Center for Hospice Care
choices to make the most of life

Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
October 18, 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
October 18, 2017
7:30 a.m.

A G E N D A

1. Approval of August 16, 2017 Minutes *(action)* – Wendell Walsh (2 minutes)

2. President's Report *(information)* - Mark Murray (16 minutes)

3. Finance Committee *(action)* – Lori Turner (8 minutes)
   a. August and September 2017 Financial Statements

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

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

6. Board Education – Quality Assessment & Performance Improvement (QAPI) Program – Rebecca Fear (12 minutes)

7. Chairman's Report and Discussion of the 2018 Board Meeting Frequency Proposal *(information)* – Wendell Walsh (5 minutes)

Next meeting December 20, 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
August 16, 2017

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 7:30 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 06/28/17 meeting as presented. The motion was accepted unanimously.	L. Turner motioned M. Newbold seconded
3. President's Report	• Census – July ADC was 382 and through 08/14 ADC 368. The budget breakeven case-mix we need is 383, but we don't spend everything in the budget so actually with July's expenses we need an ADC of 348. We lost 10% of our census during the last four days of July, so August census started very low. 44% of July admissions died in seven days or less. Last Friday we lost nine patients, all with a length of stay of four days or less. • Our census in Skilled Nursing Facilities has decreased. One reason may be due to a disincentive from Indiana Medicaid via IGT (intergovernmental transfers) from several years ago. If a nursing home is owned by a county hospital, their Medicaid reimbursement is higher and the state doesn't have to provide their match portion. However, hospice patient days don't count towards these patient days or the additional payments, so this could be a reason why some nursing homes are not interested in putting people on hospice. They also often say they can do hospice and palliative car on their own. • We are attempting to streamline admissions as much as possible and break down internal barriers to eligibility. One concern is that due to the CMS audits of live discharges, the medical staff may not be approving patients for admission unless everything is perfect. CHC has a very low live discharge percentage compared to national and state averages. The only Hospice Medicare requirements for eligibility are they have to be Medicare eligible, and two doctors have to agree they would be surprised if the patient was alive in six months from now. We had a	

Topic	Discussion	Action
	good meeting with our admission and medical staff about this, and will get back together again on 09/01 to see how we are doing. • The reports from our professional liaisons from our referral sources are encouraging. Craig H. has been asking the liaisons to do investigative research of referral sources and if they have any issues. For many of them, their census is down as well. They are very happy with our response time. • Our live discharge rate is well below the state, national, and jurisdiction levels for hospice. Some of CMS' concerns are ineligible patients being admitted and then discharged alive. Our live discharge rate with length of stay of 61-179 days in 10/01/15-09/30/16 was 23.8% compared to 40.4% nationally. Our live discharge rate for no longer terminally ill in the same period was 7.9% compared to 16.4% nationally. • LaPorte Office – LaPorte Hospital decided they don't want to have a GIP contract with us. They said they don't have office space to rent, nor does Beacon. • Community-based palliative care – We are moving forward with a new palliative care product line as a way to keep in touch with patients that are not eligible for hospice yet. We will monitor them, once a month nurse practitioner visits, and keep better track of these patients and get them into hospice care at the appropriate time. • New HMB rates go into effect 10/01/17. The rates are based on the Core Based Statistical Area of individual metropolitan areas in the U.S. and their corresponding hospital wage index. We will be receiving one of the largest year-over-year increases in recent history. The St. Joseph County increase for Routine Level of Care is going up $6.31 per day for the first 60 days. • In the board packet is an article called, "What's the CHC Difference? Ten Things You Should Know." This will be in the next issue of the H&P physician newsletter, which is geared towards doctors and referral sources. Feel free to share this information with others. • In the board packet are charts showing the BreatheEasy and HeartWize statistics for 2016. Dave H. is working on a product line that we will be able to market to hospitals, Medicare managed care, acute care facilities, and insurance companies showing that we do an excellent job in managing these patients and reducing readmissions to the hospital. Our liaisons are getting excellent responses when	

Topic	Discussion	Action
	sharing this information. • We are looking into the possibility of using our inpatient units for patients with non-hospice related symptom management when they get out of hospital and before they go home or to a nursing home. We found in our research that this is not being done in any state in the country. Ohio passed a law for nursing homes to have specific palliative care beds, but it didn't include hospices. Mark is meeting with the Indiana State Department of Health Director of Acute Care and the Assistant Commissioner of Health, along with the Executive Directors of the Indiana Hospice and Palliative Care Organization and the Indiana Association for Home and Hospice Care, on 09/01to discuss it further. • Craig H. and Char Yutzy, RN, went to Washington, DC for the Hospice Action Network Advocacy Intensives to meet with Representatives and Senators. Five people represented Indiana. They were asking the legislature to support the Rural Access to Hospice Act and the Patient Choice and Quality Care Act. • The 32nd Annual Walk for Hospice was 08/12. The St. Joe Valley Street Rods presented us with a check for $15,000. Over seven years they have raised more than $101,000 for CHC by selling Barnaby's pizza coupons. Lube-A-Thon at Tom's Car Care Center in South Bend was held on 07/28. The SJRMC Board held a retreat at our Mishawaka office yesterday. We are available for other board meetings. The more people we can get here, the better to enhance who we are and what we do.	
4. Finance Committee	• June – Operating income $1,756,358, MADS revenue $35,700, total revenue $2,167,742, total expenses $1,729,547, net gain $438,195. YTD June operating income $10,711,308, MADS revenue $227,627, total revenue $12,309,425, total expenses $9,639,737, net gain $2,669,688, net without beneficial interest in Foundation $1,319,794. • July – Census declined in July. ADC YTD 394 and budgeted to be at 402 at this point. Operating income $1,729,680, MADS revenue $32,682, total revenue $1,994,831, total expenses $1,622,576, net gain $372,255. YTD July operating income $12,440,988, MADS revenue $260,310, beneficial interest in Affiliate $1,580,865, total revenue $14,304,257, total expenses $11,262,313, net gain $3,041,944 net without beneficial interest in Foundation $1,461,079. • YTD compared to budget – Operating revenue is $249,000 below budget.	

Topic	Discussion	Action
	Expenses are $1.3MM below where budgeted to be expense-wise. We have not hired some positions or utilized some hours. We have also had some savings in direct patient care costs due to some changes with medications that went into effect last year. We didn't have a good handle on what those would be when we were planning the budget last year. There are also some building and grounds things that have not happened yet. • A motion was made to accept the June and July 2017 financial statements as presented. The motion was accepted unanimously.	J. Hsieh motioned A. Mauro seconded
5. Policies	• "Hospice House Admissions" combined a number of policies and spells out the steps for patients in the home that need to be moved to Hospice House for symptom management. It includes a flow chart for staff to follow to make sure a step is not missed. We try to manage symptoms in the home first. If Hospice House is full, we could do Continuous Care in the home with an RN for 4-8 hours, or send the patient to a hospital under our GIP contract. • "Medication Administration in Hospice House" combined another policy. This includes the schedule for administration of routine medications. • Once policies are approved, we do educate staff and monitor follow up to make sure they are following the policies correctly. • A motion was made to approve the two policies as presented. The motion was accepted unanimously.	C. Walker motioned A. Milligan seconded
6. Foundation Update	• Overall giving has been up year over year for the last five years. Through 37 months of the Crossroads Campaign to raise $10MM, we have a total of $8.75MM in total cash, pledges, and documented bequests. We have a verbal commitment for $750,000 and once we have the documentation, our campaign total will be at $9.5MM. • The PCAU biennial conference is August 24-25. We are once again co-sponsors. Two employees, Holly Farmer, Bereavement Coordinator, and Kristiana Donahue, Volunteer Recruitment Coordinator, will be going along with Cyndy Searfoss, Denis Kidde, and Mike Wargo. Holly and Kristiana submitted abstracts for the conference and were selected by their scientific committee to make presentations. After the conference they will spend time with their PCAU counterparts. Cyndy and Mike will be presenting on "Collaborations Enhancing Service Provision." Cyndy is there now and helping to audit Road to Hope files. Then they will be in	

Topic	Discussion	Action
	the field, attending meetings, and participate in working sessions with PCAU staff, stakeholders for GPIC, and meeting with different organizations like Catholic Relief Services, Feed the Hungry, Mulago Hospital School of Nursing, Hospice Africa Uganda, Uganda Martyrs University, the Congregation of Holy Cross, and the APCA. • Mishawaka Campus – We acquired the former Smith house. The terms of our buy/sell agreement with the city are we would buy the house for $245,000 and sell it to the city for $150,000, so there would be a $95,000 gap. For the $95,000 difference, the city will demolish the house, clean up the site, remove trees along the riverbank, remove the temporary Riverwalk connection, expand our Center for Palliative Care parking lot, and extend the Riverwalk to the Cedar Street bridge, which will give us more privacy and other things. The cost if we did it ourselves would be $150,000-$250,000. Plus the city is doing the landscaping. We get approval over the final design. The city hired our engineer for the final part of the Riverwalk. City officials are extremely happy.	
7. Board Education	• Mike Wargo gave a Hospice Foundation Update. We have had several special third party events as follows: • The Ninth Annual Bike Michiana for Hospice is 09/17. We have a great collaboration with the Bike Michiana Coalition. • Last year was our first Veterans Memorial dedication ceremony. • The 2017 Helping Hands Award honored first responders. We have received a lot of great feedback from the 19 departments we recognized. • The Elkhart Gardens of Remembrance and Renewal event was held in June. We will eventually hold the same event at the Mishawaka campus for people to donate benches, trees, bricks, etc. • The first "Journeys in Healing" art exhibit and silent auction was held in June. About 175 people attended—the largest to attend an in-house event. The event raised money and awareness of the program. We are trying to figure out if this could be an annual fundraising event going forward. Gross proceeds from this event were $6,700. • The Walk for Hospice was held on 08/12. • The Combat Veterans Association showed up to see the veteran memorial and did	

Topic	Discussion	Action
	a check presentation. • Lube-A-Thon was 07/28 at Tom's Car Care Center in South Bend. $3,698. Cumulative to date $62,927. • The 19th Annual NCIAIFA golf outing was held on 08/02 and raised $2,445. • The South Bend Sob Busters held their annual Mud Bog fundraiser for CHC. • St. Joe Valley Street Rods presented a check for $15,000. Over the years they have raised over $101,000 for CHC. • A local credit union had an employee fundraiser for CHC. • We are moving the publication dates for Choices and Crossroads. Each will now be published twice a year. Crossroads will have a CHC related section and vice versa. This will save us money and also help with messaging and not sending out too much material from the same organization at the same time. • Education and Collaboration – We are beginning to work on a website for the Center for Advance Care Planning & Education. Areas on the website will have things related to this. • We held the biennial "Introduction to Hospice & Palliative Care" course at Notre Dame. • We had three screenings of Frontline's "Being Mortal." Each event was well received and attended. • We have been working with Honoring Choices Indiana North Central for about two years. They had previously been called the Michiana End-of-Life Coalition and the Michiana Life Wishes Coalition, among many different names. The state organization is Honoring Choices Indiana. We will be managing this organization through the Hospice Foundation and have filed a DBA with the Secretary of State so we can receive money on behalf of the organization, do tax letters for gift recognition, etc. It is in our Strategic Plan to be the convener for all issues involving advance directives. • The Vera Z. Dwyer Charitable Trust gave a $1.75MM gift to the Hospice Foundation. $1MM is a matching grant to create a permanent endowment to establish the Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine. $500,000 paid over five years is to fully fund the first five years of the Fellowship and to establish the South Bend Region Palliative Care Education Fund. $250,000 paid over five years is to support regional community education initiatives. Four	

Topic	Discussion	Action
	doctors that are current Fellows in the I.U. School of Medicine program will be rotating with us. Dr. Kayla Herget is the first one sponsored by the Dwyer Trust. • In January we took over ownership of Global Partners in Care. We now have partnerships in 15 countries, and have 75 partners from 26 states and one Canadian province. We will continue to give the annual GPIC Partnership Award. We also help orchestrate fundraising events, press releases, and sponsor a couple of scholarship programs. We are offering "Okuyamba" and "Road to Hope" to GPIC partners to use to raise awareness in their community and do fundraising for their partners. About 30 people at Notre Dame attended a meeting to hear what GPIC is doing. Now there is a renewed sense of interest in other countries and making connections there. Unless a donor specially designates their money is to go to PCAU or GPIC, it stays here. • Okuyamba Fest was held last October. We continue to support the work of people in Uganda. The mHealth app is in its third year of implementation from Notre Dame. The third annual Road to Hope camp was held. It is modeled after our Camp Evergreen. There are currently 57 children in the Road to Hope program. 54 are fully sponsored by individuals around the country. The "Road to Hope" film has been in several film festivals around the world. • The public phase of the Crossroads Campaign was rolled out in February, and then to a group in Mishawaka. There are several giving opportunities in the campaign. If you are interested, let Mike W. know. The primary area where we continue to raise money is for Hospice House. We need another $2.5MM to meet its goal. • The dedication of the Helping Hands Award Wall of Fame was held this year. Several past award recipients attended. We did a presentation on our plan to extend the Mishawaka campus. • Give Local Day St. Joseph County was held on 05/09. A total of $588,862 was raised on our behalf. We received a distribution of $324,672, plus another $264,190 was added to our existing fund at the Community Foundation of St. Joseph County. • Mishawaka Campus – We continue to move forward with plans for the next two buildings. We are also working on the design of two residential homes that will be constructed off of Comfort Place & Cedar Street that will be sold as a residential development. Part of our agreement with the city in getting land from them was	

Topic	Discussion	Action
	that at some point we would build a residential house to sell. We are looking at breaking ground in the fall on these houses. • In the GPIC arena, no one else was stepping up to run this program. We know how to do it and have been a successful partner. NHPCO has told us we are the best of the GPIC partners. We can take what we have learned and help other programs get to the same level. Our vision as an organization is to be the premiere hospice and palliative care organization for all end-of-life issues. GPIC and PCAU is just an extension of what we do. We never send donor gifts overseas unless the donor has designated us to do so.	
Adjournment	• The meeting adjourned at 8:55 a.m.	Next meeting 10/18

Prepared by Becky Kizer for approval by the Board of Directors on 10/18/17.

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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
October 18, 2017
(*Report posted to Secure Board Website on October 12, 2017)*

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:30 AM.
This report includes event information from August 17 – October 18, 2017.
The Hospice Foundation Board meeting follows in the same room.

CENSUS

The year-to-date (YTD) average daily census (ADC) thru June 30 was 398. That fell to 391 by the end of September. Prior to July, census had not been below 400 on any single day since April 11. July had 122 admissions and 142 deaths. Ten percent of the total census died in just the last four days of July. 44% of July's admissions died in seven days or less, 43% in August and 42% in September. August admissions were up 10% from July to 134 and deaths down to 113. However, the weekend of September 9&10 saw 17 deaths in 48 hours – a record. YTD thru September, referrals that our medical staff rejected as "not hospice eligible" were up to 82 compared to 62 at the same time a year ago – about a third more. A remediation and re-education plan is in effect. By the end of September, YTD referrals are down 5% from same time in 2016. Hopefully, we hit bottom in September. At the time of this writing, October ADC is 372. Our home health census is up 44% from last year which may be a symptom of the rash of "not hospice eligible" decisions and we may have been pushing patients into home health as a last resort to get them on census somehow. The conversion rate of referrals becoming admissions continues to be very good.

