy and Agency policy is to value life and staff will respond seriously to any expressed intent to harm oneself.
- Remind the~~Inform~~ individual that information regarding the intent to harm self and/or hasten death cannot be held in confidence.
- ~~Verbal c~~Communication must be made as soon as possible to the Bereavement Coordinator or a supervisor.~~and bereavement counselor for assistance in intervention.~~
- The~~Request a~~ bereavement counselor completes a risk assessment.~~or social worker to do a suicide risk assessment.~~
- If during the risk assessment there is a risk of clear and imminent danger identified/found for the individual, ~~family, or staff,~~ the police should be notified by calling 911.
- Bereavement counselor notifies the emergency contact listed on the intake form by phone. ~~Follow any recommendations made by the physician~~.
- The ~~Call a team meeting to present~~ information gathered is reviewed with the Bereavement Coordinator/supervisor and updates are reflected in the ~~and decide upon a~~ plan of care, which might include ~~further exploration of the issue, treatment of underlying symptoms,~~ increased support by staff,~~and/or volunteers,~~ attention to precipitating factors, or referral to a mental health agency, psychiatrist, etc.
- A bereavement counselor will provide regular follow up with the individual/ family.
- Document all circumstances and action plans surrounding the situation in Progress Notes in Cerner.
- After Hours – Triage calls nursing leadership. On call social worker will do a suicide risk assessment.

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REGULATION: 42 CFR 418.106(a) – Managing Drugs and Biologicals

PURPOSE: The hospice must ensure that the interdisciplinary team confers with individuals with education and training in drug management to ensure that drugs and biologicals meet each patient's individual needs.

PROCEDURE: **Initial Medication Review and Profiling**

1. At the initial nursing visit the Admission Nurse will review all current medications and biologics the patient is taking.

2. The Admission Nurse will review this list for accuracy, repeated therapies, and any other relevant considerations related to medication therapy meeting the patient's individualized needs.

3. This review will include all prescription and over-the-counter medications, dose, frequency, and route of administration.

4. All current and valid medications will then be profiled into the patient's electronic medical record (EMR) for electronic interfacing with our pharmacy management agency.

Ongoing Medication Review and Profiling

1. Medications and biologics can be reviewed and updated by hospice physicians and nurse practitioners at the time of admission, weekly interdisciplinary team (IDT), Hospice House initial IDT, and other times as needed.

2. During these reviews the hospice physician or nurse practitioner will review for: (1) relatedness to the terminal prognosis; (2) efficacy of the medication regimen; (3) duplicate therapy and any other relative considerations related to medications meeting the patient's individualized needs.

3. Case Managers and visit nurses can review medications ordered and profiled in the EMR with patients or family members at any of the following times: (1) Care Plan review and updating; (2) during comprehensive assessments; (3) prior to recertification of hospice services.

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4. During medication profile reviews completed by nurses, they will be reviewing efficacy, appropriateness, relatedness to terminal illness, and any side effects of medication therapy and any other relative considerations related to medications meeting the patient's individualized needs.

5. The medication profile review will be documented in the EMR and updates are to be made in the medication profile for electronic interfacing with our pharmacy management agency.

Effective Date: 02/17	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

Signature:  President/CEO

Center for Hospice Care

PATIENTS WITH KNOWN OR DISCOVERED INFESTATIONS IN HOSPICE HOUSE

Section: Patient Care Policies Category: Hospice Page: 1 of 3

REGULATION: 42 CFR 418.52 – Patient rights

PURPOSE: To ensure appropriate patient care for those patients in Hospice House who are known to be infested with parasites ~~such as scabies, lice, and bed bugs~~.

POLICY: Any patient admitted for care at the Agency's inpatient units who are known or discovered to be infested with parasites will receive care in a manner to cure the infestation and protect other patients from the spread of the parasites.

PROCEDURE:

1. Instruct the patient/family that the patient's personal items will be limited to clothing necessary to transport the patient to Hospice House.

2. The Hospice House RN is to notify Maintenance and the Hospice House Coordinator via email of the patient's arrival (see Infestations Procedure Steps).

