Center for Hospice Care
choices to make the most of life

Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
February 21, 2018
7:30 a.m.

BOARD BRIEFING BOOK

Table of Contents

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
February 21, 2018
7:15 a.m.

A G E N D A

1. Introduction of New Board Members – Wendell Walsh (3 minutes)

2. Consent Agenda (2 minutes):

   A. Approval of December 20, 2017 Minutes *(action)*
   B. Policies *(action)* – Sue Morgan available to answer questions

3. President's Report *(information)* - Mark Murray (15 minutes)

4. Finance Committee *(action)* – Lori Turner (10 minutes)

   A. December 2017 Year End Pre-Audited Financial Statements *(action)*

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

6. Board Education – 2017: The Year in Review – Mark Murray (18 Minutes)

7. Chairman's Report – Wendell Walsh (10 minutes)

   A. Executive Committee Recommendation on Renewal of Pres/CEO Employment Agreement *(action)*
   B. Pres/CEO rejoins the meeting for discussion of Employment Agreement

Next meeting May 16, 2018 at 7:30 a.m.

# # #

Center for Hospice Care
choices to make the most of life

CHAPTER TWO

MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
December 20, 2017

Members Present:	Amy Kuhar Mauro, Anna Milligan, Carol Walker, Jesse Hsieh, Lori Turner, Mary Newbold, Suzie Weirick, Tim Portolese, Wendell Walsh
Absent:	Ann Firth, Jennifer Ewing
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 10/18/17 meeting as presented. The motion was accepted unanimously.	L. Turner motioned M. Newbold seconded
3. President's Report	• In September census hit a low for the year and we have been slowly recovering. This is mainly due to short lengths of stay. To meet budgeted expenses we need an ADC of 383 and for actual expenses 348. Budgeted revenue is down $924,000, but budgeted expenses are down almost $2MM. We are projecting to serve over 2,000 patients for the fourth year in a row, so we continue to be in the top 3% in the country in the annual number of patients served. Our market share has decreased over the past five to six years due to increased competition, many of which didn't exist three years ago. A lot of for-profits are coming into the market over promising and under delivering, and those patients slowly come back to us. The bottom line is providing good patient care. • We have not had our hospice survey yet, which was scheduled for October. A new law was passed four years ago that all hospices in the country must be surveyed at least every three years, because on average it was running every 11 years. Indiana is swamped doing regular surveys and follow ups on complaints, which they have to do within 24 hours. We are very prepared for whenever it takes place. • Optum Hospice Pharmacy Services said CHC is the "best demonstrated practice model" of their customers. They came out with a new program for hospices to help them pick the most effective and cost effective medications for patients. We asked if we should sign up, but they said there was nothing they could do for us because we were the best of the best. It shows how good our medical directors are in picking the	

Topic	Discussion	Action
	best medications for our patients at the best cost. • We had a field visit from Worker's Compensation Loss Control and they were very impressed with our safety programs for staff. We have not had any issues or accidents in our history, and make sure safety is important. They visited us, talked to staff, and were very pleased with what they found. • Our community-based palliative care program has not gotten off the ground, so we will be scheduling an internal summit with key stakeholders to get this moving. Historically palliative care is done under our home health license. These are patients that would be in that program and we would keep in touch with them over the course of a year or two. We will make this a major goal for 2018. • Thank you letters from families and schools are in the board packet. We provide free bereavement programs for students. Anna M. suggested contacting school principals, because they have identified a need for grief counseling for children with family members in prison. We will look into that. • The new U.S. tax plan vote will come today. Rates will be lower as of January 1st, so donors should make charitable gifts before the end of year because they will be worth more this year than next year due to the lower rates. • The dedication of new bricks and plaques for the Veterans Memorial was held on 10/26. The annual Holiday Memorial Services was held on 11/19 had the second highest attendance in its history at 736. We received great comments from those that attended. Okuyamba Fest was held on 10/12. • Our temporary LaPorte office is ready. A larger one is being built across the street. We are waiting for permission from the ISDH and CMS for this additional office. We have hired a Patient Care Coordinator and a Professional Relations Liaison. • A week ago Mark met with Seema Verma, the CMS Administrator. The meeting included Edo Banach, President/CEO of NHPCO, Judi Lund Person, NHPCO VP of Regulatory & Compliance, and Angie Sells, President of AseraCare. It went very well. • MedPAC gave a presentation on 12/08. Their report stated the overall growth of hospice care is driven by the growth of for-profit hospices. The number of nonprofit hospices has been shrinking. The number of hospices continues to go up, and the ALOS has been flat the last three years. The average cost per day for Routine LOC for freestanding providers is $124, Median $125, Medicare payment per day $159,	

Topic	Discussion	Action
	and the share of hospice days is 97.8%. According to MedPAC data, Medicare is generally paying more than the Routine LOC is costing across the country. MedPAC gets its data off of the Medicare Cost Report, but inexplicably, they don't include the cost of bereavement and volunteer programming. The profit margin by for-profits is 16.4% and nonprofits 0.1%.	
4. Finance Committee	• 2018 Flex Spending Account Limit – The Finance Committee approved keeping the limit at $2,000 for 2018. A motion was made to approve setting the flex spending limit at $2,000 for 2018. The motion was accepted unanimously. • 2017 Retirement Plan Audit – The Finance Committee reviewed the audit of our retirement plan. There were no deficiencies, issues, or recommendations. The audit is an IRS requirement. A motion was made to accept the Retirement Plan Audit as presented. The motion was accepted unanimously. • October Financial Statements – Total operating income was $1,779,852, MADS revenue $39,656, beneficial interest in Foundation $110,830, total revenue $1,931,237, total expenses $1,641,938, net gain $289,299, net without beneficial interest in Foundation $178,469. October YTD operating income $17,484,169, MADS revenue $374,983, beneficial interest in Foundation $1,938,701, total revenue $19,823,324, total expenses $16,187,833, net gain $3,635,491, net without beneficial interest in Foundation $1,696,790. • November Financial Statements –Total operating income $1,737,682, MADS revenue $39,395, beneficial interest in Foundation $869,201, total revenue $2,652,296, total expenses $1,619,955, net gain $1,032,341, net without beneficial interest $163,140. November YTD operating income $19,221,850, MADS revenue $414,377, beneficial interest in Foundation $2,807,902, total revenue $22,475,618, total expenses $17,807,791, net gain $4,667,827, net without beneficial interest $1,859,925. • A motion was made to accept the October and November 2017 financial statements as presented. The motion was accepted unanimously. • 2018 Budget – We are projecting to serve 1,121 patients and an ADC of 398—a 3.8% increase. This translates to $22MM operating income, total revenue $23.3MM, total expenses $21.8MM, net gain $1.4MM. We project a 5% increase in revenue based on the ADC. Expenses are up 11% primarily associated with staffing. 53% of overall expenses are staffing. We will see an increase in direct care costs with a	S. Weirick motioned J. Hsieh seconded T. Portolese motioned S. Weirick seconded A. Mauro motioned A. Milligan seconded

Topic	Discussion	Action
	higher ADC. We will continue a robust outreach campaign as well. Raises are based on a set scale and annual performance evaluation. We look at the average increase over the past several years and put that in the budget. A big portion of fundraising revenue is investment gains and losses. We budgeted a 5% return. • A motion was made to accept the 2018 budget as presented. The motion was accepted unanimously.	J. Hsieh motioned S. Weirick seconded
5. QI Committee	• The QI Committee met on 11/28. The group works very hard and is willing to criticize anything to make us better. The committee's goals have gotten better and we keep going forward.	
6. Foundation Update	• Crossroads Campaign – We have made some great strides this year. Overall revenue is up $1MM from the same time last year. We have gone over our $10MM campaign goal. The plan is to continue the campaign for another 1½ years, because we are in year 3½ of a five year campaign. We still have some underfunded priorities. Our focus in 2018 will be to raise money for the new inpatient unit. We plan to begin construction next year and we are still under-funded in that area. We received a gift from Ernestine Raclin and the inpatient unit will be named something like the Ernestine M. Raclin House. We want to move away from the term Hospice House. There is still $1.5MM remaining for the inpatient unit. • We have raised about $3.5MM of the $5MM capital projects, so we continue to pursue that. We developed a brochure we can use with potential donors we have not met with yet or received a commitment. The other underfunded priority is the Hospice and Palliative Medicine Fellowship Program. We received $750,000 from the Vera Dwyer Trust—$500,000 for the Fellowship program for five years and $250,000—or $50,000 a year for five years—for community education. We also have a challenge grant to raise $1MM for a permanent endowment for the Fellowship program. So far we have raised about $150,000 of that, so there is about $850,000 remaining to be raised. • GPIC – We continue to make strides. We took the program over from NHPCO a year ago. There are actually about 65 partners instead of 75. We have gone through a process to create a 3-5 year strategic plan in the next couple months. • Center for Education and Advance Care Planning – This consists of various education programs, community education programs, screening of "Being Mortal," etc. We also work with various organizations in the community and universities. We	