September 2017	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Patients Served	452	1,657	1,681	-1.43%
Original Admissions	120	1,271	1,296	-1.93%
ADC Hospice	337.20	357.04	376.99	-5.29%
ADC Home Health	26.70	30.53	21.26	43.90%
ADC CHC Total	363.90	387.57	398.25	-2.68%

August 2017	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	458	1,537	1,540	-0.19%
Original Admissions	134	1,151	1,155	-0.35%
ADC Hospice	335.23	359.49	377.07	-4.66%
ADC Home Health	30.42	31.01	21.16	46.55%
ADC CHC Total	365.65	390.50	398.23	-1.94%

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	**2017** Sept	**2017** Oct	**2017** Nov	**2016** Dec
S.B.:	224	227	223	227	228	226	212	203	213			220
Ply:	69	67	67	72	72	69	66	67	65			78
Elk:	87	86	87	95	97	99	94	88	77			96
SBH:	5	6	6	5	4	5	6	5	6			6
EKH:	4	3	4	4	4	4	4	3	3			4
Total:	390	388	387	402	406	403	382	366	364			404

HOSPICE HOUSES

September 2017	Current Month	Year to Date	Prior Year to Date	Percent Change
SB House Pts Served	34	280	268	4.48%
SB House ALOS	4.85	5.13	5.46	-6.04%
SB House Occupancy	78.57%	75.20%	76.23%	-1.35%
Elk House Pts Served	24	222	241	-7.88%
Elk House ALOS	3.58	4.52	5.26	-14.07%
Elk House Occupancy	40.95%	52.49%	66.06%	-20.54%

August 2017	Current Month	Year to Date	Prior Year to Date	Percent Change
SB House Pts Served	34	259	238	8.82%
SB House ALOS	4.56	4.91	5.37	-8.57%
SB House Occupancy	71.43%	74.78%	74.82%	-0.05%
Elk House Pts Served	27	204	219	-6.85%
Elk House ALOS	2.89	4.50	5.32	-15.41%
Elk House Occupancy	35.94%	53.91%	68.27%	-21.03%

PATIENTS IN FACILITIES

Of the 452 patients served in September 143 resided in facilities. Of the 458 patients served in August 161 resided in facilities. The average daily census of patients in skilled nursing homes,

assisted living facilities, and group homes during September was 122; August was 125 and September YTD was 129.

FINANCES

Karl Holderman, CFO, reports the September 2017 Financials will be posted to the Board website on Friday morning, October 13th following Finance Committee approval. For information purposes, the unapproved August 2017 financials are presented on the next page. Due to the addition of GPIC and the confusing nature (personal editorial comment) of "beneficial interests," I am now presenting within this report the same financial format which the board sees in the monthly financials and board meeting PowerPoint. The beneficial interest of GPIC rolls into the Hospice Foundation and the beneficial interest of the HF rolls into CHC. However, all three entities are separate organizations with separate boards of directors, but due to HF's status as an IRS Type II supporting foundation, we are required to report the beneficial interests. We will continue to have a combined year-end audit report in April of 2018, as usual, which will include all three entities within a single audit.

It should be noted that several unusual events took place in August that affect the combined monthly totals. One was the $97,000 loss on the sale of an asset with the HF. The asset was known as the Smith house. This is something we did not budget for and is certainly a different philosophical direction for the HF board, and one that made perfect sense. While the City of Mishawaka will be making more than $97G of improvements to the property by tearing down the house, extending the Riverwalk, putting in landscaping and additional parking lot for us, we have no way to mitigate the loss on the sale of the house to the city unless the City of Mishawaka makes improvements to our property before the end of the year -- like removing the current curved Riverwalk section that goes through our land. We have no reason to believe this will happen during this calendar year and the loss will remain on the 2017 HF finances. The HF also sent $100G to Indiana University School of Medicine as part of a local trust gift to the Crossroads campaign. The funds were received earlier this year and we must account for gift receipts when we receive them, as well as grant out the funds for the purpose they were given. However, we are debiting this amount over the last four months of the year to help cushion the disbursement. NHPCO has similar experiences on a regular basis. For example, receiving a $5MM grant from the Veterans Administration in the year it comes in and then accounting for prior year grant expenses over the following five years. The house was demolished the week of October 9th.

On 8/31/17, Hospice Foundation's Intermediate Investment Pool totaled $4,530,631 and the Long-Term Investment Pool totaled $19,446,507. At the end of August 2017, our combined (CHC, HF, GPIC) net gain is just over $3MM, with YTD investment gains comprising just over $2MM of that. Overall net w/o investments were $972,000. CHC alone at 8/31/17 was $512G below budget on revenue, but $1.5MM below budget on expenses. Combined total assets of all organizations were at $48.6MM on 8/31/17. Debt associated with the Mishawaka Campus project is $896,611, down from nearly $5MM earlier this year. At the end of August, the "all in" margin was 25% and CHC alone without fundraising, investments, and the beneficial interest(s) was 10%.

August 2017 Financial Information

August 2017	Center for Hospice Care	Hospice Foundation	GPIC	Combined
CHC Operating Income	1,639,765			**1,639,765**
MADS Revenue	38,427			**38,427**
Development Income		140,748		**140,748**
Partnership Grants			38,456	**38,456**
Investment Income (Net)		109,469		**109,469**
Interest & Other	1,370	3,071	559	**5,000**
Beneficial Interest in Affiliate	(49,657)	1,081		
Total Revenue	**1,629,905**	**254,369**	**39,015**	**1,971,865**
Total Expenses	**1,644,362**	**304,026**	**37,934**	**1,986,322**
Net Gain	**(14,457)**	**(49,657)**	**1,081**	**(14,457)**
Net w/o Beneficial Interest	*35,200*	*(50,738)*		
Net w/o Investments				***(123,926)***

Year to Date Summary	Center for Hospice Care	Hospice Foundation	GPIC	Combined
CHC Operating Income	14,080,753			**14,080,753**
MADS Revenue	298,737			**298,737**
Development Income (Net)		1,144,284		**1,144,284**
Partnership Grants			148,754	**148,754**
Investment Income (Net)		2,055,339		**2,055,339**
Interest & Other	23,464	55,130	128,973	**207,567**
Beneficial Interest in Affiliate	1,531,207	128,990		
Total Revenue	**15,934,161**	**3,383,743**	**277,726**	**17,935,433**
Total Expenses	**12,906,673**	**1,852,536**	**148,736**	**14,907,945**
Net Gain	**3,027,488**	**1,531,207**	**128,990**	**3,027,488**
Net w/o Beneficial Interest	*1,496,281*	*1,402,217*		
Net w/o Investments				***972,149***

CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

CHC participated in a Community Healthcare Disaster Drill on September 20. The mock disaster was a plane crash at the South Bend airport. Two of our crisis certified personnel from the bereavement department took part. Participation in this exercise allows us to meet disaster drill training required by the Centers for Medicare and Medicaid Services (CMS). Their new Emergency Preparedness Requirements will be implemented on November 15, 2017. CMS requires us to participate in one active drill and one table top drill annually. Our Assistant Director of Nursing, Tammy Huyvaert, RN, is acting as our representative on the Healthcare Coalition Preparedness Alliance. The CHC Safety and Emergency Preparedness Committee is updating and completing a revised Safety and Emergency Preparedness Program which will also bring us into compliance with the new CMS regulations. It includes a Hazard Vulnerability Analysis of our risk for various types of disasters. We have also been informed that we will receive a $1,500 grant from the state for our emergency preparedness needs. The money will be applied to our Universal Alert Notification System expenses. This is a system which automatically notifies all CHC personnel by email, cell phone and land line phone of a disaster situation.

Peter Baenziger, M.D., a Fellow from the Indiana University Hospice and Palliative Medicine program in Indianapolis, recently completed a four-week rotation through our program. He was already Board Certified in Pediatrics and received further training with two complicated CHC pediatric patients during his stay with us. One patient was a newborn with a congenital heart problem. He also participated in the extubating of an adult patient. Dr. Baenziger was very appreciative of his experience here and expressed that he had learned a great deal. Andrew Fellers, M.D., a Family Medicine resident at SJRMC, rotated through our agency for training from July 31 through August 25.

We have been able to develop a third option for the delivery of patient medications (for refills only) from our medication supplier, DeliverCareRx. Starting July 24, we have been able to order a three-day delivery service (versus a two-day delivery) on refills. When our nurses order this delivery method for refill medications, we save 40% on the cost of delivery. This reduces the delivery cost of these refills from $10.00 per delivery to $5.95 per delivery. During the month of August, we used the three-day drug delivery method a total of 86 times. This was our first full month of utilizing this method of drug ordering and delivery and the total number may increase further over time. We saved $348.30 in August. At this rate, annual savings would equal $4,180.00.

DIRECTOR OF NURSING UPDATE

Sue Morgan, DON, reports…

Saint Mary's College and Bethel College have had their School of Nursing Board Meetings, of which CHC is a member. Both schools will have a reaccreditation survey in the next 6 months and CHC will participate in the accreditation process.

Flu Shots were offered to all employees at the All Staff Meeting on September 27. The Clinical Staff with direct patient contact are required to receive the flu shot. Flu shots will continue to be offered during the first two weeks of October.

The Nurses were updated on Infection Prevention and Risk Reporting (incident reports). This was a self-learning packet to be completed independently and a post competency quiz.

We continue to prepare for our first hospice survey by Indiana State Department of Health in three years. This will be a Medicare hospice recertification and a licensure survey for the State of Indiana. "Ride alongs" were completed at each office to assure compliance with the Conditions of Participation (COP's). The Patient Care Coordinator accompanied a Case Manager on a home visit to evaluate infection control practices, HIPAA, and patient care. This prepares the case manager for a potential "ride along" with the actual surveyor. Additionally, mock surveys have been completed at all the offices. The focus is to educate the staff and review the current top ten hospice deficiencies as identified by CMS in preparation of the actual survey.

Saint Mary's College and Bethel College have utilized CHC for their community clinical rotations. Senior nursing students spend 8-24 hours with a Case Manager performing home visits and in our Hospice Houses.

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 September 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	431,871.55
May	332,141.44	416,792.85	446,125.49	427,057.81	635,004.26	579,888.08	574,854.27
June	427,098.62	513,432.22	534,757.61	592,962.68	794,780.62	710,175.32	1,066,118.11
July	487,325.01	579,801.36	604,696.88	679,253.96	956,351.88	1,072,579.84	1,277,609.56
August	626,466.72	643,819.01	783,993.15	757,627.43	1,042,958.42	1,205,050.76	1,346,219.26
September	724,782.28	736,557.59	864,352.82	935,826.45	1,267,659.12	1,297.009.78	1,466,460.27
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	149,569.94
May	51,753.98	90,909.04	40,825.52	100,285.70	160,178.34	93,318.98	142,982.72
June	90,718.18	92,036.89	65,815.51	97,258.66	159,776.36	127,315.24	146,200.17
July	53,536.39	62,069.43	69,939.27	38,243.88	93,586.27	52,394.52	61,505.45
August	83,202.86	64,017.65	92,732.69	79,015.87	86,606.54	97,470.92	63,593.03
September	94,000.56	92,808.58	80,335.67	84,011.71	99,931.45	92,459.02	120,261.01
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 August and September 2017 included meetings with donors and prospective donors as we progress through the first year of the public phase of our comprehensive campaign. Other activity included follow-up with employees expressing interest in participating in the Crossroads Campaign because of presentations made earlier in the year and follow up emails. Through 39 months of our 5-year campaign (7/1/14 thru 9/30/17) total cash, pledges and documented bequests total $9,117,354. We await documentation for the remaining $750,000 of a $1 Million gift pledged for the Hospice House. Inclusion of this $750,000 verbal commitment increases the total to $9,867,354.

We were invited by the Schurz Communications Foundation to submit a proposal for a Crossroads Campaign gift, and make a brief presentation to its board of directors on August 24. We were notified in early September that our proposal for a $100,000 gift was accepted. The Schurz Foundation pledge will be paid over the next five years. It will be directed to support construction of the new Hospice House and Clinical Staff Building. We are confirming Schurz Foundation's choice of naming opportunities.

A meeting took place with a prospective donor from Elkhart capable of making a significant gift, and follow up with this donor prospect will take place in early October. As expansion plans for LaPorte are taking shape, we have a meeting scheduled with the leadership of the Healthcare Foundation of La Porte on October 24 to advance our effort to gain its support.

Planned Giving

Work with a planned giving prospect continued in late August and through September. A follow up meeting took place at the donor's home. We learned that this planned gift will be directed to support CHC/HF's community education and collaborative partnerships. We were asked to draft specific language for this bequest to Hospice Foundation. The gift will total between $75,000 and

$100,000. On September 28, we received confirmation that our planned gift language was edited, reviewed and is now included as part of the donor's estate plan.

Annual Giving

We continue to receive donations in response to our annual Friends of Hospice campaign, which kicked off in May. We have begun planning for our Annual Appeal mailing which goes out in November.

Special Events & Projects

With a couple of events still to come, 2017 has proven to be a very busy year. We held our Heroes for Hospice Fun Run & Walk on August 12, which brought approximately 175 people to our Mishawaka campus and raised $12,278. Bike Michiana for Hospice, held on September 17, was another success with approximately 900 riders and participants. This year's bike event raised $79,680, and feedback on the ride was overall very positive.

Okuyamba Fest took place10/12. Upcoming events include our first Veterans Tribute Ceremony on 10/26, where we will dedicate donated memorial items. Jim McCloughan, who was recently awarded the Congressional Medal of Honor by President Trump for heroism in the Vietnam Conflict, is our guest speaker: https://www.army.mil/medalofhonor/mccloughan/

Our two event series sponsorships in Elkhart, Drive-in Fridays and Groovin' in the Gardens, wrapped up at the end of last month, and raised excellent brand awareness for Center for Hospice Care.

Partnership with the Palliative Care Association of Uganda (PCAU)

PCAU's bi-annual conference, which was held in conjunction with the Uganda Cancer Institute, was attended by more than 450 participants. While most were from Uganda, representatives from many other Sub-Saharan African countries, Europe and the US also attended. CHC's sponsorship was prominently displayed during the program and in the abstract/conference guide.

Center for Hospice Care employees Holly Farmer (Bereavement Coordinator) and Kristiana Donahue (Volunteer Recruitment Coordinator) presented at the conference and both presentations were very well received. Holly was part of a workshop titled, "Working with Children as Patients and Care Givers." Other presenters in that workshop included Prof. Julia Downing (CEO of the International Children's Palliative Care Network) and Ben Ikara (Uganda Child Cancer Foundation). Kristiana's presentation, "More Than a Heart: The Importance of an Effective Volunteer Training Program," was part of the Capacity Building break-out session on Thursday, August 24th. She continues to field questions via e-mail from attendees about building effective volunteer training programs. Mike Wargo, Cyndy Searfoss, Denis Kidde and Lacey Ahern also were part of the conference. They, along with PCAU board president Dr. Sam Guma held a well-attended workshop entitled "Collaborations Enhancing Service Provision" that provided information about the work of Global Partners in Care. The group held numerous meetings and working sessions with PCAU staff, GPIC and PCAU stakeholders, those involved in the Road to Hope program (including 15 children) as well as other staff exchange activities. Team member meetings included many organizations with whom we have various relationships, including Feed

the Hungry, Mulago Hospital School of Nursing, Congregation of the Holy Cross, Hospice Africa Uganda, Uganda Martyrs University, Kawempe Home Care, Ugandan Ministry of Health and the African Palliative Care Association (APCA). In addition, the team made new connections with several other organizations with which we may collaborate in the future, including: United Nations High Commission on Refugees (UNHCR), American Cancer Society, U.S. Department of State representatives working at the US Embassy in Kampala, International Association for Hospice & Palliative Care (IAHPC). The group also met with the six students currently enrolled in the Diploma in Clinical Palliative Care (DCPC) program sponsored by CHC. The students were effusive in their thanks for their sponsorship in the program and in conveying how they will be empowered to make palliative care available to those who need it when they return to the districts upon graduation.

Road to Hope Program/Documentary

Holly, Cyndy and Kristiana audited and digitized several of the Road to Hope files related to the 57 children currently enrolled in the program. After the resignation of the first Road to Hope coordinator in the spring, duties related to the position were handled by members of the PCAU staff. A coordinator, who managed a similar program at Hospice Africa Uganda, has been hired. Based on our audit and Road to Hope student visits, we will be working with Tom Marantette, Digital ND Lead Architect at the University of Notre Dame's Office of Information Technologies, to develop a mobile application to capture information about Road to Hope students gathered during field visits. The vision for this process is to dovetail this app with the mHealth app discussed previously. Trained community volunteers could be equipped with the same mobile phone used for mHealth and send information about the children they have referred to the program to PCAU offices on a regular basis. This monitoring would be performed in addition to scheduled periodic visits by the Road to Hope Program coordinator.