~~2.~~3. Inspect medications from home. If any evidence of parasites, double bag and order new medications for the patient.

~~3.~~4. When the patient arrives to Hospice House~~,~~ escort the patient to their room (or upon discovery of an infestation). ~~, p~~Place all personal items in a double bag and have the family take the items home with them. If no family is present, double bag patient clothing in clear plastic bags, securing each bag tightly at the top and place the bag in the closet in the patient's room. Clear bags are utilized to allow visualization of bed bugs and lice.

~~4.~~5. All linen used for patient care will be double bagged and placed in a hamper inside the patient's room, until it is picked up by the approved laundry service. In Elkhart, the double bagged linen will be thrown away in the dumpster.

~~5.~~6. Consult the hospice medical director to obtain an order for the appropriate product to use in the treatment of lice and scabies.

~~6.~~7. Personal protective equipment, i.e., ~~protective barrier~~ gown, gloves and shoe covers, will be worn by all staff, ~~and~~ volunteers, and family entering the patient's room. The PPE will be removed at the patient room door~~,~~ prior to leaving the room.

~~7.~~8. The patient will receive a bed bath/shower appropriate for the patient's condition in their room~~, i.e., bed bath, showers, etc.,~~ with products appropriate to treat the parasite. Following the bath, the patient will be clothed in hospital gowns only (no clothes from home). ~~Consult the hospice medical director for the appropriate product to use in the treatment of lice and scabies.~~

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~~8.~~9. Following the prescribed medical treatment for the parasite, patients will be assessed for reoccurrence of the infestation every shift.

~~9.~~10. Follow the appropriate process for room preparation, decontamination, and proper handling of linen for patients with infestations (see Infestations Procedure Step). ~~terminal cleaning process below for effective decontamination of the room upon patient discharge:~~

~~Bed Bugs~~

- ~~Empty the room of all personal care items, double bagging the items. Send double bagged items home with family or discard the bag in the designated dumpster.~~
- ~~Vacuum the floor thoroughly with a brush attachment. Wash the brush attachment in hot water and detergent after use.~~
- ~~Wash floors and walls with soapy water.~~
- ~~Vacuum the mattress and bed to remove any potential live bugs and debris. Thoroughly wipe the mattress with the Agency approved cleaning product.~~
- ~~Open and inspect electrical outlets and switch plates for signs of bed bugs, but do not wash them.~~

~~Lice~~

- ~~Do not survive long if they fall off a person and cannot feed. Nits cannot hatch and usually die within a week if they are not kept at the same temperature as that found close to the human body.~~
- ~~Vacuum the floor and furniture, particularly where the infested person sat or lay.~~
- ~~Clean mattress and pillows according to regular standards of terminal room cleaning.~~
- ~~Blankets and bedspreads are to be laundered or dry cleaned.~~

~~Scabies~~

- ~~Environmental disinfection using pesticide sprays or fogs is unnecessary and is discouraged.~~
- ~~Wear isolation gown, gloves, and shoe covers while cleaning the room.~~
- ~~Bag bed linens and hand the bag to a person outside the room door who will place the bagged linen in a biohazard bag to be placed in the laundry hamper.~~
- ~~Clean the room, furniture, and bathroom following the Agency policy on Hospice House Patient Room Cleaning.~~

~~10.~~11. Upon~~Report~~ the discovery of a parasite infestation, report to your supervisor and Maintenance immediately and complete~~. A~~ an incident report. ~~will be completed and forwarded to the Director of Nursing for appropriate follow up~~.

~~11.~~12. If a patient is discovered to be infested with scabies or lice ~~parasites~~ after their admission into Hospice House, any exposed personnel ~~all staff and patients~~ will be treated with appropriate medications according to physician instructions. ~~who have been identified as having prolonged, direct skin-to-skin contact with an infested patient before the patient has been treated.~~

~~12.~~13. In any event of a suspected exposure outbreak, Human Resources will be notified to identify staff and volunteers potentially affected. ~~A record with staff names and patient name and room number will be kept on file for two months after the discovered outbreak of infestation. Symptoms can take up to two months to appear in exposed persons and staff.~~