Topic	Discussion	Action
	are working with Honoring Choices Indiana North Central (HCINC), a coalition of medical programs and faith communities. This was initiated about three years ago to encourage people to have the conversation about questions at the end of life. The coalition concluded they didn't want to start their own 501c3, but rather align themselves with another organization with similar goals. This has been one of the strategic plans of the Hospice Foundation to be the convener for these issues. So we created a DBA under the Hospice Foundation for HCINC. Through the Secretary of State of Indiana we can receive gifts directed towards that initiative. So we set up a separate line item on the financials for it. We also have some money from the Vera Dwyer Trust for community education, and we can use a portion of that to help with HCINC initiatives. • Mishawaka Campus – We are working towards breaking ground on the clinical staff building in April, and then the inpatient unit in the summer. We have been in conversation with the owner of the house on Madison Street. If we purchase his home, it would add more parking for the inpatient unit. • We have a number of events planned for 2018. It will be the 25th anniversary of Camp Evergreen, 10th anniversary of the Elkhart Campus, and the 10th anniversary of our partnership with PCAU.	
7. Nominating Committee	• Four CHC Board members are eligible for a second three-year term: Ann Firth, Jesse Hsieh, MD, Lori Turner, and Suzie Weirick. The Board agreed by consensus that they should serve a second term. • New Nominations – Jennifer Houin from Plymouth and Tricia Luck from LaPorte are nominating to be new CHC Board members effective January 1, 2018. With their addition, we will be at 13 members and the Bylaws say we can have 9-15 members. The officers will remain the same for 2018. • A motion was made to accept the nomination of Jennifer Houin and Tricia Luck for the CHC Board of Directors. The motion was accepted unanimously.	T. Portolese motioned M. Newbold seconded
8. Board Education	• Vicki Gnoth, Director of Human Resources, did a presentation on CHC Employee Benefits.	
Adjournment	• The meeting adjourned at 8:50 a.m.	Next meeting 02/21

Prepared by Becky Kizer for approval by the Board of Directors on 02/21/18.

_____ _____

Carol Walker, Secretary Becky Kizer, Recording Secretary

Center for Hospice Care
choices to make the most of life

CHAPTER THREE

POLICIES

PURPOSE: The purpose of this guideline is to establish a procedure on using a blood glucose monitor (BGM).

POLICY: Hospice House staff will be FDA compliant with CLIA and manufacturer guidelines.

PROCEDURE:

1. CHC will be FDA compliant by maintaining a current CLIA Waiver.

2. BGM will be done according to physician's orders or nursing order due to change in patient condition that may be related to low glucose levels.

3. Each BGM will have control testing done at a minimum of:
   a. When a new bottle of test strips is opened
   b. When reagent lots are changed
   c. When patient results seem questionable
   d. Whenever there is a question the meter or test strips may not be functioning properly
   e. If the test strips were left open or has been exposed to light
   f. After calibration
   g. Each time the batteries are changed
   h. When meter has been dropped
   i. When the test kit temperatures exceed the manufacturers limits.
   j. According to manufacturer recommendations

4. Control testing will done in accordance with directions from manufacturer of BGM.

5. BGM log for control testing will be completed each time control testing is done. Completed logs will be kept in the Hospice House Coordinator's office for one year. See attached.

6. All staff that performs blood glucose testing will show yearly competency in blood glucose testing and control testing.

7. Clean monitor after every use with an EPA registered disinfectant detergent or germicide that is approved for healthcare settings or a solution of 1:10 concentration of bleach. Wipes may be used; if blood is visibly present on monitor, two wipes must be used; one wipe to clean and one wipe to disinfect.

Facility: Dr. Smith's Office
Location: 123 Main Street
Atlanta, GA 55555

Results Log with QC – Quantitative Test

Test Name: XYZ ALT

Reportable Range: 5-400 U/L

	Date	Sample ID / Patient ID	Test Results	Initials	Test Lot number / Test Exp. Date	QC Level 1 Control	QC Level 2 Control
1	5/5/2012	5/5/2018 / Steve Smith	Male: 30U/L	CO	C843/06-31-2013	lot #: 91750566 range: 43-78 U/L result: 57 U/L	lot #: 91750566 range: 132-242 U/L result: 203 U/L
2	5/5/2012	5/5/2019 / Chris White	Male: 22U/L	CO	C843/06-31-2013	lot #: 91750566 range: 43-78 U/L result: 58 U/L	lot #: 91750566 range: 132-242 U/L result: 221 U/L
3	5/7/2012	5/5/1930 / Sam Jones	Female: 14U/L	CO	C843/06-31-2013	lot #: 91750566 range: 43-78 U/L result: 57 U/L	lot #: 91750566 range: 132-242 U/L result: 221 U/L
4						lot #: range: result:	lot #: range: result:
5						lot #: range: result:	lot #: range: result:
6						lot #: range: result:	lot #: range: result:
7						lot #: range: result:	lot #: range: result:
8						lot #: range: result:	lot #: range: result:
9						lot #: range: result:	lot #: range: result:

** Reportable Range is the range of results for which a test system has been proven to yield accurate results. This is usually found in the manufacturer's instructions for the test.*

REGULATION: 42 CFR 418.106(d)(1) – Drugs and biologicals, medical supplies, and durable medical equipment

PURPOSE: To place emergency medications in the home to be used for symptom management.

POLICY: CHC nurses will place appropriate Care Kits in the home to insure medications are available in the event the patient has a symptom that cannot be controlled by current medication regime.

PROCEDURE:

1. All patients not in an Extended Care Facility (ECF), acute care facility, or hospice inpatient unit will have a Care Kit ordered related to their terminal diagnosis.

2. Admitting nurse will order appropriate Care Kit, according to Attachment A, under order sets in Cerner.
   (a) Admitting nurse will explain Care Kit to family and what to do with it when it arrives.
   (b) Admitting nurse should obtain a local supply of Morphine/Lorazepam if there is the potential patient may become symptomatic before Care Kit arrives.

3. When a pediatric patient < 2 years old needs a Care Kit, the admitting nurse will complete a Pediatric Comfort Care Kit Order Worksheet and upload to Admission Level in Cerner.
   (a) When a pediatric patient experiences a 5% gain or loss in weight, a new worksheet will be completed and dosages will be updated in Cerner.

4. Admitting nurse will call CHC contracted pharmacy for delivery.

5. CHC contracted pharmacy will send prescription for Schedule II drugs to CHC medical director for signature.

ATTACHMENT Pediatric Comfort Care Kit Worksheet
Attachment A – Comfort Care Kit, Cardiac Comfort Add On, Seizure Care Add On

Center for Hospice Care
choices to make the most of life™

Pediatric Comfort Care Kit Order Worksheet

Patient Name: _____ DOB: _____

Allergies: _____ Weight: _____Kg Height: _____in

Diagnosis: _____

Date: _____

Call contracted pharmacy service Pediatric Pharmacist for recommendation on doses and complete below.

Name of pharmacist; _____

Contact number for pharmacist: _____

For Pediatric Patients < 2 years old (Do not use for neonates 28 days or less)

RX				
Drug	**Strength**	**Qty**	**Initial Mg/Kg/Dose**	**Directions**
Acetaminophen (Tylenol) suppository	120 mg	3	10-20	____ mg rectally every 4-6 hours as needed for mild pain or fever; *Max daily dose 75 mg/kg/day*
Metoclopramide (Reglan)	5 mg / 5 ml	15 ml	0.1 – 0.2	____ ml (_____mg) by mouth every 6 hours as needed for nausea or vomiting
Lorazepam (Ativan)	2 mg / ml	30 ml	0.02 – 0.05	____ ml (_____mg) by mouth, under the tongue or rectally every 4 hours as needed for anxiety, restlessness, or seizures
Morphine Sulfate	10 mg/5 ml	15 ml	0.2 – 0.5	____ ml (_____mg) by mouth, under the tongue or rectally every 3 hours as needed for moderate pain or dyspnea

Do not exceed adult starting dose or maximum doses. If patient experiences a 5% weight gain or loss, the dose will need to be recalculated.

Requesting RN (print name):_____

Verify above orders with CHC MD/NP and place orders under verifying MD/NP in Cerner.