The Road to Hope documentary was screened on September 26th at the Addicott/Joshi Performance Hall on the campus of IU South Bend, courtesy of the Ernestine M. Raclin School of the Arts. The screening was attended by more than 25 people. Proceeds from the $20/ticket sales benefit the Road to Hope program, as do proceeds from the sales of Okuyamba and Road to Hope DVDs. Mike Wargo, Cyndy Searfoss and Marvin Curtis, dean of the Ernestine M. Raclin School of the Arts and composer of the film's original score, participated in a lively and engaged Q&A session following the film.

Education

The Hospice Foundation hosted internationally recognized speaker Donna Schuurman, Senior Director for Advocacy and Training and Executive Director Emeritus at The Dougy Center for Grieving Children and Families in Portland, OR for two half-day seminars for the community and counseling professionals. Schuurman shared her extensive knowledge on topics related to grief and families with CHC staff members from bereavement, nursing, social work and spiritual care as well.

Mishawaka Campus

We closed with the City of Mishawaka on the property at 209 N. Cedar Street. Though the difference between the purchase and sale prices resulted in a $97,000 loss for the Hospice Foundation, it was the right business decision and will ultimately result in significant non-monetary

gains. Under terms of the Buy-Sell agreement, the City will demolish the house, clean-up the site, remove the trees and overhanging brush along the river bank, remove the temporary Riverwalk connection that currently extends across our property to Madison Street, expand our parking lot at the Center for Palliative Care and extend the Riverwalk directly to the Cedar Street Bridge. These efforts by the City will exceed $97,000.

Work on planning for the new clinical staff building and inpatient facility has continued. Mike is now engaged in regularly scheduled, ongoing meetings with Helman Sechrist Architecture (architect), Jones Petrie Rafinski (engineer), DJ Construction (builder), Office Interiors (interior designer) and a host of contractors and subcontractors to prepare for a ground-breaking in 2018.

Residential Housing on Cedar Street

Architectural design is completed and construction cost estimates have been secured for construction of two new residential homes to be located at the corner of Comfort Place and Cedar Street. Chris Chockley, of Jones Petrie Rafinski, is working with the City of Mishawaka to have the parcel subdivided and replatted. Lauren Dunbar, of Cressy & Everett, has completed a competitive market analysis and we are now working to obtain written appraisals to determine appropriate asking prices. Construction on the first of the two homes can begin whenever we decide we are ready to move forward.

COMMUNICATIONS, MARKETING, VOLUNTEER, AND ACCESS

Craig Harrell, Director of Marketing and Access, reports on marketing and access activities for August and September…

Referral, Professional, & Community Outreach

Our Professional Liaisons continue to contact doctor's offices, clinics, hospitals, group homes and extended care facilities to build relationships and generate referrals. In August and September our three Liaisons completed 800 visits to current and potential referral sources within our service area. The Liaisons are making efforts to meet with referral sources, leadership to leadership. Our leadership team varies, but is typically our Director of Nursing, Admissions Coordinator, the Patient Care Coordinator, Director of Marketing & Access and the assigned Professional Liaison. It's been successful in getting the facilities to discuss issues and concerns that they're less likely to share in passing. In doing so, we can address and correct them and theoretically start with a clean slate. Sometimes there aren't any issues which allow us to the opportunity discuss in detail services they may be less familiar with and to solidify relationships. For many this is the first face-to-face they've had with people they've talked to on the phone for years.

In September Craig and Marketing Assistant, Barb King met with the Marketing Director of St. Joseph PACE. During the meeting, it was shared that a high percentage of their patients suffer from CHF. We shared about the effectiveness of our HeartWize and BreatheEasy programs in keeping patients from readmitting to the hospital or emergency room. We're in the process of developing a product that can be utilized specifically for St. Joseph PACE clients who may not yet be eligible for hospice and which would help them to remain at home.

In the last report, we announced that Char Yutzy, RN for CHC and Craig attended the Hospice Action Network's Advocacy Intensive in Washington, D.C. This event allowed us an opportunity to speak directly to our representatives concerning issues and policies affecting the hospice industry and to present our personal stories behind those issues. They met with Congressmen and Senators from Indiana to gain their support of bills that would allow hospice to be presented as an option earlier in an illness and make hospice more accessible for individuals in rural areas. In addition to Congressman Andre Carson (7th District) signing on to H.R. 2797 – The Patient Choice and Quality Care Act, we also learned that he cosponsored H.R. 1676 – PCHETA. Congresswoman Jackie Walorski (2nd District) has agreed to cosponsor H.R. 1828 - the Rural Access to Hospice Care Act and Indiana Senator Joe Donnelly will cosponsor S.693 – the Palliative Care and Hospice Education and Training Act.

Volunteer Department

Through my participation in National Hospice Executive Roundtable (NHERT) and some of their success in bringing the supervision of the Volunteer Coordinators under Human Resources, we decided to do the same. Policies and record-keeping procedures closely mimic those of HR and will allow marketing to focus on growing our census. An organizational announcement was made that as of September 1, supervision was transitioned to Vicki Gnoth, Director of Human Resources.

Volunteer Training & Recruitment

We interviewed 12 new volunteer candidates and had 34 new inquiries in August and September. The bulk of the inquiries continue to be from South Bend (31) while one was from Elkhart and two were from Plymouth.

Access

For the months of August & September, the Referral Specialists received 842 and 731 incoming phone calls to the Admissions Department, respectively. Our same or next day admits in September was an impressive 61.64%.

Website

During the months of August and September, CHC's website hosted 5,214 users, of which 66% were new users. Federated Digital Solutions (FDS) generated 1,269 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

In September, we created a Facebook Manager account to monitor all our Facebook pages (Center for Hospice Care & The Hospice Foundation) in one place. We've also had issues with Facebook creating separate, non-official pages that we must claim and merge into our existing page. We're sharing posts from both pages to give more exposure to The Hospice Foundation who has fewer followers. Also, with multiple employees being able to edit these pages, it becomes less burdensome on just one or two employees. We recently created a LinkedIn page for Center for Hospice Care, Indiana. Unfortunately, many of our employees had already either listed themselves

as working for Center for Hospice Care in Connecticut or working for The Hospice Foundation. We notified and instructed them on how to correct this and nearly all have made the necessary changes. The 'Behind the Scenes' that focuses on CHC employees has been so popular, that we've also added a 'Volunteer Focus' being published by Kristiana Donahue, Volunteer Trainer.

Facebook (Center4Hospice)

Center for Hospice Care's social media presence is increasing steadily. We continue to use Facebook to communicate information and events. CHC surpassed 3,500 followers, reached 61,195 people for August and September, had 165,943 impressions, 395 shares, and 141 comments. These metrics indicate marked growth across the board. Posts that performed particularly well were emotive, behind-the-scenes posts about staff members. We continue to run a boosted posts campaign for our Facebook which resulted in 10,633 actions at an average cost of $0.02 per action. This is fantastic performance and an increase of over 9,000 actions in August over July. Overall our ads reached 46,766 people, had 49,467 impressions and 2,678 clicks.

Posts in August and September reached a total of 86,985 Facebook members. Our two most popular posts occurred in August with the most popular featuring Camp Evergreen. It was our agencies first Facebook Livestream. The second highlighted the Elkhart facility. Both focus on the uniqueness of CHC.

Digital Overview

From August 1 - September 30, the digital campaign generated 77 calls. Google industry benchmarks show an average click-through rate in the Health & Medical field of 1.79%. In August-September CHC's click-through rate was 12.14%.

POLICIES ON THE AGENDA FOR APPROVAL

There are two policies on the agenda for board approval.

The first one is new:

"Anatomical Donation" -- covers staff instructions regarding insuring patient rights for those who have requested tissue, eye, or whole-body donation under the Uniform Anatomical Gift Act. This does not happen frequently, but we believed having a policy / resource readily available for staff is a good idea. We also have a staff person who was previously employed by the Indiana Donor Network and she assisted with this policy development

The other policy simply updates to reflect current practice:

"Meal Preparation" – changes were to include Hospice House and the fact that under the Retail Food Establishment regulations, staff may not "cook" food and that the stove is for the use of family members who wish to prepare food for their loved on. Families are not covered under the RFE regulations.

2018 BOARD MEETINGS AND POTENTIAL CHANGES TO FREQUENCY

For several months, the Executive Committee has been discussing changing the frequency of board meetings from six to four each year. A proposal from the Executive Committee is included in the board packet.

LaPORTE OFFICE UDATE

We have identified rental space 0.6 miles from the city limits of LaPorte thanks to Dave Haley and Google. It's located at 307 West Johnson Road, the most traveled county road in the state of Indiana which presents many vehicles seeing our sign and logo. It's in Phase I of the Legacy Hills Business Park which is adjacent to the Legacy Hills Golf Course. According to a well-known local resident who has agreed to be a CHC board member in 2018 to represent that area, it is in the "happening part of town." It's located northwest of the city of LaPorte and 5.4 miles or six minutes from the Toll Road interchange. It's eleven miles or 18 minutes from Michigan City. We would begin in a 1,522-square foot office for now and move into a larger office when Phase III of the office park is completed by the first half of 2018. We recently had nine patients in LaPorte County with four of them within the city limits. Other patients were in Michigan City, Rolling Prairie, LaCrosse, and Trail Creek. We currently have five contracts with nursing homes / assisted living facilities to provide hospice services within LaPorte County. The lease to commence November 1, 2017 was signed the week of October 2nd. There were no real estate brokers used.

MEETING WITH INDIANA STATE DEPARTMENT OF HEALTH REGARDING USING HOSPICE INPATIENT UNITS TO PROVIDE PALLIATIVE CARE FOR PATIENTS WHO HAD NOT ELECTED HOSPICE CARE YET

On 09/01 I met with the Assistant Commissioner and Director of Acute Care for the Indiana State Department of Health (ISDH) in Indianapolis. I was joined by the Executive Directors of the Indiana Hospice and Palliative Care Organization and the Indiana Association for Home and Hospice Care. ISDH had asked the Center for Medicare and Medicaid Services (CMS) about providing palliative care for non-hospice patients in a hospice inpatient unit prior to our meeting and CMS simply and abruptly said, "No." So as a group, we brainstormed about what to do and the fact that there is a need for this service. Some of the ideas discussed were a hospice / hospital joint venture using the hospital's license since they can provide up to 30 days of inpatient palliative care as a transition. Unfortunately, regardless of its size, such a facility would still have to be a mini hospital and follow the Facility Guidelines Institute guidelines for designing and building hospitals. This is not feasible for our project. We talked about asking the state legislature to expand the scope of state hospice licensure for non-hospice care in a hospice inpatient unit. But, licensure expansion is generally frowned upon by the legislature and the governor's office. It would also require an additional survey under rules that don't exist and the ISDH wasn't interested in that because they are only being paid by CMS for half the costs of the surveys that they are currently performing on behalf of Medicare. Another idea discussed was having licensing as a residential care facility (RCF) with home health care being brought in to provide palliative care. But the facility would need to meet the physical plant standards for an RCF as well have a licensed health facility administrator on duty. Depending on the number of beds / residents, it would need to be separate from the Hospice House. Finally, we discussed unlicensed beds that could meet the "separate and

distinct" CMS rules. We could have up to four beds that were unlicensed, would not require a survey by any entity, and we could provide palliative care via our home health license. This would require a wall and a door separating these up to four residential beds. They could share a common lobby and hallway. Those beds could not be used for a general inpatient (GIP) level of care under hospice. In providing care, the Hospice House nurse could see the patients and become a home health nurse as soon as she walked through the door. Payment would be primarily via home health insurance and private pay. A plus of having this ability would be to move a patient out of Hospice House to these beds when they and their family refuse to leave after they are no longer GIP. A downside would be we could have up to four empty beds on the residential side, have a full inpatient unit and another one coming and could not use the empty residential beds for GIP. Going this direction would require a change in the current architectural and floor plans which are very far along. Many hospice houses across the country have designated residential beds that are separate and distinct from the hospice inpatient unit. They are used for private pay respite and there is no requirement as to their health condition or meeting Medicare eligibility requirements for anything because Medicare doesn't pay for custodial care. But, depending upon their health condition, they could qualify for home health care and Medicare / Medicaid reimbursement and commercial insurance could pay. Due to the ongoing scrutiny by CMS regarding usage of the general inpatient level of care, the overall declining number of days nationally due to this scrutiny, the fact we are not currently using the 14 beds we have now at capacity, and the flexibility that residential beds will provide, it is my recommendation that after we receive written information regarding the CMS definition of "separate and distinct" that we ask the architects to examine how to physically meet those requirements in the new unit and have ten GIP beds and two non-hospice, non-licensed residential beds that will not be surveyed or inspected by any governmental entity. A preliminary architectural rendering of these two rooms that are "separate and distinct" has been completed by Helman-Sechrist and the week of October 14th I was informed the ISDH was interested in reviewing the plans.

NATIONAL HOSPICE EXECUTIVE ROUNDTABLE UPDATE

The National Hospice Executive Roundtable (NHERT) is a collection of eleven hospice CEOs from leading non-profit hospice agencies throughout the United States who meet in-person three times per year to develop and share industry best practices. I have been a member since 2009. Arguably, these are the eleven most influential non-profit hospice programs in America currently caring for over 7,000 hospice / palliative care patients each day. Meetings are usually rotated at member sites. You may remember that CHC hosted the group in June. We met at Ohio's Hospice / Hospice of Dayton October 8-10. Besides program updates, the new Pres/CEO of the National Hospice and Palliative Care Organization in Alexandria, VA visited our group in-person for a two-hour listening session. Other guest speakers included Charles M. Bane, MD, of the Dayton Physicians Network who presented an update on the Oncology Care Model. The CEO of Patients' and Consumer Pharma, Joe D'Silva presented an update on new compounding pharmaceutical products. We also toured the Hospice of Dayton inpatient units as well as the new administrative offices of Ohio's Hospice. Several programs reported a drastic drop in census which began at the end of July. While some of our members have recently retired, we have added some new members. The NHERT now is comprised of the CEOs from the following programs:

Care Synergy (The Denver Hospice, Halcyon Hospice, Pikes Peak Hospice and Palliative Care), Denver, CO.

Empath Health (Suncoast Hospice, Tidewell Hospice), Clearwater, FL
Ohio's Hospice (Hospice of Dayton, Hospice of Central Ohio, Hospice of Miami County, Community Mercy Hospice, Hospice of Butler and Warren Counties, and Community Care Hospice), Dayton, OH.
Bluegrass Navigators, Lexington, KY
Hospice of Northwestern Ohio, Toledo, OH
Arkansas Hospice, North Little Rock, AR
The Elizabeth Hospice, San Diego, CA
Delaware Hospice, Wilmington, DE
Midland Care Connection, Topeka, KS
Transitions LifeCare, Raleigh, NC
Center for Hospice Care, South Bend, IN

BOARD COMMITTEE SERVICE

Committee service by all board members is encouraged by the Executive Committee. A listing of the Committees of the Board and a brief description of each is attached to this report for your review. The Personnel Committee will be meeting in 2018 prior to June 30 to review the CHC and the affiliates 2018-2020 Human Resources Policy Manual. Also, please note the "Specialty Committees" section which is open to all board members.

CMS's NEW HOSPICE COMPARE WEBSITE "A MESS"

At the September NHPCO / HAN board meeting, NHPCO President / CEO (a former CMS Director) called the new Hospice Compare website, "…a mess." Demographic information (e.g. address, telephone, even tax status) is incorrect and some hospices in some zip codes don't show up as even serving the area where the public might desire to perform a compare. CMS has indicated they have no intention of correcting any errors until the next "data refresh" scheduled for some time in the first half of 2019. Banach said he will tell CMS to "…take it down" or NHPCO / HAN will request Congressional intervention to make them take it down. After careful review, CHC has not identified any such issues with our individual demographic information.