REFERENCES
Center for Disease Control and Prevention, Resources for Health Professionals – Institutional Settings
Cornell University, Guidelines for Prevention and Management of Bed Bugs in Shelters and Group Living Facilities

HOSPICE HOUSE: INFESTATIONS PROCDURE STEPS

At the time of Admission

1. Before patient arrives, place all items needed for bathing/showering in patient's room or shower room. Include gown, extra bedsheet, and isolation cart at door.
2. Upon patient arrival, escort patient to patient's room or shower room for bed bath or shower, including washing hair.
3. Double bag all personal clothing to send home with family. If no family, double bag patient clothing in clear plastic bags, securing each bag tightly at the top and place in patient's room until picked up.
4. RN is to notify Maintenance and Hospice House Coordinator via email of patient's admission.

During patient's stay in Hospice House

1. All linen used for patient care will be double bagged and placed in hamper inside patient's room until picked up by Laundry service (South Bend) or discarded in dumpster (Elkhart).
2. PPE (gloves, gowns, shoe covers) will be worn by all staff, volunteers and visitors entering patient's room and then removed at door and discarded in trash bin before leaving room.
3. When emptying trash, double bag all trash before taking to dumpster.

Upon patient's Discharge

1. Empty room of all personal care items.
2. Double bag and send home with family or discard in dumpster.
3. Vacuum mattress, bed, floor and room furniture with designated vacuum. Empty canister of contents into trash. When vacuuming is completed, take vacuum and double bag. Then give the bagged vacuum to Maintenance for cleaning and inspection.
4. Perform a complete room clean per Hospice House room cleaning checklist. Use quat solution for cleaning of all hard surfaces.
5. During normal business hours, RN is to notify Maintenance and Hospice House Coordinator via email of patient's discharge, so room inspection can be performed by Maintenance. ** If after hours, and the room is needed for immediate use, RN is to call Maintenance on call for room inspection.

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REGULATION: 42 CFR 418.60 – Infection control

PURPOSE: To manage and prevent the spread of certain infections which are resistant to antibiotics. These organisms can include, but are not limited to: MRSA, VRE, ESBL's, PRSP, *Acinetobactor baumanni*, and Clostridium difficile (C. diff).

POLICY: **General Guidelines**:

- Standard Precautions must be used in providing care for all patients, including those known to be infected or colonized with an MDRO
- These precautions are especially important during all contact with patients and their immediate environment, when the potential for contact with a patient's blood, any body fluid, secretions and excretions (except sweat). This includes contact with a patient's non-intact skin and mucous membranes(OSHA standards, 2001)
- When a patient with an MDRO (infected or colonized) is admitted, the registered nurse assessing the patient will make the determination whether the patient's care requires the use of Contact Precautions.
- Initiate Contact Precautions, if the patient has uncontrolled secretions or drainage and it is determined there is likelihood of contamination of clothing and potential for transmission to other patients
- Initiate Contact Precautions, if the patients home environment has evidence of poor compliance with Standard Precautions

PROCEDURES: **Patient Care in Home Care and in Hospice House**

1. When a patient with an MDRO(infected or colonized) is admitted, the registered nurse assessing the patient will make the determination whether the patient's care require Contact Precautions
2. Assure that documentation is present in the patient record for the presence of an MDRO infection or colonization and the precautions in place (Standard or Contact Precautions) is communicated to the entire care staff.
3. Communicate presence of an MDRO infection or colonization by completing an Infection Surveillance Report

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4. Minimize equipment taken into the home, such as nursing bags. Use only equipment necessary to provide patient care. If possible, leave the equipment in the patient's home or supply disposal one patient use equipment (e.g. stethoscope).

5. Any equipment soiled with body substance, secretions, or fluids will be cleaned by following the Housekeeping Cleansing and Disinfection policy and Exposure Control Plan

6. Educate the patients, visitors and in home care givers on use of Standard Precautions(or Contact Precautions, if deemed necessary) and appropriate environmental cleaning if needed

7. Hospice House patients will have a signage placed on their door to alert visitors to contact the nurse before entering.