Name of CHC MD/NP: _____

Care Kits Attachment A

Comfort Care Kit

- **Acetaminophen 650mg Suppositories**, 4 (four) suppositories, Insert 1 suppository (650mg) rectally every 4 hours as needed for mild pain or fever
- **Bisacodyl 10mg suppositories**, 2 (two) suppositories, Insert one suppository (10mg) rectally once daily as needed for constipation
- **Haloperidol 2mg/ml oral concentrate**, 15 (fifteen) ml, Take 0.5ml (1mg) by mouth or under the tongue every 4 hours as needed for agitation, nausea, and vomiting
- **Hyoscyamine 0.125mg SL tablets**, 12 (twelve) tablets, Place 1 tablet (0.125mg) under the tongue every 4 hours as needed for secretions
- **Lorazepam 0.5mg tablets**, 10 (ten) tablets, Take 1 tablet (0.5mg) by mouth every 6 hours as needed for anxiety or agitation
- **Prochlorperazine 10mg tablets**, 4 (four) tablets, Take 1 tablet (10mg) by mouth every 4 hours as needed for nausea and vomiting
- **Morphine Sulfate oral concentrate** 20mg/ ml, Take 0.25ml (5mg) by mouth or under the tongue every 3 hours as needed for pain or shortness of breath

Cardiac Comfort Add On:

- **Furosemide 10mg/ml solution for injection,** 2 (two) x 2 ml vials, Inject intravenously or intramuscularly every 2 hours as directed as needed for edema. Do not exceed rate of 10 mg/min if given intravenously and dose is less than 120mg
- **Morphine sulfate 10mg/ml solution for injection,** 2 (two) x 1 ml vials, Inject 0.5ml (5mg) intravenously or subcutaneously every 2 hours as needed for severe chest pain or shortness of breath

Seizure Care Add On:

- **Acetaminophen 650mg Suppositories**, 4 (four) suppositories, Insert 1 suppository (650mg) rectally every 6 hours as needed for mild pain or fever
- **Bisacodyl 10mg suppositories**, 2 (two) suppositories, Insert one suppository (10mg) rectally once daily as needed for constipation
- **Hyoscyamine 0.125mg SL tablets**, 12 (twelve) tablets, Place 1 tablet (0.125mg) under the tongue every 4 hours as needed for secretions
- **Lorazepam 0.5mg tablets**, 10 (ten) tablets, Take 1 tablet (0.5mg) by mouth every 6 hours as needed for anxiety or restlessness
- **Prochlorperazine 10mg tablets**, 4 (four) tablets, Take 1 tablet (10mg) by mouth every 4 hours as needed for nausea and vomiting
- **Lorazepam 2mg/ml**, 30cc, 2mg administer per rectum every 20 minutes x3 prn for seizures

Center for Hospice Care

HOME HEALTH AIDE / CERTIFIED NURSE AIDE SERVICES

DRAFT

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

REGULATIONS: 42 CFR 484.80(g)(3) – Home Health Aide Services
Indiana Administrative Code: 410 IAC 17-14-1 – Scope of Services

PURPOSE: The Agency provides Home Health Aide/Certified Nurse Aide (Aide) services to patients and families for the care and support.

POLICY: To provide care and support to patients and families, by a certified nursing aide, within the professional class scope and under the supervision of a registered nurse in accordance to the established plan of care.

PROCEDURE:

1. The services of an Aide are available to patients and families on a part-time, intermittent basis, and visits are generally scheduled.

2. The Aide provides direct care to patients, such as: bathing, mouth care, and other hygienic related duties and tasks. The Aide can also be available for light housekeeping, preparing light meals, and giving emotional support.

3. All patient care activities and visits are provided by an Aide in accordance to the established plan of care and under the supervision of a Registered Nurse.

Effective Date: 02/94	Revised Date: 12/17 ~~05/16~~	Board Approved: 10/19/16
Reviewed Date: 03/17		Signature Date: 10/19/16

Signature: President/CEO

REGULATION: 42 CFR 484.80(c)(1) – Competency Evaluation Inservices Training
Indiana Administrative Code: 410 IAC 17-14-1

PURPOSE: The Agency will hire Home Health Aide/Certified Nurse Aides (Aide) with current certification and are in good standing with the State of Indiana, and who have successfully met the requirements of the Agency's Aide Competency Evaluation Program.

POLICY: The Agency's Aide Competency Evaluation Program addresses all sections and subsections of Federal and State Conditions of Participation for Home Health programming. Competency evaluation is through written examination, oral examination, and observation of specific duties and tasks.

To successfully complete the Agency's Competency Evaluation Program, the Aide must:

- Pass a written competency exam with a 90% minimum score.
- Meet all elements required on the Aide Competency Evaluation Skills Checklist (see attachment).
- Training and education pertinent to job duties and responsibilities as required.

PROCEDURE:

1. The Aide must be validated on any duty or task they will be assigned to perform according to the Aide Competency Evaluation Skills Checklist.

2. The following skills and tasks will be evaluated by observing the Aide's performance with a patient (not a manikin).
   (a) Communication skills, including the ability to read and write. Ability to give verbal report of clinical information to patients, family members/caregivers and coworkers within the Agency.
   (b) Reading and recording temperature, pulse, and respiration.

   (c) Appropriate and safe techniques of personal hygiene and grooming that includes:
      - Bed, sponge, tub, and shower bathing
      - Hair shampooing by a variety of methods
      - Skin and Nail Care
      - Oral Hygiene
      - Toileting and elimination
      - Safe transfers and ambulation
      - Normal range of motion and positioning
   (d) Recognizing emergencies
   (e) Nutrition and fluid intake

(f) Infection control procedures
(g) Physical, emotional development needs of the population served by the Agency.
(h) Other applicable skills deemed necessary by the Agency.

3. Competency evaluation must be performed by a Registered Nurse. This can include more than one RN and other skilled professionals under the supervision of the RN.

4. An Aide is not considered competent to perform duties and tasks independently until they have been evaluated by the RN as to having met the requirements satisfactorily.

5. Documentation of the Aide Competency Evaluation Program includes:
   - RN Competency Evaluation Nurses qualifications of: RN with two years minimum nursing experience, at least one year of which must be in home health care.
   - Confirmation competency was determined by direct observation and that skills were performed satisfactorily.
   - Documentation of any additional skills that are taught and tested.

Center for Hospice Care

AIDE COMPETENCY EVALUATION
SKILLS CHECK LIST

Name:_____

Competency Evaluated Topics	Date met	Comments
Mobility (non-simulated) *Circle skills evaluated*		
• Ambulation: Assist, Cane, Walker or Crutches • ROM: Upper or Lower; Active or Passive • Transfer: Assist, Wheelchair, or Bed-to-Chair • Positioning: In a Bed or Chair		
Personal Care (non-simulated) *Circle skills evaluated*		
• Oral: Dentures, Natural Teeth, or Gum Care • Bath: Complete or Partial Bed Bath • Bath: Shower, Tub, or Sponge bath • Finger Nail Care (*except with Diabetic Patients*) – soak, files, or trim • Hair: Shampoo – Bed, Sink, or Bathtub • Prevention of Skin Breakdown: Recognition of Pressure Areas		
Bodily Functions (non-simulated) *Circle skills evaluated*		
Toileting: • Bathroom or Commode • Bedpan • Urinal Cather Care • External Catheter • Internal Dwelling Catheter		
Vital Signs (non-simulated) *All must be evaluated*		
• Temperature • Respirations • Pulse		
Nutrition *All must be evaluated*		
• End of Life nutrition • Oral intake monitoring		
Infection Control *All must be evaluated*		
• Linen Change: Bed Occupied with Pt.; Bed Unoccupied **(non-simulated)** • Handwashing and Hand Hygiene **(non-simulated)** • Proper use of PPE_____ • Vehicle Equipment storage		

Center for Hospice Care

AIDE COMPETENCY EVALUATION
SKILLS CHECK LIST

Name:_____

Competency Evaluated Topics	Date met	Comments
Communication Skills with Patient, Family, Staff *All must be evaluated*		
• Observation, Reporting & Documentation of Pt. Status **(non-simulated)** • Respect of patient privacy • Review of Patient Bill of Rights		
Maintenance of a Clean, Safe, Healthy Environment: *All must be evaluated*		
• Recognizing slip, trip and fall hazards • Preserving a clean patient environment		
Other Individual Agency Requirements: *All must be evaluated*		
• Elder Justice & Abuse Prevention • Hospice Philosophy • Recognizing Emergencies • Safe Driving		
Certification as C.N.A in Indiana in good standing		
Other Topic's Evaluated—write in below and include method of evaluation		

Aide Competency Evaluation/12/17

Evaluator(s) signature(s): _____ Date_____

_____ Date_____

AIDE Signature _____ Date:_____

*** All RN evaluators will possess a minimum of 2 years Nursing experience, at least 1 of which in Home Health or Home Heath Hospice Care***

REGULATION: CFR 484.80(d) – Home Health Inservice Training
Indiana Administrative Code: 410 IAC 17-14-1 – Scope of Services

PURPOSE: The Agency will provide inservices as continuing education to Home Health Aide/Certified Nursing Aides, referenced as Aides.

POLICY Aides must receive continuing education totaling 12 hours per calendar year—January 1st through December 31st annually.

PROCEDURE:

1. The Agency's Aide inservices are taught by a Registered Nurse with at least two years nursing experience, at least one year of which must be in Home Health Care, or by other individuals under the general supervision of the afore designated RN.

2. General supervision means that the RN approves the content and attends the presentation to ensure the content is consistent with the Agency's policies and procedures.