POLITICO ARTICLE "HOSPICE IN CRISIS"

I encourage you to read the article attached to this report. I have also attached NHPCO President/CEO Edo Banach's response. The article covers some of our biggest challenges, including the fact that we have a 30-year-old Medicare benefit for end-of-life care that has not kept up with a changing society, changing family structures, a surge in medical machinery and ICUs, the conveyor belt of high-tech medicine, stagnant rules and regulations, a medical fix is always within reach, chronic diseases – the slow-motion killers of prolonged deaths, and a system that pays for the volume of care and not the value.

OUT AND ABOUT

Mike Wargo, two HF staff and two CHC staff went to Kampala, Uganda in late August.

I attended Hospice Action Network and NHPCO Combined board issues sessions in San Diego on September 17.

Four CHC staff attended the NHPCO Interdisciplinary Team Conference in San Diego September 18 – 20.

I attended the National Hospice Executive Roundtable meeting in Dayton, OH October 8 – 10.

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

Dave Haley's Census Charts.

Proposal regarding frequency of board meetings beginning in 2018.

Description of Committees of the CHC Board

Press Release for Bike Michiana for Hospice.

Copy of article, "Yale Study: Earlier Hospice Care Would Improve Quality End of Life."

Copy of Politico article, "Hospice in Crisis."

Response on above article from NHPCO Pres/CEO Edo Banach.

Article from The Chronicle of Philanthropy regarding how fewer Americans are finding room in their budgets for charity.

Press Release regarding our 6th Annual Okuyamba Fest.

Copy of Compliance Committee Meetings 09/14/17.

Copy of QI Committee Minutes 08/22/17.

Two policies that are on the agenda for approval.

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

August and September 2017 Financials

Copy of the latest "H&P" Newsletter for referral sources. NOTE: This issue includes ten differentiators that separate CHC from all other competitors.

NEXT REGULAR BOARD MEETING

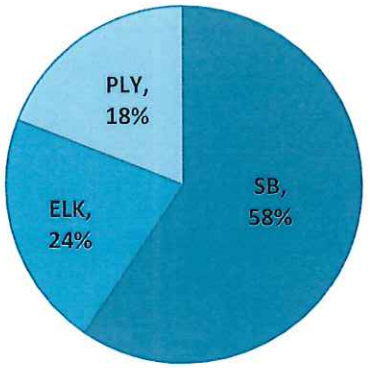
Our next regular Board Meeting will be **Wednesday, December 20th at 7:30 AM** in Conference Room A, first floor at the Mishawaka Campus, 501 Comfort Place, Mishawaka, IN 46545. In the meantime, if you have any questions, concerns, suggestions or comments, please contact me directly at 574-243-3117 or email mmurray@cfhcare.org .

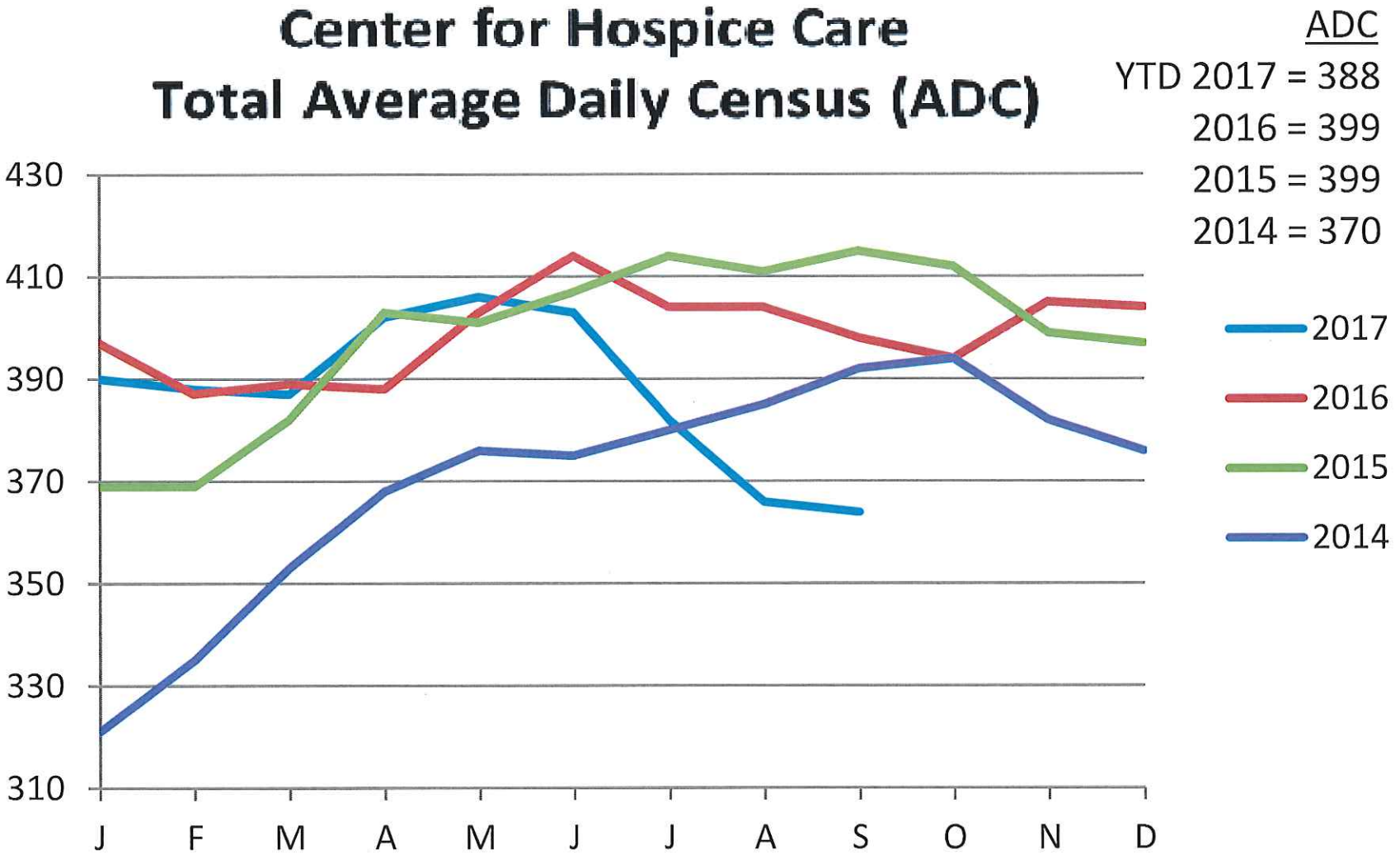
# # #

Center for Hospice Care
2017 YTD Average Daily Census (ADC)
(includes Hospice House and Home Health)

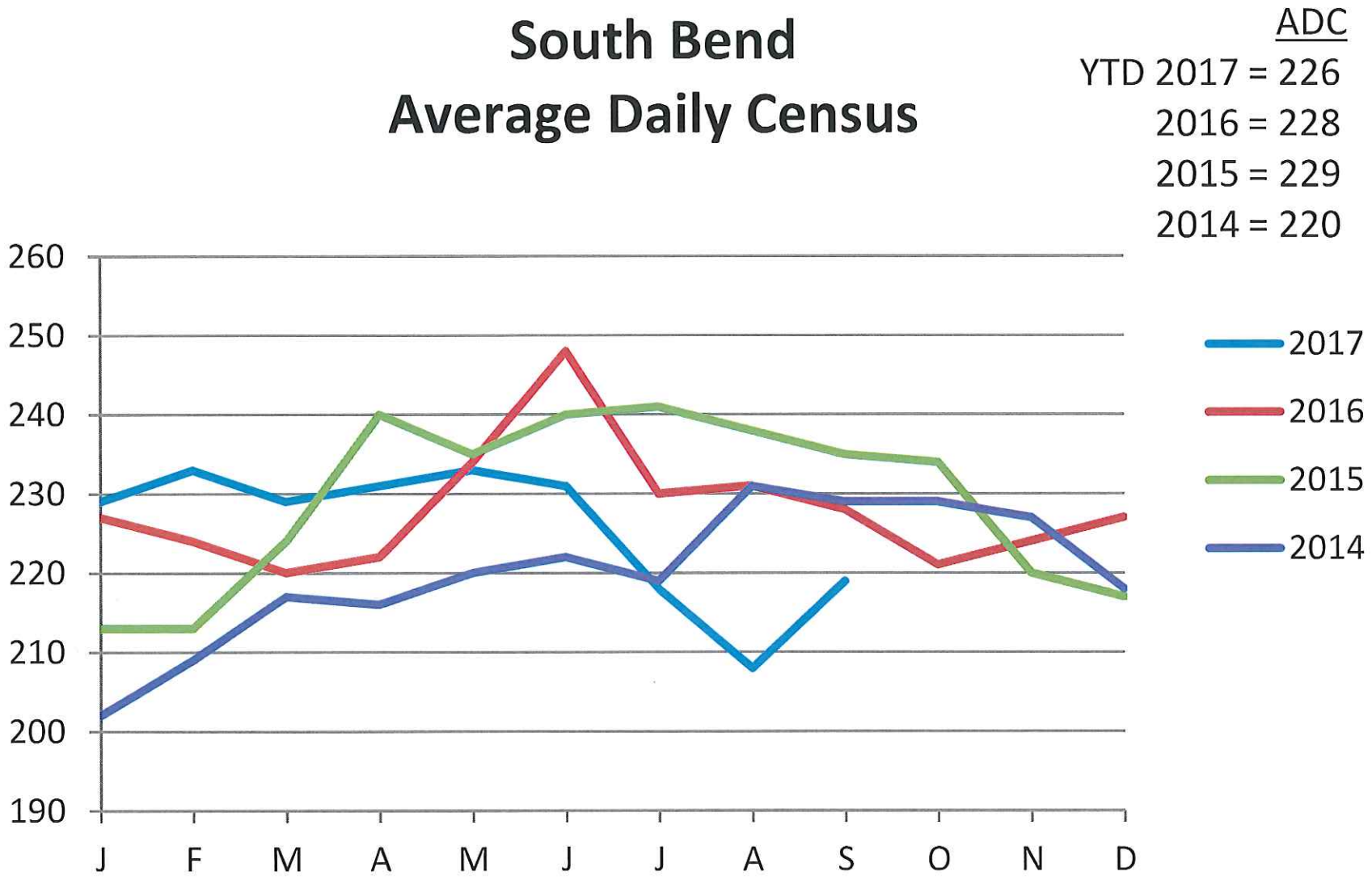
	All	South Bend	Elkhart	Plymouth
J	390	229	91	69
F	388	233	89	67
M	387	229	91	67
A	402	231	99	72
M	406	233	101	72
J	403	231	103	69
J	382	218	98	66
A	366	208	91	67
S	364	219	80	65
O				
N				
D				
2017 YTD Totals	3488	2031	843	614
2017 YTD ADC	**388**	**226**	**94**	**68**
2016 YTD ADC	398	229	95	74
YTD Change 2016 to 2017	-10	-3	-1	-6
YTD % Change 2016 to 2017	**-2.5%**	**-1.3%**	**-1.4%**	**-7.8%**

2017 YTD ADC by Branch

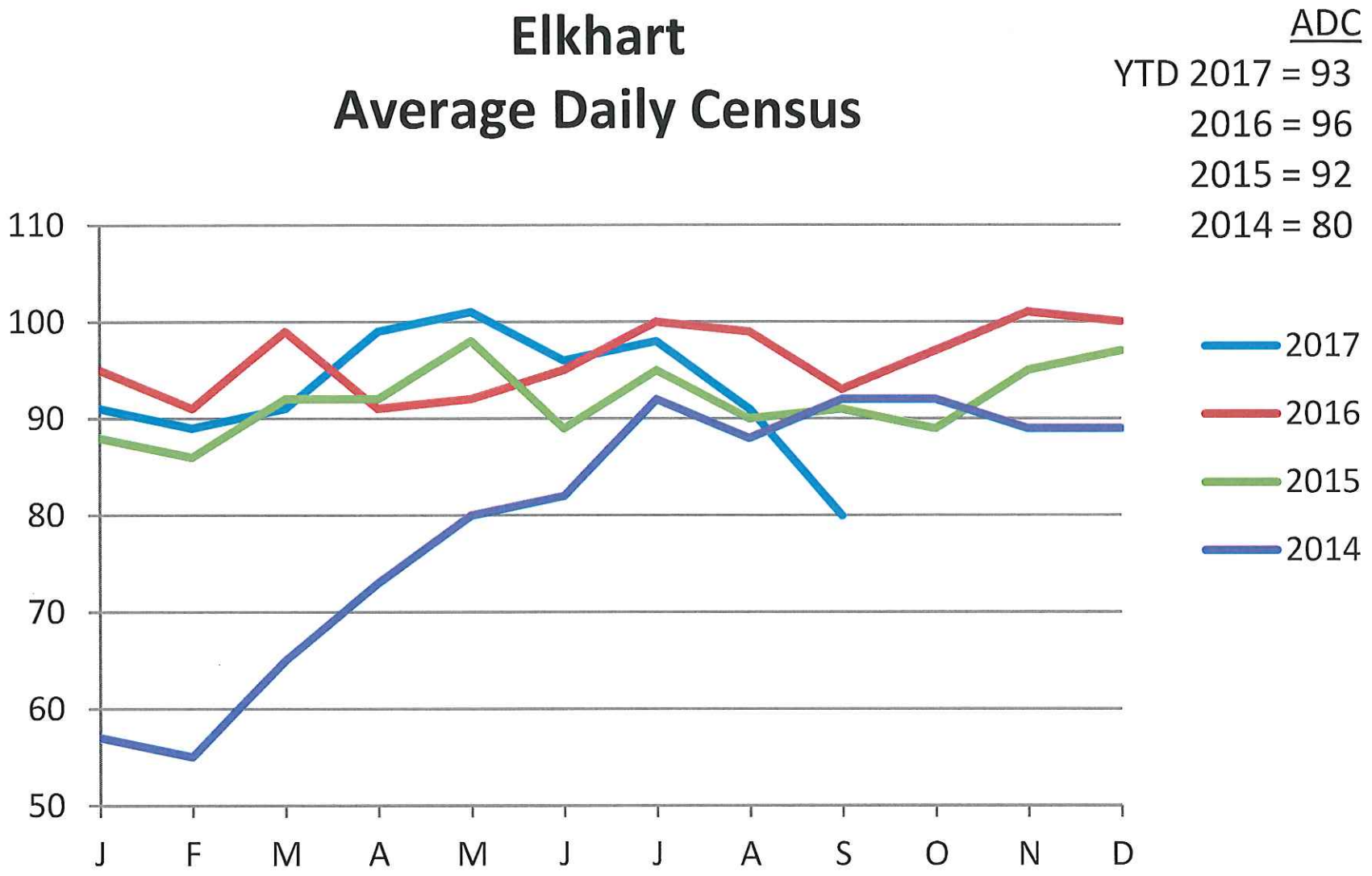



Center for Hospice Care
Total Average Daily Census (ADC)
ADC
YTD 2017 = 388
2016 = 399
2015 = 399
2014 = 370
430
410
390
370
350
330
310
J
F
M
A
M
J
J
A
S
O
N
D
2017
2016
2015
2014