Administrative Measures and Training

1. Prevention and control of MDRO's are an active part of the agency's infection control and quality programing.

2. Monitoring and analyzing surveillance data periodically to identify patients with MDRO's, these monitoring activities can include; resistance trends, common referral sources and staff compliance with standard precautions and hand hygiene

3. Infection control practices including, MDRO prevention and control is part of initial staff education and ongoing education for all clinical staff.

Attachments: Guide to Implementing Standard vs. Contact Precautions

References: Management of Multi-Drug Resistant Organisms in HealthCare Settings, 2006(CDC) www.cdc.gov/mdroGuideline2006.pdf. Retrieval date 6.1.16

Management of the Patient with a Multi-Drug Resistant Organism in the Home: Standard vs. Contact precautions, Mary McGoldrick, 2009

Managing Multidrug-Resistant Organisms in Home Care and Hospice, prevention and control. Mary McGoldrick and Emily Rhinehart. Home Health Care Nurse, 2007.

Effective Date: 03/17	Revised Date:	Board Approved:
Reviewed Date:		Signature Date

Signature: President/CEO

Guideline for Implementing Standard vs. Contact Precautions

Use when a patient is known to be infected or colonized with an MDRO. Assess the patient on admission and as needed to determine the type of precautions needing to be implemented.

	Yes	No
1. Secretions are contained or controlled—such as the patient is continent, or the urine and/or stool is contained in a brief/depends or collection device		
2. Wound or open skin is covered and any drainage is contained within the dressing		
3. Indwelling device— Indwelling Urinary Catheter, Tracheostomy, Central line. With drainage that is contained		
4. If the patient has a productive cough, this the patient adhering to good respiratory/cough etiquette		
If YES to all of the above questions, implement **Standard Precautions**—if NO for any questions 1 through 4 proceed to below		
5. Cognitively intact and competent. Is the patient or caregiver able to comprehend directions and instruction regarding infection prevention and control measures in the home?		
6. Cooperative and compliant. Is the patient or caregiver able willing to follow directions regarding infection prevention and control measures in the home? Such as: Covering mouth, using a tissue to contain respiratory secretions and disposing of them in waste can, routinely performing hand hygiene, etc.		
7. Cleanliness. Are patient's hands, clothes and home environment generally clean?		
If YES to questions 5, 6, 7, implement **Standard Precautions.** If NO to questions 5,6,7, implement **Contact Precautions**		

5 S's to prevent and control the transmission of MDRO's

- Standard Precautions—ALWAYS
- Stress hand hygiene before and after all patient contact, after glove removal and handling items in the patients home
- Select dedicated patient care equipment for the patient to use, when feasible or thoroughly clean and disinfect all shared equipment before and after use
- Surface barrier
- Schedule the patient for the last visit of the day, whenever possible

References:

McGoldrick, Mary(2009). Management of the patient with a Multidrug-resistant organism in the home: Standard Precautions vs. Contact Precautions

Apic Offical Guide to Infection Control in Home Care and Hospice, 2nd Edition 2006

REGULATION: 42 CFR 418.54 – Initial and Comprehensive Assessment of the Patient

PURPOSE: To provide a standard of care for all patients being admitted from an acute hospital facility to Hospice House (HH).

POLICY: Patients requiring General Inpatient (GIP) level of care, respite, or routine care in the inpatient unit setting will be identified through the interdisciplinary process.

EQUIPMENT: DME required for symptom management or safety of the patient will be ordered from Alick's Home Medical by the HH Nurse, and will need to be delivered to HH prior to patient transportation from the hospital.

PROCEDURE:

1. Admissions department will request a physician's order from the hospital if one has not already been written to admit the patient to HH. If the physician's order for hospice services is more than seven days old, the physician must be contacted and a new order obtained. The order is to include "Admit to Inpatient Level of Care at Hospice House."

2. All medications will be ordered by a physician or nurse practitioner in accordance with the patient's plan of care.

3. An interdisciplinary team (IDT) meeting must take place prior to HH admission. The IDT will be facilitated and documented by the Admission Department. Documentation will include full names of staff participating and must include a physician, admission nurse/representative, HH nurse, and a social worker. If a nurse practitioner is scheduled to make rounds on the day the admission is taking place, then the nurse practitioner should be included in the IDT. The spiritual care counselor may need to be included per team discretion.