3. The Agency will maintain documentation that demonstrates inservice training requirements are being met.

4. Inservice training shall total 12 hours from January 1st through December 31st inclusive, with a minimum of eight (8) hours in any of the following subject areas:
   (a) Communication Skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other Agency staff.
   (b) Observing, reporting, and documenting patient status and the care furnished.
   (c) Reading and recording temperature, pulse, and respirations.
   (d) Basic infection control procedures and standard precautions.
   (e) Basic elements of body functioning and changes to body functions that must be reported to the Aide's Case Manager or Supervisor.
   (f) Maintaining a clean, safe, and healthy environment.
   (g) Recognizing emergencies and knowledge of emergency procedures.
   (h) Physical, emotional, and developmental needs of and ways to work with the population served by the Agency, including respect for patient, patient's privacy, and the patient's property.
   (i) Appropriate and safe techniques in personal hygiene and grooming, including the following:
      - Bed, sponge, tub, or showing bathing
      - Shampooing utilizing a variety of techniques

- Nail and skin care
- Oral care
- Toileting and elimination

(j) Safe transfer techniques
(k) Normal range of motion and positioning
(l) Nutrition and fluid intake
(m) Medication assistance
(n) Other tasks the Agency may have the Aide perform

REGULATION: 42 CFR 484.80(g)(h) – Assessment and Duties of the Home Health Aide

PURPOSE: To ensure Home Health Aide/Certified Nurse Aides (Aides) are assigned duties by the RN or other skilled professional is in accordance with the patient's written plan of care, ordered by the physician, permitted by state law, and are consistent with the Aide's training and education.

POLICY: Duties of the Aide include:

- Provision of hands on personal care.
- Performance of simple procedures as an extension of nursing or therapy services.
- Assistance with ambulation or exercises.

PROCEDURE: **As a member of the IDT:**

1. All duties or assigned procedures will be within the Aide's scope of practice for an Aide in the State of Indiana.

2. The Aide may only perform a task they have been trained to perform.

3. Aides are included as a member of the Interdisciplinary Team (IDT) and are to take part in IDT meetings, and be involved in the patient's care.

4. During relevant IDT meetings, the Aides are to contribute to the discussion either by communicating in person, by phone or electronically with the Case Managers, or by attending IDT meetings in person.

Supervision of Aide Duties – No less frequently than every 14 days:

1. An RN or other appropriate skilled professional who is familiar with the patient's plan of care must make an onsite visit to the patient's home no less frequently than every 14 days.

2. During the Aide Supervisory Visit, the Aide does not need to be present. The RN or appropriate skilled professional is evaluating that the plan of care is being followed and that the care being provided is meeting the patient and family needs.

3. If during the supervisory visit a concern is identified without the Aide being present, an RN or skilled professional must go onsite at the next scheduled visit to address the concern.

Supervision of Aide Duties – Annual onsite visit:

1. An RN or other appropriate skilled professional must make an annual onsite visit to the location where the patient is receiving care in order to observe and assess each Aide while he/she is performing care.

2. The Aide annual onsite supervision must ensure that the Aide furnishes care in a safe and effective manner including, but not limited to, the following elements:
   a) Following the patient's plan of care for completion of tasks and duties assigned to the Aide by the RN or other skilled professional.
   b) Maintaining an open communication process with the patient, representative, caregivers, or family.
   c) Demonstrating competency with assigned tasks.
   d) Complying with infection prevention and control policies and procedures.
   e) Reporting changes in the patient's condition.
   f) Honoring the patient's rights and privacy.

3. The annual onsite supervisory visit will have documentation evaluating at minimum elements (a) through (f) above.

4. In element (b) listed above, maintaining open communication process means: The Aide is able to explain what they are doing with the patient, be able to ask the patient open ended questions, seek feedback from the patient, and respond to needs and requests of the patient, representatives, caregivers, and family in an effective manner.

5. If during the annual onsite visit a deficiency in care provision is noted, a full competency evaluation in according with Agency policy: Home Health Aide/CNA Competency Evaluation Program will be conducted and documented.

6. Additional training and education may also be conducted to ensure deficient care practices are corrected.

Center for Hospice Care

AIDE COMPETENCY EVALUATION
Annual on site Supervisory—CFR 484.80(g)(h)

Name:_____

Evaluated Skills	Date met	Comments
Mobility (iii) ** *Circle skills evaluated*		
• Ambulation: Assist, Cane, Walker or Crutches • ROM: Upper or Lower; Active or Passive • Transfer: Assist, Wheelchair, or Bed-to-Chair • Positioning: In a Bed or Chair		****Evaluate skill performance against care plan (i)(iii)**
Personal Care (iii)** *Circle skills evaluated*		
• Oral: Dentures, Natural Teeth, or Gum Care • Bath: Complete or Partial Bed Bath • Bath: Shower, Tub, or Sponge bath • Finger Nail Care (*except with Diabetic Patients*) – soak, files, or trim • Hair: Shampoo – Bed, Sink, or Bathtub • Prevention of Skin Breakdown: Recognition of Pressure Areas		
Bodily Functions (iii) ** *Circle skills evaluated*		
Toileting: • Bathroom or Commode • Bedpan • Urinal Cather Care • External Catheter • Internal Dwelling Catheter		
Vital Signs *Circle Skills evaluated*		
• Temperature • Respirations • Pulse		
Nutrition (iii) ** *Circle skills evaluated*		
• End of Life nutrition • Oral intake monitoring		
Infection Control (iv) *Circle skills evaluated*		
• Linen Change: Bed Occupied with Pt.; Bed Unoccupied • Handwashing and Hand Hygiene • Proper use of PPE_____ • Vehicle Equipment storage		

Center for Hospice Care

AIDE COMPETENCY EVALUATION
Annual on site Supervisory—CFR 484.80(g)(h)

Name:_____

Competency Evaluated Topics	Date met	Comments
Communication Skills with Patient, Family, Staff (ii) *Circle skills evaluated*		
• Observation, Reporting & Documentation of Pt. Status—reporting changes **(v)** • Respect of patient privacy**(vi)** • Review of Patient Bill of Rights**(vi)**		
Maintenance of a Clean, Safe, Healthy Environment: *Circle skills evaluated*		
• Recognizing slip, trip and fall hazards • Preserving a clean patient environment		
Other Individual Agency Requirements: *Circle skills evaluated*		
• Elder Justice & Abuse Prevention **(vi)** • Hospice Philosophy • Recognizing Emergencies**(v)** • Safe Driving		
Certification as C.N.A in Indiana in good standing		
Other Topic's Evaluated—write in below and include method of evaluation		

Aide Competency/Annual On-site Supervisory 12/17

Evaluator(s) signature(s): _____ Date_____

_____ Date_____

AIDE Signature _____ Date:_____

***** All RN evaluators will possess a minimum of 2 years Nursing experience, at least 1 of which in Home Health or in Home Hospice Care***

REGULATION: 42 CFR 418.64 – Core Services
42 CFR 418.102 – Medical director

PURPOSE: To ensure that the physician employee of the Agency meets the general medical needs of the patients to the extent that these needs are not met by the attending physician.

POLICY: The Agency employed physician Medical Director will be licensed in the State of Indiana.

Oversight of physician services in the hospice is the responsibility of the Medical Director, who:

- Compliments the attending physician's care
- Acts as a medical resource to the interdisciplinary team, Hospice Physicians, and Nurse Practitioners.
- Ensures overall continuity of the program's medical services

Physician services will meet the general medical needs of the patient, in addition to palliation and management of the terminal illness and related conditions to the extent that they are not met by the attending physician.

The degree of the Medical Director involvement will vary depending on the degree of the attending physician involvement and may, therefore, differ from patient to patient.

All hospice employee physicians are direct employees of the Agency. Physician services may not be subcontracted

The Medical Director will chose a Hospice Physician designee to serve as the Medical Director in his/her absence.

RISK AREAS:

- Improper delegation of core services and professional management responsibilities to nursing homes, volunteers, and privately paid professionals.
- Inadequate management and oversight of subcontracted services, which results in improper billing.

Effective Date: 02/94	Revised Date: 01/18	Board Approved: 01/17/06
Reviewed Date: 01/18		Signature Date: 01/17/06

Signature: President/CEO

REGULATION: 42 CFR 418.106 – Drugs and biologicals, medical supplies, and durable medical equipment

PURPOSE: To provide safety and consistency in the delivery of medication for all patients in the Inpatient Unit (IPU).

POLICY: Nursing personnel shall ensure safe and effective administration of medications. Medications will be administered by an RN to patients as ordered by a physician or nurse practitioner. RNs may administer medications via oral, sublingual, topical, rectal, subcutaneous, intramuscular, intradermal, intravenous, or inhalant routes.