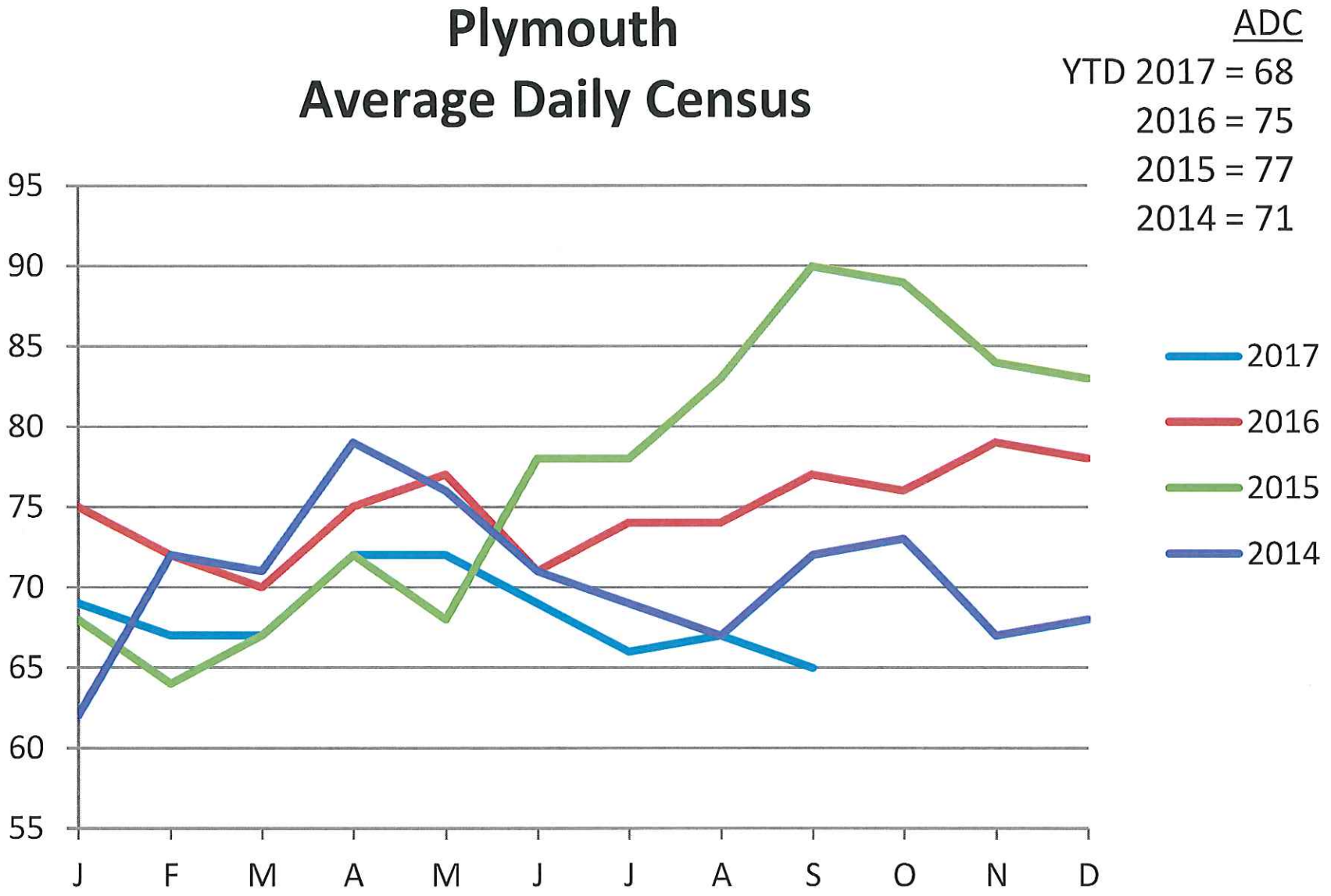
South Bend
Average Daily Census



Elkhart
Average Daily Census



Plymouth
Average Daily Census



PROPOSAL

Effective 1-1-2018, the Board and the Finance Committee will each meet four times per year: in February, May, August and November. The Executive Committee will meet by conference call four times per year in early January, April, July, and October (roughly six weeks after the previous Board meeting).

PROS	CONS
Impact on board members.	
Reduces time demands on members.	If a member misses a meeting, six months (rather than 4 months) will pass between meetings she/he attends.
Members might be more likely to attend and it might be easier to recruit new members.	In almost every case, the absence of a member is not by choice, but due to circumstances beyond her/his control. This is true regardless of the number of meetings.
No meetings during holiday season in December.	Meetings may last longer; perhaps 90 minutes instead of 60 minutes.
The Executive Committee meetings could be followed by a succinct email to all board members with pertinent financial and operational updates.	
All members are asked to commit to (a) serving on a committee and/or (b) helping with an event. This helps all to know their involvement is important.	Board members not serving on the Executive Committee might think their involvement is not important.
We can solicit board feedback, perhaps a brief survey to be filled out at the end of each meeting.	
Would not affect a member's ability to: (1) oversee the CEO; (2) enact policies; and (3) serve as an ambassador in the community.	A more extensive orientation for new board members may be necessary.

Impact on Board's ability to act.	
If needed, the Executive Committee can act between meetings of the full board.	If a quorum is not present, six months will pass between meetings at which official action is taken.
Special meetings of the full board could be called. In the event of a major change the board could return to more frequent meetings. The By-Laws provide for flexibility – the only requirement is that the board meet at least quarterly.	Would not have adequate involvement in the event of a major change in the organization. One example would be overseeing the work of a new CEO (although our CEO will be with us for several more years).
Quarter-to-quarter comparisons can be more helpful than month-to-month comparisons.	
More time between the Finance Comm. meeting and the Board meeting would better enable non-committee members to review in advance of the board meeting.	
Less time spent on items like approval of minutes and review of financials at the board meeting would free up more time for discussion/questions about various topics.	Some members review the materials published on line before the meeting and some do not.
Impact on CHC staff.	
Reduces time demands on CHC staff, which has more duties (e.g. MADS, GPIC, etc.). The staff devotes about 35 hours to each meeting (this does not include activities the staff would do even if there is no board meeting).[1]	

[1] This proposal has not come from staff and we are not aware of any complaints from staff about the frequency of our meetings. If we decide not to make a change, the staff will continue their excellent participation. That said, CHC staff has expressed support for the proposal.

Center for Hospice Care
Committees of the Board of Directors

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

Bylaws Committee
The Bylaws Committee shall consist of the Executive Committee of the Corporation and other appointees by the Chair of the Board of Directors in such numbers as they deem necessary. It shall have the responsibility of reviewing the Corporation's Bylaws at least once every three years. This committee will meet again in 2018.

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

Personnel Committee
The Personnel Committee shall consist of the Executive Committee and other appointees by the Chair of the Board of Directors, and be chaired by the Chair of the Board of Directors. This committee shall concern itself with the review and recommendations for approval of the Personnel Policies governing the staff of the Corporation. This committee meets at least biannually to review the Human Resources Manual and as needed. The committee will meet again in 2018.

Professional Advisory Group
This Committee shall advise the Corporation on professional clinical issues, participates in the review of the Corporation's clinical programming, patient care policies, procedures and clinical records as required by the federal and/or state Home Health regulations. Membership is to include but not be limited to:

- At least one physician
- One registered nurse
- Appropriate representatives of disciplines involved in delivery of Home Health services under the Corporation's state home health license and federal certification to provide home health care services.
- At least one member of the group is neither an owner nor an employee of the Agency.

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

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

Center for Hospice Care to hold 9th Annual Bike Michiana for Hospice.

Center for Hospice Care is excited to be hosting its 9th annual Bike Michiana for Hospice cycling event in partnership with the Bike Michiana Coalition. This year's ride takes place on Sunday, Sept. 17 at St. Patrick's park in South Bend.

MISHAWAKA, IN (PRWEB) SEPTEMBER 06, 2017

Center for Hospice Care is excited to be hosting its 9th annual Bike Michiana for Hospice cycling event in partnership with the Bike Michiana Coalition. This year's ride takes place on Sunday, Sept. 17 at St. Patrick's park in South Bend. Registration is $60 per adult and is open online until 5:00pm on Friday, September 15. Onsite registration begins at St. Patrick's park at 7:00am Sunday, September 17.

This year's ride again features family-friendly ride options (3.5-11.1 miles), as well as a 25, 66, 82, or 102-mile option. Known for its great SAG stop food, this year's event will keep the tradition going. Local restaurants Yesterday's, Tapastrie, Moser's, Lasalle Grill, Uptown Dining Group and Froehlichs will be participating.

For more information, please visit bikemichianaforhospice.org or foundationforhospice,org.

About Center for Hospice Care and the Hospice Foundation

Established in 1978, Center for Hospice Care is an independent, community-based, not-for-profit organization, improving the quality of living through hospice, home health, grief counseling, and community education. With offices in South Bend, Plymouth, Elkhart and Mishawaka, CHC serves Elkhart, Fulton, Kosciusko, LaGrange, LaPorte, Marshall, Porter, St. Joseph and Starke counties in Northern Indiana.

The Hospice Foundation is committed to supporting the work of CHC through community outreach and education, fundraising activities and other special events. The Foundation helps CHC keep its 37-year promise that no one eligible for hospice services will be turned away, regardless of their ability to pay.

Yale: Hospice Patients Are Admitted Too Late

Half of patients admitted into hospice care are admitted only within the last two weeks of their life, according to a recent study from Yale University physicians. This timeframe undercuts the hospice benefit, which can extend for six months, and reveals some of the challenges related to seniors in the last stage of their life.

In addition, many of the patients admitted within the last few weeks of their lives had experienced symptoms related to their conditions for weeks or months prior.

Late Arrivals

Yale researchers observed 562 decendents who died between 1998 and 2014, 43.4% of which were admitted into hospice, according to the study, "Distressing Symptoms, Disability, and Hospice Services at the End of Life: Prospective Cohort Study," which was published in the Journal of the American Geriatrics Society on Tuesday.

"The good news is that hospice is used commonly—almost half of the persons who died," Thomas Gill, MD, lead author of the study, told Home Health Care News. "The bad news is it is used often only at the

very end, in the last few weeks, of life. That diminishes the possible benefit of hospice." Gill is also a professor of medicine, epidemiology and investigative medicine and the Humana Foundation professor of geriatric medicine at Yale University.

The benefit, which was created in 1982 and can apply for a six-month period, is underutilized to relieve symptoms of a terminal diagnosis.

Based on prior research, the Yale team was surprised to find that patients' symptoms had an influence on hospice admission, with cancer and advanced dementia as the most common conditions for hospice admission.

"The condition that is more predictable is cancer; that's why it's used more for cancer than other conditions," Gill explained.

However, even these patients are admitted late, with half of study participants having a duration of less than 13 days.

"We're not talking about half the patients who were in for two or three months," Gill said. "Half were only two or three weeks—a long way from six months."

While cancer patients might be more likely to be admitted to hospice earlier, as the disease can be somewhat easier to predict, it's much harder to pinpoint when death is near in dementia patients. And symptom descriptions often come from proxies rather than patients themselves, who can be debilitated by the disease.

End-of-Life Discussions

A big part of the admissions issue is that the conversations needed to discuss quality of life are simply tough ones to have. Families, patients and doctors need to make hard decisions based on a person's preferences and conditions. The situation is a deeply personal one.

"It's challenging and difficult to have honest discussions with patients and families about end-of-life care," Gill said. "Issues related to death and dying are always challenging. ...If it's framed properly, patients are often thinking about their death and many would welcome an honest discussion. It's a matter of breaking through those preconceived notions."

Outside of hospice care, stakeholders—and even artists—are working on bringing these discussions to the forefront of care, and doctors can even be reimbursed for having end-of-life care talks with patients.

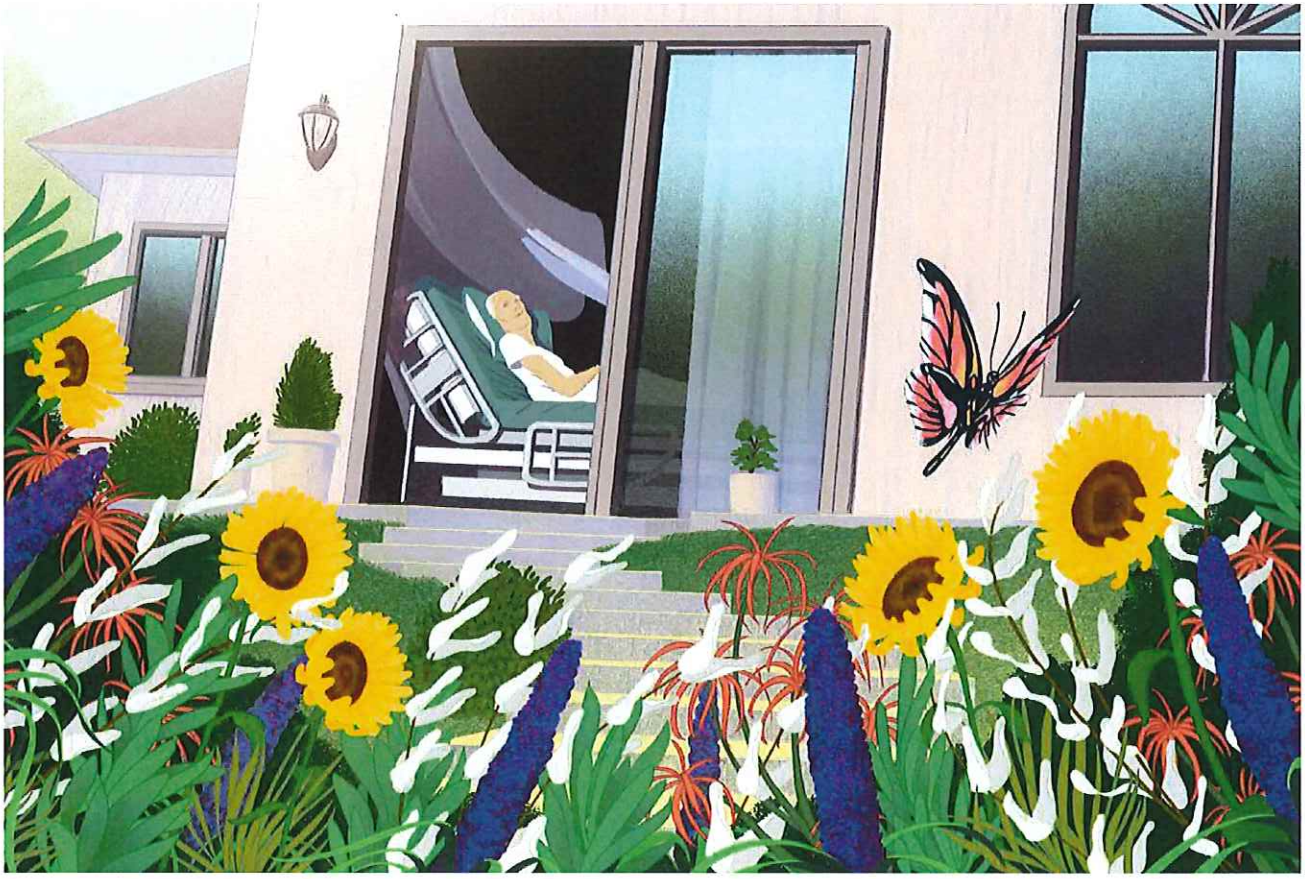
However, they are still happening too late, based on the study results, Gill said.

As most hospice is offered at home, admitting seniors sooner to the benefit could actually save on costs down the road by preventing hospitalizations and relieving symptoms.

"It's a matter of thinking about hospice sooner," Gill said. "Most hospice is provided in the home, and it doesn't require a lot of doting resources. ...Many persons in the last phase of their life don't want to spend a lot of time in the hospital, they want to be home. ...Using hospice sooner is not necessarily more costly to society or to the Centers for Medicare & Medicaid Services (CMS)."

Written by Amy Baxter

POLITICO



Michael Marsicano for POLITICO

The Agenda
AGING IN AMERICA

Hospice in crisis

The most important end-of-life movement in a generation struggles in an era of changing families and prolonged deaths.

By **JOANNE KENEN** | 09/27/2017 05:01 AM EDT

It might seem odd to talk about "innovations in dying," but in recent decades the hospice movement has become an important new pathway for the most difficult phase of life. As American health care has become ever more high-tech and expensive, the hospice model of home-based care for terminally ill patients has enabled millions of Americans to die peacefully in their own houses, without painful medical procedures—often greatly reducing stress on both the families and the health care system.

Now, however, the hospice model is coming under stress of its own. Some of that's because the industry has changed, with a lot more for-profit hospice agencies and investor-owned chains, which are coming under scrutiny from regulators. But much of the stress comes from shifts in how we die, how we live—and with whom. These are big demographic changes that make the original conception of hospice harder to carry out as it was once intended.

With baby boomers aging and likely to live with serious illness for several years, understanding how best to take care of the aged and the dying is becoming an ever more pressing issue in America—emotionally, morally, and financially. "We need to address this very quickly," said Joan Teno of the University of Washington, a prominent geriatrician who both practices and researches end of life care. "The tsunami of frail elderly people with complex multiple illnesses is coming."