4. The following information needs to be included in the IDT discussion:
   (a) Code Status
   (b) IDT discussion to include, but is not limited to:
      (1) Most recent vital signs if pertinent to eligibility
      (2) Mental Status
      (3) Pain
      (4) Respiratory – if pertinent to eligibility
      (5) Cardiovascular – if pertinent to eligibility
      (6) Gastrointestinal – if pertinent to eligibility
      (7) Genitourinary – if pertinent to eligibility
      (8) Musculoskeletal – if pertinent to eligibility
      (9) Skin – if pertinent to eligibility

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(c) Infusion/Access Sites – Femoral, jugular, and PICC lines will need to be discontinued/removed at the hospital prior to transportation to HH, unless the IDT deems necessary. Patients may be admitted to HH with peripheral sites. Upon arrival, the HH Nurse will determine patency to use or discontinue.

(d) Special consideration such as isolation precautions, safety concerns, or infestations. If a patient has been treated for C-Diff and continues to have loose stools, the patient will be placed in isolation upon admission. If the patient has finished treatment and has formed stool, isolation is no longer required.

(e) Social status to include POA, health care representative, family, as well as anticipated discharge plan/goal.

(f) Hospital contact person and phone number.

5. Consents will be signed by the Admission Nurse/Representative prior to transportation of the patient to HH. Consents will be either handed to the HH staff or uploaded to the patient's Outlook folder. The Admission Nurse will complete the TB and Communicable Disease screen. The Admission Nurse will complete the LCD and attach it to the Pre-Assessment contact in Cerner.

6. If an Admission Representative is completing the pre-assessment, a chest x-ray will be used to meet admission criteria. At the time of HH admission, the HH nurse will then complete the TB and Communicable Disease screen. The HH Nurse will then review the LCD in Cerner, update as needed, and lock the form.

7. After the pre-assessment has been completed and the IDT determines the level of care appropriate for HH admission, the IDT will review the patient's needs and begin to develop a plan of care. Once the IDT agrees to transfer the patient to HH, the HH Nurse will do the following:
   (a) Obtain and review the patient's chart.
   (b) Facilitate DME delivery to HH.
   (c) Call the hospital RN caring for the patient to obtain report.
   (d) Phone the HH physician or nurse practitioner to obtain orders for HH.
   (e) Fax new medication orders to Omnicare and request medication releases from the Emergency Drug Kit (EDK).
   (f) After the DME and medication releases have been received, the HH Nurse will call the hospital contact person to have them set up transportation.
   (g) Complete the new patient checklist which includes steps for admitting patients in Cerner.

8. After receiving the patient into the assigned HH room:
   (a) Perform a complete assessment.
   (b) Complete a Fall Risk Assessment.
   (c) Complete a Braden Scale Assessment.
   (d) Review HH services, environment, guest guidelines, and nutritional information sheet with the patient and family.
   (e) Continue to document status of patient, assessment, and treatment at minimum during each shift.
   (f) Discharge planning from HH will begin upon admission to HH.
   (g) Support Services staff will continue to follow the patient while in HH unless otherwise designated.

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REGULATION: 42 CFR 484.16 – Group of Professional Personnel

PURPOSE: To ensure an annual program evaluation is completed.

PROCEDURE: An annual program evaluation is completed each year as part of the annual budget development process. All managers are asked to evaluate their specific areas of agency programming and make recommendations for changes, additions, and deletions of programming as part of their annual budget requests. They are required to list all current programming expenses that may be eliminated for the upcoming year.

They are also required to provide details of any new programming requests. All new programming items must be substantiated by meeting the following criteria:
(a) Enhance patient care
(b) Directly increase revenue or decrease expenses
(c) Increase staff productivity

Any new requests for programming must meet all three requirements and be substantially and realistically defended in writing prior to being considered.

The outcomes of this annual program evaluation become the following year's budget, which is reviewed and approved by the agency's governing body.

Effective Date: 03/17	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

Signature: President/CEO