PROCEDURE:

1. Medication Orders

a) A physician or nurse practitioner shall write all orders for medications on a physician order form.

b) The RN or specially trained IPU staff member will enter medication orders into the Electronic Medical ~~Health~~ Record (E~~H~~MR). ~~If orders are entered into EHR by staff other than an RN, the RN must review and note the orders.~~ All orders entered in the EMR shall be double-checked by an RN to ensure accuracy and completeness of orders. -Noting orders include reviewing physician written order and EM~~H~~R orders are identical. Documentation of this verification will be noted on the physician order form to include "noted" along with the date and the RN's signature.

c) An RN may take a Verbal or Telephone order from a prescribing practitioner. These orders will be transcribed on a physician order form and shall be read back to the ordering practitioner for confirmation of accuracy.
   i. Documentation of this order will include the prescriber's name, read back and verified (RB&V) and the RNs signature.
   ii. Medication order components shall include the name of the medication, the dose, the route, and the frequency. If a PRN medication is written, the indication shall also be included.
   iii. The RN shall check for allergies at the time of the verbal/telephone order.
   iv. The practitioner must confirm order's accuracy and sign printed medication order within 72 hours.

d) Ordering medications from the pharmacy will be done by the RN for medications. All medication orders are to be faxed to the contracted pharmacy. Order (either covered or non-covered) will be identified.
   i. The contracted pharmacy will profile all orders, but only send the medications requested.

PURPOSE: To provide assistance and information to families in the event they are requesting a private pay autopsy.

POLICY: CHC Social Work Department will work with and provide information to families that are requesting autopsy of the hospice patient.

PROCEDURE:

1. Explanation to family that an autopsy is private pay.

2. Explanation to family that transport to site for autopsy is private pay.

3. Contact Coroner to help facilitate request for autopsy and gather information on what is needed.
   (a) St. Joseph County Coroner – (574) 235-5038
   (b) Elkhart County Coroner (through Elkhart County Dispatch) – (574) 533-4151
   (c) Marshall County Corner – (574) 936-0246
   (d) Western Michigan University (will take out of state) – (269) 337-6164
   (e) Fort Wayne Forensic – (260) 245-3037 or (260) 431-5952
   (f) Fort Wayne Forensic Pathologist – (260) 760-3727

4. Contact County Coroner if body needs to be stored until pick up.

5. If requested, copy pertinent paperwork from chart.

6. If family requests tissue or cornea donation, contact Indiana Donor Network (see policy on Anatomical Donation) they will work with Coroner if patient is eligible.

REGULATION: 42 CFR 418.28 Revoking the election of hospice care

PURPOSE: To comply with state and federal regulations in the revocation process.

POLICY:

1. The agency should neither request nor pressure the patient/family or representative in any way to revoke his/her election.
2. The Revocation form will be signed the **day** the Agency is informed or made aware of the patient/primary caregiver (PCG) decision to revoke. The revocation forms for both HMB and MHB will be placed in all admission packets in order to be available for immediate signing.

3. Signature must be dated the same day as the revocation.

4. ~~Revocation occurs when it is the patient/primary caregiver's determination to pursue treatment not present in the patient plan of care.~~ Patient and families should be educated that hospice entails certain limits in the way care will be provided, including restrictions on obtaining care outside the care arranged for or provided by the hospice, and the patients liability for care received without the hospice's involvement.

5. Patients who remain eligible and desire care are not pressured to revoke due to the expense of the care requested.

6. Hospitalized patients being discharged to a Skilled Nursing Facility (SNF) Medicare A skilled bed must be ~~given the option to revoke~~ educated on their options related to revocation in order for regular *Medicare to cover their SNF days. They should not be discharged.*

7. **The following questions should be answered at the IDT meeting regarding the reason for revocation:**
   - Patient's name
   - Financial class
   - Hospice diagnosis
   - Description of incident that has led up to this meeting
   - Options
   - Expected outcomes
   - Is this in their plan of care
   - Related to pain and symptom management of hospice diagnosis
   - Did the patient/primary caregiver contact the Agency first

   Document the above in the patient record.

8. **In any certification period, a revocation on the part of the patient/family causes all days remaining in that benefit period to be permanently lost; however, the patient may sign back into the HMB/MHB program. This will automatically begin with the next certification period.**

Center for Hospice Care
choices to make the most of life

CHAPTER FOUR

PRESIDENT'S REPORT

Center for Hospice Care

President / CEO Report
February 21, 2018
(*Report posted to Secure Board Website on February 15, 2018)*

This meeting takes place in Conference Rooms A at the Mishawaka Campus at 7:30 AM. This report includes event information from December 21, 2017 to February 21, 2018. The Hospice Foundation and GPIC Board meetings follow immediately in Conference Room C.

CENSUS

For the fourth consecutive year, CHC cared for over 2,000 patients in a calendar year. Patients served in 2017 totaled 2,091. According to the latest Medicare statistics, CHC continues to rank in the top 3% of all hospice programs in the U.S. There are 4,199 Medicare hospice provider numbers in the nation. The top 3% would be 126 programs. With just 32% of the hospices being not-for-profit a case could be made there are about 42 non-profit hospice programs in the nation at or above CHC when it comes to annualized numbers of patients served. Average Daily Census (ADC) has continued to recover since the low of 366 in August 2017. ADC was 380 in December and January. At the time of this writing, February is running an ADC of 386. January had an impressive number of new admissions totaling 155, the most since April 2017 and an increase of 12% from December. From a budget standpoint, we need an ADC at our current case mix of 345 to breakeven. January 2018 deaths in seven days or less came in at 38% which is down from calendar year 2017's 42%. The numbers of patients served in both inpatient units was down in 2017 from the prior year, but the average length of stay (ALOS) was up at both locations. Various efforts at increasing the overall ALOS proved successful during 2017 and the ALOS for Medicare hospice patients saw a 12% increase from 73 in 2016 to 82 days last year.

January 2018	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Patients Served	524	524	535	-2.06%
Original Admissions	155	155	148	-4.73%
ADC Hospice	360.19	360.19	361.17	-0.27%
ADC Home Health	19.71	19.71	28.55	-30.96%
ADC CHC Total	379.90	379.90	389.72	-2.52%

December 2017	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	475	2,091	2,109	-0.85%
Original Admissions	139	1,701	1,721	-1.16%
ADC Hospice	359.45	356.34	376.26	-5.29%
ADC Home Health	20.55	27.98	22.63	23.64%
ADC CHC Total	380.0	384.32	398.89	-3.65%

Monthly Average Daily Census by Office and Hospice Houses

	2018 Jan	**2018** Feb	**2018** Mar	**2018** Apr	**2018** May	**2018** June	**2018** July	**2017** Aug	**2017** Sept	**2017** Oct	**2017** Nov	**2017** Dec
S.B.:	223							203	213	215	216	221
Ply:	71							67	65	69	73	72
Elk:	77							88	77	78	77	79
SBH:	5							5	6	5	4	4
EKH:	4							3	3	4	4	4
Total:	380							366	364	371	373	380

INPATIENT UNITS (IPU)

January 2018	Current Month	Year to Date	Prior Year to Date	Percent Change
SB IPU Pts Served	29	29	35	-17.14%
SB IPU ALOS	5.07	5.07	4.49	12.92%
SB IPU Occupancy	67.74%	67.74%	72.35%	-6.37%
Elk IPU Pts Served	28	28	30	-6.67%
Elk IPU ALOS	4.46	4.46	4.13	7.99%
Elk IPU Occupancy	57.60%	57.60%	57.14%	-0.81%

December 2017	Current Month	Year to Date	Prior Year to Date	Percent Change
SB IPU Pts Served	29	350	354	-1.13%
SB IPU ALOS	4.07	5.25	5.42	-3.14%
SB IPU Occupancy	54.38%	71.86%	74.94%	-4.11%
Elk IPU Pts Served	28	295	307	-3.91%
Elk IPU ALOS	4.43	4.62	5.09	-9.23%
Elk IPU Occupancy	57.14%	53.31%	61.05%	-12.68%

PATIENTS IN FACILITIES

Of the 524 patients served in January 2018, 154 resided in facilities. Of the 475 patients served in December 155 resided in facilities. The ADC of patients in skilled nursing homes, assisted living facilities, and group homes in January was 122; December was 126 and December YTD was 128.

FINANCES

Karl Holderman, CFO, reports the December 2017 Financials will be posted to the Board website on Friday morning, February 16th following Finance Committee approval. For information purposes, the unapproved November 2017 financials are presented below. At the end of November 2017, our combined CHC's net gain, including the beneficial interest in the HF/GPIC was $4,667,827, with YTD investment gains comprising nearly $2.9MM. Overall net w/o investments were $1,775,766. CHC alone at 11/30/17 was $923,961 below its budget on revenue, but $1,996,188 below budget on expenses. On 11/30/17, Hospice Foundation's Intermediate Investment Pool totaled $4,510,707 and the Long-Term Investment Pool totaled $19,406,153. The combined total assets of all organizations were $49.4MM on 11/30/17.