In theory, hospice would be an ideal system to deal with this tsunami. From the time it was developed in Britain in the 1960s and '70s, it represented a pushback against the over-medicalization of death, emphasizing comfort care and emotional support over disruptive medical interventions. It put great emphasis on family; hospice care is often delivered by close relatives rather than medical staffers. And it was originally designed with cancer in mind, at a time when cancer killed quickly.

Nowadays, however, dying itself has changed. Cancer isn't the death sentence it was, and thanks to new waves of drugs that prolong life in late-stage disease, it can be hard to know when it's time to stop treatment and emphasize pain relief. More than half of hospice patients have dementia, heart disease, and other slow-progressing disorders—and most of

those have more than one such diagnosis, and a panoply of symptoms. That makes it harder to prognosticate just how much time someone may have left to live. Given that hospice care is generally available only to people likely to die within six months, prognosticating is important. Even to the practiced medical eye, it's not always clear exactly when a patient is crossing that almost imperceptible line between "very sick" and "dying."

Families, too, have changed since hospice took root in the U.S. health system. They tend to be smaller, and live farther apart. More women work–making it harder for them to take on traditional roles as full-time caregivers. And millions of old, frail Americans—divorced, widowed, or never married—now live alone without family nearby, or without family at all. The most isolated are sometimes called "the unbefriended."

"We have different illnesses, and different social situations than the traditional hospice user," said David Stevenson, an expert on aging at Vanderbilt Medical School.

What hasn't changed is the basic payment system—a per diem system—and the basic regulatory framework. Hospice is largely covered by Medicare, which pays a flat daily rate—usually around $145 to $160, with some variation based on geography and length of stay. Hospices get paid more for limited spells of crisis care in the home setting (and "home" can include a nursing home or an assisted living facility) or when a patient does get inpatient hospice care, usually briefly, in a hospice house or hospice-designated bed or wing in a hospital.

No matter how good and caring the hospice team—nurses, aides, social workers and, as desired, chaplains—much of the work falls to the family. And even when the family is willing and well-equipped, as my own family was as we took care of my father with hospice in the final months of his life, it's not so easy to die at home.

For those with less support—it can be monumentally difficult. But no less important.

"There are people who would literally rather die than leave home. And they are really left without a good option," said Dr. Drew Rosielle of the University of Minnesota, who, like his fellow palliative care physicians, works hard to keep his patients safe at home as long as possible. "The patients who genuinely don't have loved ones who can essentially move in with them—most of those people do not die at home."

They end up getting care they don't want, in a place they don't want to be in—and it costs more. "The ER, a hospital bed or a nursing home. That is our long-term care system for people who don't have a support system." said Edo Banach, the new president and CEO of

the National Hospice and Palliative Care Organization, who took the job knowing it's time for some fresh thinking about hospice—and the rest of American health care.

Even strong advocates of hospice know that it's time for changes to match the complex medical needs of today's patients and the demographic realities of the country—as well as trends arising from long-term use of hospice in existing institutions like nursing homes. But in the near future, there aren't a whole lot of fabulous solutions, at least not ones that don't cost a lot of money.

This is where Washington might come in. But a comprehensive national long-term care program is so challenging economically and politically that hardly anyone in the capital even bothers talking about it. Medicaid offers long-term services and supports in the community or in nursing homes—but only to poor people, or people who become poor after spending all their money on care. Plus, congressional Republicans want to cut Medicaid, not grow it. The Obamacare repeal plans would take hundreds of billions from Medicaid, raising questions about how America plans to pay for its elder care as that bill rises.

By default, improvisation becomes policy. "We spend a lot of time cutting and pasting," said Dr. Christian Sinclair, a former president of the American Academy of Hospice and Palliative Medicine, who is now practicing mostly outpatient palliative care at the University of Kansas Medical Center. And patching together care from friends, neighbors, some volunteers from church, is an increasingly inadequate response to the tidal wave of baby boomers now growing old. Can it be fixed?

IN SOME WAYS, hospice is a throwback to how we died before the surge of medical machinery and ICUs, and it can seem jarring that the movement would take root in contemporary America at all. When patients elect hospice, they must usually give up on curing or containing their disease—a difficult decision to make in a system that dangles the promise of a medical fix just within reach. In practice, people often turn to hospice for only a handful of days, at the very end, after using up a lot of expensive high-tech care that may have drawn out death more than it extended life.

Once they do elect hospice, a whole different philosophy of care begins. It's more than easing physical pain and managing symptoms, though there's that. It's built around team-based care, both physical and emotional, and it's intended to support the family as well as the patient. Surveys over the years, as well as Medicare's new "Hospice Compare" quality project, have found high satisfaction rates with hospice care.

But dying people can require companionship around the clock—and the paid hospice team isn't there 24/7, not even close. Families—or home aides when a family can afford to hire

them—fill the gap. The care is complex and intensive, not in the sense of "intensive care," but hands-on intense. "It's a person who is dying," said Ann Mitchell, the CEO of Montgomery Hospice outside Washington, a veteran of hospice since its early days. "That takes a lot of care and a lot of time."

Family support is so crucial that some hospices won't even try to arrange home care for someone on their own; the last big survey of hospices, conducted a decade ago, found that more than one in 10 hospices refused to take on a patient without a family caregiver. But most doctors and hospices work to keep that patient at home, safely. "We try to have a plan in place," said Dr. Holly Yang, a hospice and palliative care physician at Scripps Health in San Diego, who like the other physicians interviewed for this article is engaged in both patient care and public policy.

Patients who are mostly on their own may do OK for a while, but decline is inevitable. They may not be able to prepare their meals, feed themselves, get out of bed—or manage their meds. They may experience acute pain, disorientation, shortness of breath. And when that happens, instead of calling the hospice nurse, the instinct is to call 911.

Even if the hospice patient who is rushed to the hospital ends up back home, all those transitions likely made things worse. Care gets disrupted, protocols get changed, mistakes get made—and costs rise—with each handoff. "It impacts the quality of care," said Teno, the geriatrician, who has studied care transitions extensively and who has been a medical director in nursing homes and hospice. "It's crying out for someone to fix it."

If the Medicare agency and Congress aren't diving into reinvention of hospice, doctors and policy experts have some ideas of their own—though not always with clear-cut ways to pay for them. By and large, they are still in the "floating ideas" stage, not agenda items for Congress or the Medicare agency.

Some physicians interviewed suggested tiered payments, which would replace the one size fits all daily rates. In other words, they could pay more for a patient with a particularly complex condition, or for a patient who can't stitch together the necessary social support system. Another idea is to create more flexibility on how Medicare defines "continuous care"—a higher level of care for which the hospice gets a higher rate. Right now "continuous care" means an eight-hour block of hospice-provided care. Some doctors think paying for smaller blocks, like four hours, might be more practical.

One researcher mused about shifting the myriad quality markers that Medicare and private health plans now require so they have a sharper focus on end of life, and rewarding those that do it well. Hospitals measure and refine, for instance, how quickly they can get a heart

patient in to the room for cardiac procedures; why not do the same for getting a dying patient into the most appropriate and compassionate setting?

One doctor suggested that four or five hospice patients could live together, sharing the cost of caregivers, who know to quickly summon the hospice nurse, not an ambulance, when things get tough. It wouldn't be the same as staying "at home" for patients who really wanted to live out their days in their own homes. But it could be a home-like substitute, and there are scenarios where the arrangement could make the caregiving costs more affordable for some.

Some experts see promise in using more inpatient care, whether in a freestanding "hospice house"—a more formal and regulated setting for care—or a section of hospital or nursing home. Hospice houses are more common than they were 20 years ago, but they are still not the norm. By 2015, the proportion of deaths in America that took place under inpatient hospice care rose to 8 percent, from zero in 1999, according to research recently published in Health Affairs. With soup on the stove, cookie dough in the fridge, and places for those who do have family and friends to gather, such houses don't feel institutional. Mostly they're used for a brief stay to control a crisis, or for a few days of respite care for family caregivers. But some who have studied hospice extensively, like Elizabeth Bradley, a health policy expert who recently became president of Vassar College, say it's worth thinking about how this inpatient setting can take on a bigger role, at least toward the end. "It makes a lot of sense," she said. "It's not home—but it's homelike. And it's set up to pass you through the end of life."

It's appealing, but comes with its own cultural and financial challenges. For one thing, it's not how most hospices, still attuned to home-based family care, see their mission, at least not now. Nor can they afford it under the equally home-centric Medicare fee structure, unless they have a lot of philanthropic support. "We've hit a few cases where we didn't feel safe with the patient home situation, where we brought them in for a respite stay and we added routine days onto that because there was no safe discharge plan," Dr. Patrick White, chief medical officer of BJC Hospice in Missouri, said of the 16-bed hospice house it opened a few months ago. "But it's really frustrating for us that financially the hospice takes a huge hit for that. It's not economically viable." To get Medicare to even think about paying more for the inpatient model, there'd probably have to be a crystal clear economic case that it would save health care dollars elsewhere, and not be one more big bill tacked on to the last year of life.

ONE INNOVATION THAT does help people stay at home independently is telemedicine or telecare—health care delivered remotely, over the internet or by phone. Medicare doesn't

pay for telemedicine in most settings. But it's catching on under the per-day payments that hospice gets, and under other "value-based" or lump-sum payments that are emerging.

It has also caught the eye of the Department of Veterans Affairs, whose administrator, David Shulkin, has declared it a top priority to allow veterans to die in their homes if they wish. "I want to be able to assure every veteran that it's their right to do so," said Shulkin, who calls this policy his "moon shot." He's working on getting more paid caregivers into the home, and expanding home technology as part of the solution.

Though the recent growth of telemedicine has often come to mean fancy apps, sensors, and monitors, with hospice it can be less expensive, as simple as a regular check-in phone call from a nurse trained to pick up on red flags or stress—heading off that 911 call, said Dr. White of BJC. "It's cheap and simple—and it's proactive, especially for patients with lower health literacy who may not have caught a sign or symptom." For patients at home alone, it's a layer of protection.

Tech is also showing promise in helping create hospice-like end-of-life care in remote areas, where people may just live too far from the nearest hospice organization to tap into its care. In an isolated rural stretch of Northern California, Dr. Michael Fratkin, founder of a company called Resolution Care, is "virtually visiting" seriously ill patients at home with a phone, a laptop, and free teleconferencing software. Many of Fratkin's patients have scant family support; in addition to physical illness, some are dealing with poverty, food insecurity, and homelessness. He makes in-person visits, too, as do nurses and community health workers. The care he provides is not hospice, but it's similar, paid for by Medicaid managed care plans in California and a few big insurers.

Recalling one patient, a veteran with liver cancer who lived way out in the country, Fratkin said: "I walked him through the last eight or nine months of his life, on the land where he lived it." Fratkin 's already getting a lot of interest from other doctors and health organizations, and his approach would easily fit into hospice. The technology is accessible enough for patients. "I'm not that much of a geek," Fratkin said.

Another development in medicine, embodying some of the philosophy and benefits of hospice, is the relatively new specialty of palliative care. This is an option for patients with advanced diseases, instead of or prior to hospice itself. But palliative care patients don't have to give up curative care, like chemotherapy, so the transition is less of a rupture, and more of a gentle slope. Similarly, some hospices now offer "open access" or "concurrent care," allowing the patient to start hospice but to keep getting "regular" treatment.

Medicare's Innovation Center is running a multi-year test of that approach for four diseases, including advanced cancer. The idea is that patients who get the symptom management and emotional supports of hospice and palliative care, and who come to better understand their own illness, make different choices. "If we walk earlier with that patient, and he or she starts realizing the burdens of treatment outweigh the benefits. ... It's a more humane way of doing it, and I think it will save money," said Ann Mitchell of Montgomery Hospice. That money could then be used to meet all sorts of needs we don't pay for now—like more help at home.

On a broader level, the steps needed to create the next iteration of hospice may dovetail with the steps being taken to address the bloated, expensive American health care system. "The focus isn't just on diagnosis and medical tests and drugs and durable medical equipment, but on meeting the patients' whole needs. That's really where it's at," said Joe Rotella, a long-time hospice doctor now working with the hospice and palliative medicine academy, which has put forth its own ideas for reform. "We're just kind of waiting for the system to catch up."

A raft of experiments are under way aimed at shifting how we finance and deliver care; some are advanced through the more esoteric provisions of Obamacare, the ones the country hasn't spent eight years fighting about. Others are linked to a bipartisan new law that will change how Medicare pays physicians—with an emphasis on value of care, not volume of care. Many of the ideas being tested and explored entail more and better management of chronic diseases—the slow-motion killers that, eventually, bring people to hospice's door.

If these experiments bear fruit, we could move toward a system where families can be supported, not exhausted. Where patients can get the holistic approach pioneered by hospice, without "giving up" on more aggressive treatment. Where patients who understand their choices can get off the conveyer belt of high-tech medicine, and find whatever balance of curative and palliative care is right for them. For both those who are surrounded by family, and the "unbefriended," it could become a little less hard to die at home.

Joanne Kenen is POLITICO Pro's health care editor.

Thursday, September 28, 2017

Read Past the Headline

Despite an unfortunate and misleading headline that appeared in *Politico* yesterday, "Hospice in crisis," the article is actually a thoughtful look at what we as a provider community face in caring for people at the end of life. For those who may have seen this headline in your news tracking or social media feeds, I'm sure you were immediately concerned, as was I. However, I encourage you to read past the headline.

The article explores how demographic, competitive and public policy changes are challenging the hospice industry. The author Joanne Kenen – who NHPCO spoke with for her reporting – is not pointing an accusatory finger towards hospice, but is instead exploring the changing environment in which we must provide care. (As an aside, it should be noted that Kenen did not write the headline, that was done by editorial staff at *Politico*.)

A better headline would have been "Hospices Navigate Changing Environment." Unfortunately, crisis sells and our challenges do not.

While it is true that hospices are challenged by changing demographics and patient needs, the crisis is most acutely felt by patients and their families. As providers, we know that when people wait until they are actively dying to access hospice, our patients and family caregivers are unable to fully utilize and benefit from the wide range of services that we provide. Those of you on the frontlines know this best.

Part of our job is to innovate while we continue doing what we already do so very well. NHPCO is eager to work with Congress, the Administration and other stakeholders to enact policy changes that allow patients to receive palliative care earlier, expand access to concurrent hospice care, and support the delivery of other services that improve care for individuals with serious and advanced illness near and at the end-of-life.

In fact, we are supporting legislation that our affiliate the Hospice Action Network is championing on Capitol Hill that would likely help more Americans access quality hospice care in a timelier fashion. If you are not familiar with our two major legislative priorities, the Patient Choice and Quality Care Act and the Rural Access to Hospice Act, I hope you'll visit the links to learn more on the HAN website.

We are pleased that Kenen took the time to interview me as part of her research and I trust this conversation will be ongoing. We had a thorough conversation about the realities of caring for the dying, which we are encouraged could lead to additional reporting on the important work NHPCO is doing on behalf of the hospice community.

Thank you for your continued work towards providing high quality care to an ever increasingly complex population in an evolving health care landscape. I can attest to the amazing work I have seen firsthand from one corner of the country to the other and I am proud of the dedication, compassion and understanding I see among the hospice community to adapt to the world around us.

By Edo Banach
President and CEO

THE CHRONICLE OF
PHILANTHROPY

NEWS AND ANALYSIS
OCTOBER 03, 2017
✔ PREMIUM

How America Gives Special Report: Breaking the Charity Habit

By Drew Lindsay

HEATHER FINNECY DITO

Second Harvest Food Bank 16% increase in size of average gift over past three years. 8% decrease in number of donors over the same period.

Each year, the charity world waits eagerly for the announcement of how much individual Americans gave to charity. And each year, that annual total doggedly climbs higher, faltering only occasionally. Four of the past five years, it has broken its own record, prompting confetti sprays and paeans of praise to this country's generosity.