November 2017 Financial Information **Error! Not a valid link.**

November 2017	Center for Hospice Care	Hospice Foundation	GPIC	Combined
CHC Operating Income	1,737,682			**1,737,682**
MADS Revenue	39,395			**39,395**
Development Income		845,613		**845,613**
Partnership Grants			17,961	**17,961**
Investment Income (Net)		257,299		**257,299**
Interest & Other	6,018	(21,228)	376	**(14,834)**
Beneficial Interest in Affiliate	869,201	(1,491)		
Total Revenue	**2,652,296**	**1,080,193**	**18,337**	**2,883,116**
Total Expenses	**1,619,955**	**210,992**	**19,827**	**1,850,774**
Net Gain	**1,032,341**	**869,201**	**(1,491)**	**1,032,341**
Net w/o Beneficial Interest	*163,140*	*870,692*		
Net w/o Investments				***775,042***

Year to Date Summary	Center for Hospice Care	Hospice Foundation	GPIC	Combined
CHC Operating Income	19,221,850			**19,221,850**
MADS Revenue	414,377			**414,377**
Development Income (Net)		2,278,420		**2,278,420**
Partnership Grants			243,948	**243,948**
Investment Income (Net)		2,892,061		**2,892,061**
Interest & Other	31,489	(6,757)	129,663	**154,395**
Beneficial Interest in Affiliate	2,807,902	128,451		
Total Revenue	**22,475,618**	**5,292,175**	**373,610**	**25,205,050**
Total Expenses	**17,807,791**	**2,484,273**	**245,159**	**20,537,223**
Net Gain	**4,667,827**	**2,807,902**	**128,451**	**4,667,827**
Net w/o Beneficial Interest	*1,859,925*	*2,679,451*		
Net w/o Investments				***1,775,766***

CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

Lisa Bryan, RN, assumed the Patient Care Coordinator position for the new branch office in La Porte on December 27. We remain waiting for the Center for Medicare and Medicaid Services Region V office in Chicago to approve the location as a new branch for home health and an additional site for hospice.

One of our hospice physicians, Jon Kubley, M.D., announced his intention to retire on May 4. On February 22, we will be entertaining a physician applicant, Nicole Shirilla, M.D., for this position. She is currently a Hospice and Palliative Medicine Physician with OhioHealth in Columbus, Ohio. She is also board certified in Family Medicine. Her background includes receiving both a Bachelors and Master's degree from the University of Notre Dame. While a student at Notre Dame she was a volunteer in the South Bend inpatient unit. We have also received interest from Anand Sandesara, M.D., MPH, who is currently completing a Hospice and Palliative Medicine Fellowship at UCLA. He is a board-certified Pediatrician who was born and raised in Chicago and has relatives in Merrillville, Indiana. He is scheduled to visit us in mid-March.

On February 26 we will have another Hospice and Palliative Medicine Fellow, from Indiana University School of Medicine in Indianapolis, start a training rotation through CHC. She is Elaina DiOrio, MD, and will be here through March 9th. She is board certified in Emergency Medicine and views the Emergency Department as a great setting to include Palliative Care. She believes Palliative and Emergency Medicine can form the perfect synergy and have an important role in patient outreach. We look forward to her visit.

For 2016 and 2017 our HeartWize (for Congestive Heart Failure patients) and BreatheEasy (for Chronic Obstructive Pulmonary Disease patients) performance program figures were as follows:

HeartWize:

Out of 480 patients:
7 (1.5%) went to the emergency room
10 (2.1%) were admitted to a hospital
461 (96.5%) did not go to a hospital or ER

BreatheEasy:

Out of 551 patients:
5 (0.9%) went to the emergency room
16 (2.9%) were admitted to a hospital
530 (96.2%) did not go to a hospital or ER

The above patients were the "worst of the worst" in terms of their disease. These outstanding performance numbers are reflective of the excellent medical and nursing care provided to them by our CHC clinical team. We are extremely proud of these high-quality performance figures.

DIRECTOR OF NURSING UPDATE

Sue Morgan, DON, reports…

The Nursing Goals for 2017 have been evaluated and 2018 goals established. They are reviewed and progress is updated monthly at the Nursing Leadership Meeting.

Education Programs 2017

- Revision of Nurse Aide orientation with checklists
- Infection Control—trunk fair, blood borne pathogens and MDORO's—with new policy roll out (this is Methicillin drug resistant organism)
- Home Health 101
- NHPCO webinar at a Nurses meeting: "Documentation: Compliant and Complete"
- The Experience Model and Shape of the Visit
- The Role of the LPN with a skills grid and new policy
- Annual Skills Fair—Infusions and CVAD's (this is circulatory vascular artery device), CHC's We Honor Veterans Program and how to access resources, and wound care
- Medication Validations Education
- Tracheostomy Care Education
- Volunteer trainings: routine onboarding, and Annual update all day event in June

Preparation for Hospice Survey by Indiana State Department of Health (ISDH) continues. We are "survey" ready in preparation for our first hospice survey / inspection in over three years. We periodically remind the staff of the Conditions of Participation (COP's) in preparation of the survey.

Pediatric End of Life Nursing Education Consortium (ELNEC) is a pediatric certification program in the care of children within the hospice program. Two nursing staff members have received additional education in "Train the Trainer" for all the modules. All nurses are in the process of completing two modules. We have been approved Continuing Education Units after the completion of all 10 modules. All nurses have a goal to complete the modules by December of 2018. This will assist us in development of a specific pediatric palliative care program.

Quality Improvement Summary 2017

- Medication orders—new tracking and notifications to the nurses and PCC's
- Care Planning Monitors
- Hospice Mock Survey— education events and preparation activities
- Supervisory Visits—monitoring by PCC's with individual POC's
- Medication Disposal revision of policy and practice
- Medication Validations—individual monitors and 1:1 coaching/training by QA department
- IDT's use of the "Experience Model"
- Consumer Assessment of Healthcare Providers and System, and, Hospice Item Set—review and formed QAPI teams surrounding these measures
- Live Discharge data review
- Specialty Programs data review
- Ad Hoc monitors for High Risk Low occurrences: Blood Transfusions, Extubations and Pediatric Care
- Home Health chart audits and OBQI measures, new COP's with policy updates
- ECF documentation and Chart set up
- CMS General Inpatient Level of Care Audit

New and revised Medicare Conditions of Participation for Home Health are in effect as of January 2018. Revised and new policies and procedures are being rewritten and will go through the normal approval process. However, the Interpretive Guidelines have still not been published by CMS and continue to be in DRAFT form. We are not expecting a home health survey until 2019.

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

Year to Date Total Revenue (Cumulative Cash Received)

	2012	2013	2014	2015	2016	2017
January	36,775.87	83,619.96	51,685.3	82,400.(	65,460	46,552
February	88,893.51	166,563.17	109,724.36	150,006.82	101,643.17	199,939.17
March	194,345.35	264,625.29	176,641,04	257,463.8(	178,212.(	282,326.(
April	319,818.81	395,299.97	356,772.11	419,610.76	341,637.10	431,871.55
May	416,792.85	446,125.49	427,057.81	635,004.26	579,888.08	574,854.27
June	513,432.22	534,757.61	592,962.68	794,780.62	710,175.32	1,066,118.11
July	579,801.36	604,696.88	679,253.96	956,351.88	1,072,579.84	1,277,609.56
August	643,819.01	783,993.15	757,627.43	1,042,958.42	1,205,050.76	1,346,219.26
September	736,557.59	864,352.82	935,826.45	1,267,659.12	1,297.009.78	1,466,460.27
October	846,979.95	922,261.84	1,332,007.18	1,321,352.39	1,421,110.26	1,593,668.39
November	895,164.28	969,395.17	1,376,246.01	1,469,386.01	1,494,702.09	2,443,869.12
December	**1,027,116.05**	**1,185,322.83**	**1,665,645.96**	**1,757,042.51**	**2,018,630.54**	**2,730,551.86**

Year to Date Monthly Revenue

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

	2012	2013	2014	2015	2016	2017
January	32,309.58	83,380.18	51,685.37	57,971.60	52,156.98	31,552.99
February	43,783.64	82,943.21	43,038.99	67,572.77	36,182.46	35,125.58
March	102,351.84	98,212.12	66,916.68	107,457.07	73,667.84	79,387.44
April	123,998.46	130,674.68	180,156.07	162,146.87	163,425.09	149,569.94
May	90,909.04	40,825.52	100,285.70	160,178.34	93,318.98	142,982.72
June	92,036.89	65,815.51	97,258.66	159,776.36	127,315.24	146,200.17
July	62,069.43	69,939.27	38,243.88	93,586.27	52,394.52	61,505.45
August	64,017.65	92,732.69	79,015.87	86,606.54	97,470.92	63,593.03
September	92,808.58	80,335.67	84,011.71	99,931.45	92,459.02	120,261.01
October	65,904.80	56,439.02	55,208.68	53,693.27	71,323.54	127,208.12
November	46,674.33	47,133.33	44,238.83	46,870.62	66,490.16	75,809.56
December	111,236.77	130,277.99	193,065.45	161,519.80	138,328.11	286,687.74
Total	**928,101.01**	**978,709.19**	**1,033,125.99**	**1,257,310.96**	**1,064,532.86**	**1,319,883.75**

Cornerstones for Living: The Crossroads Campaign

Campaign-related work in December 2017 and January 2018 included meetings with donor prospects, donor stewardship meetings, year-end donor follow up activities, and scheduling meetings with major gift donor prospects. As we come to the end of the first year of the public phase of our comprehensive campaign, which is in its 43rd month, (7/1/14 thru 1/31/18) cash, pledges and documented bequests now total more than $10 Million. We continue to remain intently focused on securing additional funding for two underfunded priorities, which include an additional approximately $1.5 million for the new inpatient facility and $850,000 to match the $1 million challenge grant to fully endow the Vera Z. Dwyer Fellowship in Hospice & Palliative Medicine.

Preliminary conversations with the Community Foundation of Elkhart County (CFEC) resulted in the Hospice Foundation submitting a grant application to fund construction of our Mishawaka

inpatient facility. The application request for $500,000 was submitted in late December. We hope to be invited to meet with a community foundation selection committee to discuss our application in greater detail as this is the next phase of the application process outlined by the CFEC.

Plans are underway for Mike Wargo, Chris Taelman, Catherine Hiler, Mary Jane Stanley and me to host donor events in Naples, Florida on February 28 and Tampa on March 1.

Planned Giving

No estate gifts were received in December 2017 or January 2018. One of our targeted planned giving prospects sent us a campaign gift in January and we are scheduling a meeting to continue our discussion about her interest in including a CHC/HF gift in her estate.

Annual Giving

Our Annual Appeal, which was mailed late November and featured our 2018 Helping Hands Award Recipient Sister Carmel Marie Sallows, continues to perform ahead of last year's appeal. This year's annual appeal proceeds will be directed toward the *Sister Carmel Helping Hands Fund* which will support charity care.

Special Events & Projects

We are deep into planning our 2018 *Helping Hands Award Dinne*r honoring Sister Carmel Marie Sallows, CSC for her lifetime of service. The event will be held on Wednesday, May 2, 2018 from 6:00 to 9:00 pm at the Hilton Garden Inn. The Dinner Committee list is being finalized and underwriting materials will be mailed soon.

On May 24, we will have a reception for Dr. Kayla Herget, our first Vera Z. Dwyer Fellow in Hospice and Palliative Medicine. This event will also be used as an opportunity to publicly thank the Vera Z. Dwyer Charitable Trust for their incredible $500,000 gift to fund the first five years of the Fellowship as well as to announce the Trust's $1 Million challenge grant to establish a permanent endowment for this fellowship seat at the Indiana University School of Medicine. David Kibbe, Present & CEO of Indiana Trust (and trustee of the Vera Z. Dwyer Charitable Trust) and Dr. Lyle Fettig, Director of IU's Hospice and Palliative Medicine Fellowship, will be on hand to make brief remarks.

We have many other events planned in 2018 because of several anniversaries. Events include celebrations around the 25th anniversary of Camp Evergreen, the 10th anniversary of the Palliative Care Association of Uganda (PCAU) partnership, and the 10th anniversary of the Elkhart Campus.

In January, the Hospice Foundation launched its new website, which features new mobile-friendly donation forms, and a modern design.

PCAU

Our partners from the Palliative Care Association of Uganda – a partnership with CHC/HF since 2008 through Global Partners in Care -- will be visiting us this year. Their trip is tentatively scheduled for mid-July to mid-August. We generally try to have them over every other year while

we visit them in the years they are not here locally. The agenda for their visit will include: an update to CHC staff about their activities since their last visit two years ago; meetings with stakeholders throughout the community, including various departments at the University of Notre Dame; mHealth and related training sessions; partnership strategic planning sessions; and a special Okuyamba Fest fundraiser/partnership celebration marking the 10th anniversary of the partnership between CHC and PCAU. As part of our celebration we will issue a 10th anniversary partnership report. It will include information about our shared successes in making palliative care accessible to all in Uganda as well as updates on the Road to Hope program.

One of the core activities of PCAU is to support and coordinate the morphine supply chain in Uganda to ensure that oral liquid morphine is available and accessible to palliative care patients throughout the country. PCAU also acts as the secretariat for the morphine partners meetings chaired by the Ministry of Health (MoH). Hospice Foundation staff member Lacey Ahern is working with PCAU staff and the most recent global health master's student to map morphine supply throughout the country as well as the locations of nurses and clinical officers trained through the Diploma in Clinical Palliative Care (DCPC) program at Hospice Africa Uganda. This map will assist PCAU in reporting information about palliative care access and morphine supply to the MoH in a timely and accurate manner. Kaitlyn Syler, an ND global health student, will travel to Uganda in May to work with PCAU on gathering the data required for the map.

Road to Hope Program/Documentary

Retired staff member and now volunteer, Roberta Spencer recently returned from her annual trip to PCAU where she volunteers and this year assisted with an empowerment retreat for the older children in the Road to Hope program. She worked closely with the new coordinator, Lydia, and was impressed with her enthusiasm for her position and insights into dealing with children. Lydia and Mark Mwesiga, PCAU Programs Coordinator, planned the retreat and engaged an outside organization to assist with the presentations. Fourteen of the 57 children in the program attended the retreat for two full days. The theme of the inaugural retreat was "I Know Who I Am: I Am Special." The primary objective was to have the children explore their individual strengths and feel challenged to be leaders. In addition, the retreat was designed to teach them how to reach out to others in positive ways while making good decisions for themselves.

Education

In January we hired a Community Education Coordinator, Elleah Tooker, to assist in developing and presenting end-of-life programming. Elleah graduated from IU South Bend with a bachelor's degree in psychology and political science and is working closely with Cyndy Searfoss to develop our various community education activities and initiatives. The first event on the schedule is "Death by Chocolate," which will take place on National Healthcare Decision Day, April 16th. As the name suggests, "Death by Chocolate," will feature a variety of locally sourced chocolates for sampling as well as chocolate desserts along with a sandwich/soup buffet lunch. The education portion of the event takes place in the form of trivia – with some chocolate facts thrown in as well. The primary intent of this program is to educate participants about end-of-life care planning and the importance of advance directives. We will have 64 seats available. Pricing for the event is $10/person or a table of eight for $64.

Dr. Jason Marker, M.D., a faculty member at the Memorial Hospital residency program, is interested in expanding the hospice and palliative care aspect of their residency program for the 2018-2019 year. The program will have two 4th year residents in its track in Health Systems Management. During that year they have a required two-week hospice rotation that will be arranged with CHC to provide them with a deep dive into the medical functions, financing, administration and management of hospice care. This rotation is in addition to the usual family medicine rotation they would have already completed. Dr. Marker also oversees a rotation in Practice Management and Public Health, a required rotation for each of their first-year residents. The rotation is a one-month overview of community resources that residents will likely use during their time at Memorial Hospital, by connecting them with various high-quality providers during this rotation, the participants will be in a better position to make future referrals as the arise. He hopes to incorporate a half-day hospice experience in the curriculum during the upcoming year and will be working with us to determine appropriate staff members new residents should meet with to provide them the strongest overview of our services and role in the community. In addition, Dr. Marker has agreed to assist us in developing a recruiting/marketing strategy for the Vera Z. Dwyer Fellowship.

We continue to work with the Honoring Choices Indiana – North Central coalition to move that initiative forward. We have drafted a business plan for the organization, which includes a solid marketing plan, three-year budget and a position description for a future Program Coordinator. The funding for this position is planned to come from the various coalition member organizations.

Mishawaka Campus

We've entered into a purchase agreement to purchase the final home in the development of our campus master plan. We expect to close on the purchase of the property, located at 612 Madison Street on or about March 1. DJ Construction plans to use the 3-BR, 2-BA home in place of a traditional job site trailer, resulting in a projected savings to the Hospice Foundation of approximately $20,000.

Final interior design work continues on the new Clinical Staff Building and the 12-bed inpatient unit which will be named after Ernestine M. Raclin due to her generous $1MM gift. Mike continues to meet regularly with Helman Sechrist Architecture, Jones Petrie Rafinski (engineer), DJ Construction (builder), Office Interiors (interior designer) and a host of contractors and subcontractors. Construction on the Clinical Staff Building is expected to begin late next month with construction on Raclin House, the new hospice inpatient unit, commencing this summer. Plans are underway for a groundbreaking ceremony, tentatively scheduled to take place on June 12th. We have received formal appraisals for the two residential homes we intend to construct at the corner of Comfort Place and Cedar Street. Both appraisals indicate a fair market value compatible with our preliminary cash flow projections. Chris Chockley of Jones Petrie Rafinski is working with the City of Mishawaka to have the parcel subdivided and replatted. We are in the process of obtaining final construction costs on these residential units. Current plans are to begin construction on the first of the two homes this summer.