Yet fewer Americans appear to be giving to charity. In 2015, only 24 percent of taxpayers reported a charitable gift, according to a *Chronicle* analysis of Internal Revenue Service data. That's down from 2000 to 2006, years when that figure routinely reached 30 or 31 percent.

Economists caution that the number of taxpayers who itemize their taxes and report charitable giving can vary for many reasons; Americans in the past decade have taken fewer deductions of any kind. But the *Chronicle* analysis is in line with several other studies. Their conclusion is the same: The number of households making

room in their budgets for charitable giving is shrinking. One economist even wonders whether Americans have fallen out of the habit of giving.

This trend is significant, as it suggests a narrowing of support in America for philanthropy. Whether running capital campaigns, annual-giving drives, or direct-marketing efforts, nonprofits are relying on fewer, more affluent supporters.

Though recent critiques of philanthropy worry over the rise of megagifts from billionaires, nonprofit groups have become more dependent on the wealthy generally. Donations from households earning $200,000 or more now total 52 percent of all itemized contributions. In the early 2000s, that number was consistently in the 30s.

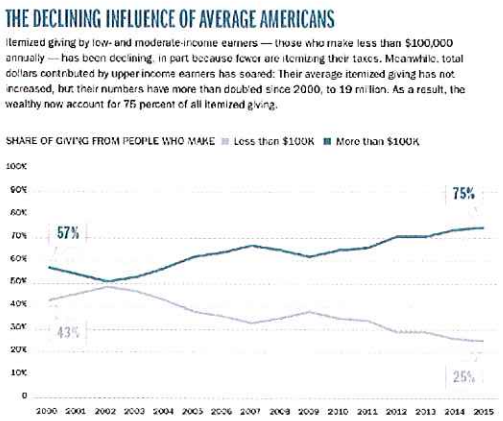
Middle-class woes and the country's widening income disparity are undoubtedly partly to blame. But some fear that organizations are contributing to the problem by courting the well-heeled and slighting the small donor.

Though granted tax-exempt status, charities can see average Americans chiefly as a nuisance, says Susan Raymond, a leading fundraising consultant whose clients have included national nonprofits and universities.

"I wish I had a dime for every meeting I have sat in in which a nonprofit has denigrated the small donor, treated that donor as an afterthought, as an also-ran, as the last item on the agenda, often tabled because time ran out," she said in a recent speech to fundraisers in Pennsylvania.

Nonprofits, Ms. Raymond noted, celebrate big gifts from the wealthy, as they should. But that celebration "can become the public face of what you value. And then it is a short distance down a slippery slope to being the public face of who you are."

A Measure of Generosity



Four times a year, officials from 70 or so nonprofits gather on a conference call and consider data that reflects on American generosity. Most of the organizations are titans with vast direct-marketing machinery to reel in thousands of small donations, often pocket-change gifts of $25, $50, or $100.

The group, called the donorCentrics Index of Direct Marketing Fundraising, includes household names like the March of Dimes, American Cancer Society, and Planned Parenthood. It has functioned almost like a stock-market index since its creation in 2002. Yet while the Dow Jones has soared in the intervening years, this measure of giving has drifted downward, a balloon with a slow leak. Annually over 14 years, the median number of small donors climbed just once, according to Target Analytics, a division of Blackbaud that runs the index; from 2005 to 2015 alone, the figure sagged 25 percent.

This decline might be dismissed as simply a failure of traditional direct-marking tactics in the age of Facebook and Venmo. But the index's retreat is mirrored in other indicators. College alumni-participation rates, for example, have slipped more than 4 percent annually since 2005. A national survey conducted by The Y found the number of households that reported volunteering for or giving to charity each went down by double digits from 2010 to 2014. It concluded America was suffering from "engagement fatigue"

Perhaps the most persuasive evidence of a giving slump comes from Indiana University's Lilly Family School of Philanthropy, which runs the Philanthropy Panel Study, a part of the University of Michigan's Panel Study of Income Dynamics. The Michigan survey is a gold-standard longitudinal analysis. The data suggests the

share of households donating to charity was 67 percent in 2004. Two years later, well before the Great Recession, that number slid to 65 percent. By 2012, it dropped to 59 percent.

The recession's beatdown on household savings, home values, and the stock market accounts for some of this decline but not all, according to Jonathan Meer, a Texas A&M economist. Even after controlling for a number of factors, including wealth and income, his analysis still found a significant drop.

This surprised Mr. Meer, who's been studying charitable giving for a decade. More data is needed to determine what's behind the precipitous decline, he says.

One possibility: While the effects of the recession have eased, memories of its trauma linger. Americans — particularly those with limited discretionary income — may be rethinking their budgets and spending habits. Says Mr. Meer: "People say to themselves, 'It turns out that my house isn't going to appreciate 15 percent every year. I could lose my job that I thought was really steady and safe. And so I'm going to adjust my giving pattern.' "

In short, for many Americans, the recession may have broken the habit of writing a check to charity. Once that habit's broken, Mr. Meer wonders, will they pick it up again?

MARK MCCARTY, COLLEGE OF SAINT ROSE

College of Saint Rose: $5.5 million in estimated contributions of four seven-figure donors in 2017.

Soft Spot in Growth

Kathy Jackson has much to celebrate as she prepares for her retirement as CEO of the Second Harvest Food Bank of Santa Clara and San Mateo Counties, in California. After she arrived in 2009 from a career in business, she helped the group ride out the recession and grow. Giving to the

$1.9 million estimated total of all other 2017 gifts and pledges.

organization by individual donors has more than doubled in the past eight years, to $26 million.

Yet this shiny apple has a soft spot. The number of individual donors to the organization has dropped 8 percent over the past three years. Supporters writing checks for $1,000 or less have declined 10 percent.

The nearby Humane Society Silicon Valley tells a similar story. Dollars are up — the group raised what it says is a record $5.3 million in fiscal 2017 — but the number of donors is down, thanks to a big drop at the small-gift level. Individuals giving less than $100 have declined 17 percent since 2012.

What's happened? Part of the answer at both organizations is that small donors have been cultivated and moved up in giving levels. But officials say other things are at work, too.

Explanations start with the widening disparity of wealth that afflicts the country broadly and Silicon Valley in particular. The region's middle class has been hollowed out in recent years. "Our impression is that middle-class families who have been the historic bedrock of our giving are struggling," says Ms. Jackson of Second Harvest. "We've seen a diminution of their giving."

Other demographic and cultural shifts may also be contributing to the decline in small gifts. Millennials have overtaken boomers as the country's largest generation, and it's well known that they aren't embracing traditional ideas of giving. Also, people are increasingly busy and bombarded with information and requests for help.

SPECIAL REPORT: HOW AMERICA GIVES

The Chronicle examines giving trends nationwide through exclusive analysis of Internal Revenue Service data. See charitable-donation figures from every state, metropolitan area, and county.

- The Data Behind The Chronicle's 'How America Gives' Special Report ✔PREMIUM
- A Look at Whether Your Area Should Be Giving More ✔PREMIUM
- Giving in the 50 Largest Metropolitan Areas
- The Secret Sauce That Spiced Up Middle Class Giving in New Orleans
- Growing Wealth in San Jose Doesn't Always Work Out Well for Charity

"They just have a lot of things going on," says Carol Novello, president of Silicon Valley's Humane Society. "How do you get your voice in the social-media mix when they are inundated?"

Giving Up on Small Donors

Nonprofits aren't blameless in the decline of small-donor giving. Many organizations cut back new-donor acquisition efforts, says Carol Rhine of Blackbaud's Target Analytics division. As donors became harder — and more costly — to acquire, some groups

facing budget pressure after the recession suspended those programs, only to get lean returns when they started them up again.

Some organizations are embracing strategies that purposely aim to raise more money from fewer donors. The March of Dimes is an interesting case study. It's famous for assembling legions of volunteers in the 1940s and 1950s to raise dollars a few at a time to fund the researchers who vanquished polio.

Yet about a year ago, the organization stopped soliciting donations for $15 or less and focused on donors willing to give more. "The phrase I use with my direct-response team is 'quality over quantity,' " says Christopher Maddocks, head of marketing. It's a strategy shift that should net more revenue, he adds; the organization was wasting money on small donors who churned on and off its rolls.

Supporters who make bigger gifts are more likely to commit to the organization for the long term. They are, in his words, "higher value" donors. In the simplest terms, the organization is investing in "donors who are in for a dollar, not for a nickel," he says.

Davidson College is another leader in small-donor giving. For 11 years, at least 60 percent of its graduates opened their wallets for the annual fund. Yet in 2013, that record 11th year, Davidson decided that the 60 percent figure had taken on too much importance.

Officials began to emphasize other fundraising measures as well, particularly metrics that relate to dollars raised. Eileen Keeley, vice president for college relations, says she told the college's trustees: "We may not get to 60 percent participation. But our goal is to raise as much money as possible for Davidson."

Four years later, giving to the college's annual fund has climbed from $14 million to $18 million. The alumni-giving rate, meanwhile, has slipped to 56.4 percent.

That's a tradeoff Ms. Keeley accepts. Alumni devotion to the college remains strong, she says. But efforts to reach large numbers of graduates and get their attention were increasingly futile. The college was resorting to tactics that were counterproductive to actually raising money. Her annual-fund team, for instance, beat the drum year-round with the message, "Any size gift matters" — a rallying cry that might make a major-gift officer cringe.

Ms. Keeley also worried that the pressure to reach 60 percent was hurting chances that annual-fund givers would become big donors later. "You end up calling someone every day for the last 10 days of the fiscal year trying to get them to give," she says. "You might get that $50 gift, but in what way does that inspire future giving?"

ERWAN ROGARD/MSF

Doctors Without Borders: 200% increase in major-gift revenue in the past three years. 500% increase in bequest giving in the past five years.

Big-Gift Hunting

The efficiency of the "fewer donors, more money" strategy is undeniable. But it's more complicated when hunting major gifts. And since the recession, nonprofits have had plenty of reason to focus on big donors. Charity leaders say government funding has dwindled as corporate support has grown finicky. At the same time, America's wealth has become more concentrated among the wealthy.

Second Harvest and the Humane Society Silicon Valley both launched new efforts in recent years to tap into the region's vaunted new wealth. "We'd be crazy not to," Ms. Jackson says. "You have to pursue where there's opportunity."

Likewise, nonprofits in metropolitan Albany, N.Y., are seeing opportunity in the growing wealth of their region, which has seen a boom in technology companies. "Major philanthropists in the area are in a position to give at a higher level," says Brian Hassett, president of the United Way of the Greater Capital Region. "That's definitely where we have to go."

Groups traditionally fueled by small gifts are also jumping into big-gift fundraising. Doctors Without Borders has added major and planned-gift staff in recent years to mine untapped potential in its donor base, says Thomas Kurmann, the organization's director of development. Its donor numbers are growing but not nearly as fast as revenue from major gifts. That increased 200 percent in the past three years and, with planned gifts, now accounts for 40 percent of all giving. The group's "fundraising pyramid is in full swing," Mr. Kurmann says.

Colleges offer perhaps the best example of the feverish hunt for big gifts. Not long ago, they swore by the 80-20 rule — the notion that 80 percent of dollars would come from the top 20 percent of donors. But last year, just 1 percent of campaign donors contributed very nearly 80 percent, according to the Council for Advancement and Support of Education.

In recent years college presidents have come under increasing pressure to raise ever-larger sums yet spend less on fundraising, says Don Hasseltine, former vice president for development at Brown University. They also must show results fast, as their average tenure is now only about seven years.

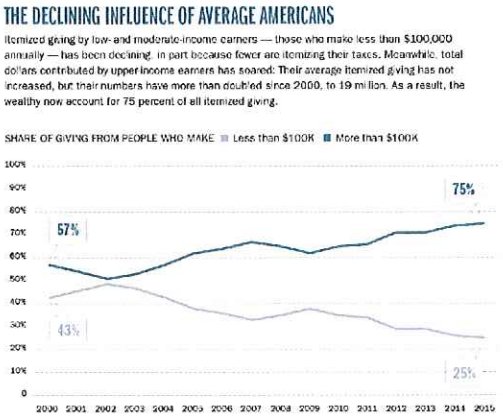
College leaders want to invest in the often-expensive efforts to boost alumni-participation rates, Mr. Hasseltine says. They know anemic annual giving can damage the pipeline that will produce tomorrow's major donors. But they can't resist the more immediate payoff of adding principal-gift officers and stewardship teams.

"There is no short-term downside for leadership to make that investment," says Mr. Hasseltine, now a senior consultant with the Aspen Leadership Group. "And you're not thinking about 25 years down the line."

These concerns extend far beyond elite universities. The College of Saint Rose, a small institution founded in Albany nearly a century ago by a Catholic order of nuns, recently celebrated a 15-year high in giving. But four seven-figure gifts alone accounted for at least $5.5 million of the $7.4 million it raised in fiscal 2017. The number of donors to the college since 2014 has dropped from about 4,100 to just under 2,600.

Ian Farrell, vice president for institutional advancement, says the college is fighting to recruit and keep more small and midlevel donors. He's marshalling new marketing efforts, crowdfunding campaigns, and more. No college or nonprofit, he contends, can let its base of contributors narrow and become reliant on a few donors giving at top levels.

"You're trying not to have your giving pyramid become a space needle," he says.



Signs of Hope

Susan Raymond, the former fundraising consultant, gave her blunt speech to fundraisers with the election results firmly in mind. A Ph.D., Ms. Raymond is a distinguished nonprofit veteran who has worked for the World Bank and the U.S. Agency for International Development. She recently joined Edmundite Missions, an anti-poverty group in Selma, Ala.

In an interview, Ms. Raymond said that the campaigns of both Donald Trump and Bernie Sanders signaled that vast numbers of middle-class voters feel shut out of the country's political and economic institutions. Nonprofits can't turn their backs on these individuals, she argues.

People inherently want to feel valued, that they are contributing to the welfare of their community or country, she says. "But right now, there's a whole bunch of people who don't feel valuable."

There are signs that charitable giving by small donors since the election may be rebounding — and reminding nonprofits of the value of these donors. Blackbaud's index of direct-marketing fundraising is reporting a boom in giving as well as in the number of donors. Much of this increase stems from opposition to Trump administration proposals on the environment, civil rights, immigration, and other issues. But there has been an "astounding increase" across almost all sectors, says Carol Rhine, the Blackbaud analyst.

This may be a momentary spike, like the surges that follow natural disasters. But Ms. Rhine believes something more lasting is at work. Perhaps Americans are rediscovering the habit of charitable giving, she says. And maybe younger people are picking it up for the first time. "It's not just 55-year-olds adding the ACLU to their giving," she says.

"People are more engaged in civic life," she says. "And how they show that is by giving more to things that matter to them."

"How America Gives" data was compiled and analyzed by Tyler Davis and Brian O'Leary.

Send an e-mail to Drew Lindsay.

This article is part of:

SPECIAL REPORT: HOW AMERICA GIVES

A version of this article appeared in the:

OCTOBER 2017 ISSUE

Thursday, October 5, 2017

Center for Hospice Care to Host 6th Annual Okuyamba Fest

Center for Hospice Care invites the community to enjoy international food, drinks and arts at its 6th annual Okuyamba Fest on October 12, 2017.

MISHAWAKA, IN (PRWEB) OCTOBER 05, 2017

On October 12, Center for Hospice Care (CHC) will host the 6th Annual Okuyamba Fest to benefit their international partner, the Palliative Care Association of Uganda. The event begins at 5:30pm and takes place on CHC's Mishawaka campus. It offers attendees the opportunity to learn more about Ugandan culture while enjoying food and beverages.

The event features a silent auction during which many hand-made Ugandan art and craft pieces will be made available. Proceeds will benefit CHC's "Road to Hope" program that supports children in sub-Saharan Africa who have been effectively orphaned after caring for their terminally ill parent or parents. Participants will also be able to sign up to sponsor a specific child in the "Road to Hope" program, to ensure this child has his or her basic needs met for food, clothing and education.

Registration for this special event is $25 a person or $45 a couple. Students with a valid Student ID can register for $5. For more information, please contact Hannah Birong at BirongH(at) cfhcare(dot)org or 574.243.3119, or visit foundationforhospice.org.

About Center for Hospice Care and the Hospice Foundation

Established in 1978, Center for Hospice Care is an independent, community-based, not-for-profit organization, improving the quality of living through hospice, home health, grief

counseling, and community education. With offices in South Bend, Plymouth, Elkhart and Mishawaka, CHC serves Elkhart, Fulton, Kosciusko, LaGrange, LaPorte, Marshall, Porter, St. Joseph and Starke counties in Northern Indiana.

The Hospice Foundation is committed to supporting the work of CHC through community outreach and education, fundraising activities and other special events. The Foundation helps CHC keep its 37-year promise that no one eligible for hospice services will be turned away, regardless of their ability to pay.

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Center for Hospice Care
Compliance Committee Meeting Minutes
September 14, 2017

Members Present:	Dave Haley, Jon Kubley, Mark Murray, Sue Morgan, Vicki Gnoth
Absent:	Craig Harrell, Karl Holderman

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 3:00 p.m.	
2. Minutes	• The minutes of the 05/11/17 meeting were reviewed. The minutes were approved by consensus. • We did make the HHS Nondiscrimination Rule changes in all applicable policies and manuals. • Sue did not follow up with Hospice of the Calumet Area about their survey process, but she did review their survey results and didn't see anything out of the ordinary. Vicki followed up with their HR department and they said there was nothing different or significant with the survey process. We don't think ISDH is using the contracted surveyors now. The contracted surveyors seemed to be more interested in the physical environment and Life Safety Code issues.	
3. Home Health Compliance Plan	• The Home Health Compliance Plan was reviewed and the following changes and clarifications were made: • Plan of Care: Physician Certification – The policy talks about IDTs, which is not a Home Health requirement. IDT is also reference in the "Utilization of Services" policy. Delete that part of the policy. Home health patients are reviewed at the biweekly IDTs, but the physicians don't sign anything. We will delete the IDT part of the policy, and Becky will review the other Home Health Compliance Policies to make sure they don't reference IDTs as well. • Securing Patient Information in the Electronic Medical Record – the CHC email address domain needs to be updated to *cfhcare.org.* Becky will make those changes. • Destruction of Clinical Records – The top should say Home Health Compliance, not Hospice Compliance. Becky will make that correction. • Investigatory Site Visit: State and Federal – Number six should be deleted, because, even	

Topic	Discussion	Action
	though we can, we have never recorded the survey exit interview and likely never will. Becky will correct it. • Verification of Physician Signature – Sue will check to see if QA is still doing random checks of signatures. Someone may be doing it quarterly. • Untimely Physician Signatures – We will leave this at 14 days, even though now turn around time is averaging four days. • Orientation Checklist – The orientation checklist is kept in the employee's file after it is completed. A copy of the form could be attached to the policy as an addendum. Delete the word "new" from the policy. • Some of the new Home Health CoPs are related to patient complaints and concerns, so Sue will make sure our policies are compliant with the new regulations.	
4. GIP Utilization	• At the last meeting we talked about Rebecca's six month report on GIP patients and documentation and working with IT on getting a GIP documentation format in Cerner. We have not started the Cerner format yet. Visits twice a day for GIP in the hospital depends upon the patient's condition. We need to start sending the emergency visit nurses in the evening in case there is a change of any sort. These would be scheduled visits. If a GIP in a hospital is waiting for Hospice House and no beds are available, the patient is not doing well, or the hospitalist says the patient cannot be moved, we should make a second visit. If the hospitalist says the patient is too frail to be moved, the nurse could assess that to make sure that is true. We have made some progress with the hospital staff not telling patients and families that they can stay in the hospital as long as they want. • Overall the biggest issue is documentation. Dr. Gifford will be reviewing this with the medical staff tomorrow. We would like to try to meet with new hospitalists or with them as a group to educate them on how GIP works. We did review everything again with the SJRMC-Mishawaka case managers a couple weeks ago. We need to look at the results from the last couple months which Rebecca is doing. That data should be brought to the next Compliance meeting in January. • We just had 14 GIP charts reviewed by Medicare and all were approved. It was a technical audit and everyone in the NHERT that was audited also had 11-12 charts requested for technical things. The audits were for things like missing signature, wrong date, etc.; nothing related to whether the documentation showed the patient was eligible	

Topic	Discussion	Action
	for GIP level of care that day. We are supposed to document what we tried in the home that failed that made the patient eligible for GIP. We do a terrible job at that. We don't have many problems at EGH because Dr. Burger is often involved and those patients go to Elkhart Hospice House.	
5. OIG Work Plan	• There is nothing in their recent report we need to be concerned about.	
6. Mock Survey Feedback	• The group will get together Friday for a wrap up meeting. With the exception of IDTs, overall we're looking good. The group did nurse visits with PCCs, car checks, visits with social work and bereavement, and did group interviews. We feel confident we are prepared for the hospice survey.	
7. Annual Compliance Inservice	• Vicki will do a general overview of the compliance program, why we have it, and what we have been working on at the September staff meeting.	
Adjournment	• The meeting adjourned at 3:35 p.m.	Next meeting TBA in January 2018

Center for Hospice Care
QI Committee Meeting Minutes
August 22, 2017

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m. Dr. Cohen chaired the meeting in Dr. Gifford's absence.	
2. Minutes	• The minutes of the 05/23/17 meeting were approved by consensus.	
3. New Members	• Terri Smith, Admissions Coordinator, and Carrie Healy, Social Work Coordinator, were welcomed to the committee.	
4. National Updates	• CMS Hospice Compare Website – The new Hospice Compare Website was reviewed. Consumers will be able to log on and compare hospices. Each agency electronically reports their data to CMS using the Hospice Item Set (HIS). The data that appears on the website was collected from 10/01/15-09/30/16. The website compares quality of care and symptom management. Our percentage for timely and thorough pain assessment when pain was identified as a problem was 58.7%. In the beginning there was confusion on how many of the seven elements needed to be counted. We don't know how often the data on the website is refreshed with new data. We did a preview a couple months ago, so we knew what our percentages would be on the website, and put mechanisms in place to improve our scores. • HIS Data – We discovered staff was looking at the HIS as a task to be completed and not matching it to the initial assessment. We did education in February with all admission nurses on how the HIS and initial assessment should match, and that at least five of the seven elements on the HIS pain assessment needed to be completed. In April we educated Hospice House staff. At the end of July our scores were up to 87%. We also did one-on-one training with individual nurses as needed. Education on correct pain screening and assessment continues for admission nurses. The Hospice House admission form was changed so it matches the one used by the admission	

Topic	Discussion	Action
	nurses. Monitoring is done routinely on the HIS elements by the Admissions Coordinator and the ADON • CAHPS Survey – We have been working on print materials for patients and families. Clinical staff orientation has been revised to include comprehensive education on end-of-life symptom control and the care kit medications. We can create custom reports of the CAHPS data through Press Ganey by service date, in addition to the standing monthly and quarterly reports. The agency coordinators meet quarterly and review the quarterly report top box scores and make recommendations for improvement projects. One area where we have improved is in identifying the correct person to receive the CAHPS survey. We are now working on staff using the language used in the survey in their conversations with patients and families, so family members become familiar with those words when completing the survey. Carol W. in the past the hospital staff was told not to use the exact language in the surveys, because it could be seen as scripting. Just an FYI to keep in mind.	
5. Performance Improvement	• Education – Seven nurses had CPR training. Power Chart training on how to use the SJRMC EMR was done so our staff can access records when caring for a GIP patient in the hospital. The annual volunteer inservice day was held in June that included education on HIPAA and Bloodborne Pathogens. Some staff attended the annual IHPCO Regulatory and Compliance Day in April. Staff also participated in an NHPCO webinar on Hospice Audits. • Emergency Preparedness – The new CMS CoPs for Emergency Preparedness go into effect in November. Tammy H. and Rebecca F. are CHC representatives on the Healthcare Coalition and District Planning Counsel for Northern Indiana. Rebecca F. participated in a District table top exercise in June. A seminar on the CoPs will be held at Memorial on 10/06. A county-wide disaster drill will be held on 09/20 at the airport in South Bend. Because of the new CMS requirements, many new people are joining the coalition, but they are not able to get everyone involved in the drill this year. We offered bereavement counseling and they were happy to have Holly Farmer and Annette Deguch, who are also certified in emergency counseling, to participate. We may also have some staff participate as volunteers for the drill. Tammy H. will be sitting on a subcommittee for education and other trainings. We did a Hazard Vulnerability Analysis so we know our vulnerabilities for emergencies. On 08/30 we will test our emergency universal alert system of staff. We have had a long standing	

Topic	Discussion	Action
	safety committee and its name will now be changed to Safety & Emergency Preparedness Committee. • Mock Survey – In preparation for this year's hospice survey, we have been meeting with different coordinators to update them on the Hospice CoPs, review the top 25 survey deficiencies, attend IDT meetings, make visit with staff, inspect medical supplies in car trunks, infection control monitoring, etc. We have created a survey resource binder for each office. We also did a review of medical records that they were completed and up-to-date.	
6. QAPI Progress Reports	• Infection Control has always been a part of our overall QAPI program. This fall we will hold our annual car trunk fair and switch out medical supplies. The annual training on Bloodborne Pathogens will be held for all staff at the 09/27 staff meeting. The annual flu vaccine will be given in the fall. There were no needle sticks in the second quarter. • Caregiver Information – We continue to monitor that the caregiver information in the chart is accurate. This will be reported on at the next meeting. • Medication Timeliness – We continue to audit that meds are placed in Cerner while the nurse is in the home. In July 100% of the nurses working were compliant and 95% were compliant in June. • GIP Audit – Based on the OIG report from spring 2016, they found that hospices billed one-third of GIP stays inappropriately costing Medicare $268MM in 2012. Hospices commonly billed GIP when the beneficiary didn't have uncontrolled pain or unmanaged symptoms. 31% of GIP claims were billed inappropriately. So CMS hired an audit agency to audit GIP claims. We were among 65 randomly chosen hospices selected for audit on 14 patient records and 11 unique patients. The claims were from 2014-2016. The auditor wanted to see if we were caring for the patients appropriately for under GIP and billing appropriately. They rejected three claims/2 unique patients. We appealed and sent more information and they agreed the patients were appropriate. Last week they reversed their original decision. Admission staff was educated on how to document GIP patients so it is clear why they are GIP. That was done in the fall of 2016. Four of the NHERT members were also among the 65 random hospices chosen, and all of them had 11-12 claims requested and 3-4 were denied for the identical reasons—primarily technical, not related to the care provided.	

Topic	Discussion	Action
7. Patient Safety	• Medication Errors – There were five medication errors in July due to drug diversion in the home. There were no errors in Hospice House or from our nurses in the field. With the opioid epidemic, we need to handle meds differently. We cannot report missing medications to the police; the family has to do it. We do offer a medication lock box. • Falls – There were 73 in July compared to 58 in June. Most of the falls occurred outside the home. For example, one happened while the patient was mowing his grass. There were no injuries as a result of these falls. We are also monitoring patients that repeatedly fall. Most are related to toileting and getting out of bed. After a second fall, the PCC is informed. Nurses were given a self-learning packet in July on falls, safety, and completing the incident report form. We do what we can in the home to train patient and family to prevent falls.	
8. Quality Indicators	• Spiritual Care – One of the first quality indicators we implemented was the content of the comprehensive assessment and counseling services. We have a daily admission report for counselors and identify any immediate needs. Those are being addressed 100%. We are working with IT on a new document to implement the established spiritual care assessment tool into Cerner. We will be looking to identify new quality indicators for 2018 based on the CoPs and reports from the Chaplaincy Network. • Social Work – We continue to do peer reviews of admission IDT documentation. The next step is working with QA and others in identifying and creating additional quality indicators as needed. • Interdisciplinary Team – We are monitoring the scope and frequency of visits for nursing, social work, and spiritual care based on the identified needs of the patient and family. In the first quarter we looked at 30% of the nursing caseloads and any social work and spiritual care visits attached to those caseloads. In March the visits made met the ordered frequency for nursing 99%, spiritual care 95%, social work 100%. We audit to see whether we are meeting the patient and family's needs, and whether the care plans are updated with the amount of visits being made in the cert period. • Nursing – One of the greatest survey risk areas is care planning. It always appears in the top 25 survey deficiencies. We average 86-88% compliance and our goal is 90%. The care plan must reflect the patient/family's goals and needs. It needs to be updated when the patient's condition changes. One identified area of weakness was updating for falls and also trouble breathing. We want to put into place a plan to replicate how the "superstars" on staff are updating their care plans, and share their processes with	

Topic	Discussion	Action
	staff. They have processes in place that are successful. We have also started real time reminder during the weekly IDTs to update the care plan when the nurse reports a change that has occurred over the past two weeks. • Experience Model – We have implanted a model for IDTs at each office that focuses on the end of life experience of the patient and family and meet their needs. In this model, the social worker talks first, then spiritual care, and then the nurse. In the past the nurse was dominating the IDT and addressing support service needs. We also look at the patient and family's goals, not just our goals. This affects all disciplines.	
9. Home Health COPs	• The new Home Health CoPs came out this year. This is the first major revision in several years. We have updated our home heath patient care policies to reflect the revised CoPs. One area was on infection control. These policies now more closely match the hospice which we already had in place. Another area was the QAPI program, which is now set up like hospice and long-term care facilities. The training and competency requirements were clarified for home health aides. Indiana's requirements have always been stricter than the Federal standards. There are now some face-to-face requirements for home health Medicaid patients. We will use the same processes that we have in place for our hospice patients that are applicable to Home Health Medicaid to ensure compliance.	
Adjournment	• The meeting adjourned at 9:00 a.m.	Next meeting 11/28

Center for Hospice Care
choices to make the most of life

CHAPTER FOUR

POLICIES

REGULATION: IC 29-2-16.1 – Uniform Anatomical Gift Act (UAGA)

PURPOSE: To ensure patient's rights for tissue, eye, or whole body donation is honored.

POLICY: Agency personnel will ensure that a patient who has requested tissue, eye, or whole body donation's decision is honored according to the self-determination act under the UAGA law.

PROCEDURE:

1. **Determination**
   a. Family/patient/caregiver notifies staff that patients has made decision to be a donor
   b. Social Work will be notified via secure message regarding decision
   c. Note will be added to Alerts titled Donation

2. **Post Death (tissue/eye donation):**
   a. CHC staff will not discuss specifics of donation regarding what can be donated or how it is done.
   b. Within 1 hour of pronouncement of death, Nurse/Social Work will call the Indiana Donor Hotline at **800-356-7757.**
   c. Nurse/SW will have patient name, birthdate, and past medical history available for donation specialist.
   d. Nurse/SW will have available name of legal next of kin/HCR and a number they can be reached at, if family is not present.
   e. Do not release body to funeral home until okay given from Indiana Donor Network.

3. **Care of the Body**
   a. Place pillow under head
   b. Gently tape eyelids closed
   c. Fill 2 gloves with ice and place gently over eyes
   d. Keep body as cool as possible

4. **Whole Body Donation**
   a. Patient or family must have completed a Bequeathal form before death
   b. Call Indiana University School Of Medicine after pronouncement at **317-274-7450**

Effective Date: 07/17	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

REGULATION: 42 CFR 418.110 – Hospices that provide inpatient care directly

PURPOSE: To ensure proper food preparation.

POLICY: All meals being prepared by staff or volunteers will be prepared in accordance with the proper procedure to ensure the quality and sanitation of the meal.

PROCEDURE:

1. The door(s) to the prep kitchen will be closed.
2. Hair nets and disposable gloves will be worn (see Hair Restraints policy).
3. Counters will be wiped down both before and after the meal is prepared using the bleach solution located under the sink.
4. Temperature of the food will be taken as described in the Test Tray policy and recorded accordingly.
5. Food will be covered while being transported to the patient's room (see Transportation of Food policy).
6. All meal preparations for Hospice House patients will be done in the microwave. The stove is not to be used for the safety of patients, staff, and the facility. Any staff or family member asking to use the stove will be educated by staff.