COMMUNICATIONS, MARKETING, AND ACCESS

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

Referral, Professional, & Community Outreach

Our Professional Community Liaisons continue to contact doctor's offices, clinics, hospitals, group homes and extended care facilities to build relationships and generate referrals. In December and January our four Liaisons completed 761 visits to current and potential referral sources within our service area.

We've already noticed a significant increase in LaPorte County patients, even before the location has opened. In January through October of 2017, we had a total of 26 patients in LaPorte County. Since we announced our upcoming location along with the hiring of Jamie Edwards as our Professional Liaison to begin calling on referral sources, we've already had 13 new admissions. We're continuing to service those patients out of our South Bend location until we receive final approval from CMS. Once that happens, we feel confident of the potential for growth in that area to continue and as we add Porter County to our service area.

Access

For the months of December & January, the Referral Specialists received 831 and 1,079 incoming phone calls respectively to the Admissions Department. We continue to struggle with late referrals, particularly from hospitals. In December we had 18 patients that died before we could admit them even with our ever-increasing response time of 67.4% of all patients being admitted same or next day. In January the DBA number increased to 25, which is an increase of 50% over the same period last year. It also accounted for 10.5% of our total referrals.

Website

During the months of December and January, CHC's website hosted 5,186 new users, which is a 6.77% increase over the same time last year. Also increased are the number of Sessions (+9.32%), Users (+9.5%), Pageviews (+19%) and Average Session Duration (+13.68%). Our most significant increase continues to be with users finding us organically through search engine optimization. In January and December 7% of visitors found us by entering our website address or through a search engine such as Google which is a 205.68% increase over the same period in 2016. In fact, we occupied the #1 Google ranking for 'hospice care Indiana' and the 6th position for 'palliative care Indiana' in December.

Social Media

Facebook (Center4Hospice)

Center for Hospice Care's social media presence is increasing steadily. We continue to use Facebook to communicate information and events. CHC reached 56,891 people for the December and January, and had 142,486 paid and organic impressions, 184 shares, and 134 comments. We also continue to share content through Twitter, Instagram and LinkedIn. Our most popular Facebook posting featured our Inpatient Units including photos of our Elkhart facility which reached over 6,100 viewers, followed by the personal video testimony of the CHC President/CEO speaking about how Center for Hospice Care improved his own mother's quality of life. The example was intended to indicate in less than three minutes of how an 'appropriate referral' is not when a loved one is actively dying, but rather when it's determined that they won't recover from

their illness. My mother was in our hospice care for 364 days. This short video has received 311 Likes and 40 Shares.

Digital Overview

Digital activity from December 1st through January 31st focused on delivering our ad to the proper audience at the proper time. For the months of December and January it generated 138 telephone calls. Google industry benchmarks show an average click-through rate in the Health & Medical field of 1.79% and we continue to be extraordinarily high at 9.15%.

COMMUNITY BASED PALLIATIVE CARE SUMMIT

A community based palliative care summit was held on February 7, 2018 with key CHC staffers to kick-off development of a Community-Based Palliative Care program. The agenda included a brief history of palliative care at CHC; funding for Palliative Care through the Crossroads Campaign; watching the webinar, "Advancing Hospice Upstream" by Schramm Consulting; PC admission, discharge, documentation in Cerner; meeting the expectations of potential referral sources and surveying them to educate ourselves on their perceptions; and a review of the many resources already on hand and available through our memberships in NHPCO, the Center to Advance Palliative Care, The Advisory Board Company, HealthPivots, and the NHERT.

POLICIES ON THE AGENDA FOR APPROVAL

There are ten new or revised patient care policies on the agenda. Half of the policies deal with certified nursing assistants (CNAs) due to the new Medicare home health Conditions of Participation (CoPs). The forms referenced in the policies are also included in your packet for informational purposes.

NEW DASHBOARD

Thank you to Karl Holderman, CFO, we have a new dashboard that summarizes 2017 from a patient served, budget and actual standpoint including comparisons to the prior year. It is an attachment to this report. It also summarizes the average daily census (ADC), operating revenue, and expenses as well within the same format. We hope that you find this useful to be able to see this information "at a glance." It is attached to this report.

2017 BEREAVEMENT STATISTICS

Of the total bereaved clients served (3,132), 20.2% were community without a previous hospice experience, 73.9% were hospice and 5.9% are deaths before admissions (DBA)/other (other = bereaved of patients who discharged alive and then died). The Bereavement Department averaged 145 deaths per month (including DBA/Other deaths) down 2%. Of the total individual/family counseling sessions (3,974) 2% were sessions with DBA/Other clients, 32% were sessions with hospice clients and 66% were sessions with community clients. Camp Evergreen served 41 teen

and youth campers with the help of 49 volunteers and 13 staff. Over 24 years, camp has served 924 total campers utilizing 570 staff and volunteers.

2017 VOLUNTEER SERVICES STATISTICS

Medicare hospice is the only provider required by federal statute to have a volunteer component. Like the required bereavement services for 13 months for family members, there is no reimbursement for the recruitment, training, annual education, or vaccinations for any of CHC's volunteers. We are required to provide a minimum of 5% direct patient care hours from volunteers when compared to direct patient care hours of paid, professional staff. Total volunteer hours of all types were down 6.2% from last year. CHC has always met the 5% minimum and the percentage to direct patient care hours came in at 6.3% for CHC for calendar year 2017. Below is the summary of 2017 Volunteer Hours compared to the previous year. While we have a wide variety of volunteer functions, only direct patient care hours are factored in the percentage calculation for Medicare. All hours are shown below and shared with the volunteers at the annual Volunteer Recognition coming up this year on April 17th.

Year To Date Volunteer Hours			
As of December 31, 2017			
Sort	**Dedcription**	**Hours '17**	**Hours '16**
1	Hospice House (Total)	3,791.60	4,583.58
1	Patient Phone Call	7.30	11.67
1	Patient Visit	5,343.18	4,673.45
2	Community Education	34.58	
2	Community Relations	917.25	921.20
2	Speakers Bureau		
2	Training and Education	1,135.75	1,175.00
3	Bereavement Camp	990.55	1,506.00
3	Bereavement Groups	241.25	215.58
3	Bereavement Phone Call	200.87	218.33
3	Bereavement Visit	26.75	4.33
3	Bereavement Letter / Note	8.97	8.20
4	Bereavement Memorial Service	53.00	90.92
4	Fundraising	114.35	127.22
5	Administrative and General	3,088.55	3,678.45
5	Deliveries	108.58	93.92
5	Funeral Home	18.67	19.50
6	Veteran Program	79.80	84.50
7	Board Committees	69.17	59.58
7	Board of Directors	90.25	102.33
	Total Hours	**16,320.42**	**17,573.76**
	Total Miles	**51,636.00**	**52,633.00**
	Total Savings (2017)	**415,145.70**	**435,617.32**
	Valued at $24.14 / Hour and $0.41 / Mile		

2017 GOALS UDPATE

Included in your packet is a copy of the final status for the 94 individual goals for 2017. Final status is broken down into four categories: "Met" means that the goal was achieved; "In Process" means the goal was started, but not yet completed during calendar year 2017 and likely carried over to 2018; "Not Doing" means after evaluating the goal we decided that for whatever reason we were not going to do the project; and "Not Met" means that we simply didn't get to that goal at all or external factors made the goal no longer realistic. Results for 2017 are as follows:

Total Number of Published Goals = 94

Met = 54 (57%)
In Process = 28 (30%)
Not Met = 10 (11%)
Not Doing = 2 (2%)

For 2017, 87% of the 94 individual goals were either completed or were in the process of being completed at the end of the year. I am particularly pleased that we could do this during a time of unexpected opportunities that presented themselves. There were no goals during 2017 that included "Go into the Adult Day Services Business" or "Assume an International Partnership Program." We are delighted to answer specific questions on any of the goals and their status at the end of the year.

Please note, each year, all annual goals are tied to the overarching goals of the Strategic Plan and their status is shared with the board annually.

2018 GOALS

Included in your packet are the 2018 Goals for Center for Hospice Care, Hospice Foundation, and Global Partners in Care. Like we have done each year for the past 18 years, we have placed individual goals under the traditional headings which match the four overarching goals of the Strategic Plan. The four overarching goals are: Enhance Patient Care; Position for Future Growth; Maintain Economic Strength; and Continue Building Brand Identification. Annual Goal development begins at the Coordinator level of management and they work their way up through Directors and eventually to the Administrative Team for final approval. We always commence with ideas and concepts from what line staff and middle management staff believes we should accomplish as a leading hospice organization which will allow us to improve and enhance our organization and the care we deliver. For 2018, we have a record 107 individual goals.

CURRENT STRATEGIC PLAN UPDATE

The current Strategic Plan, "The Envisioned Future (2016 - 2018)" was approved by the CHC Board in February of 2016. It is included as an attachment to this report along with a current "Status Update" which immediately follows. The current plan is available on the secure board website under "Documents."

CONFLICT OF INTEREST POLICY STATEMENT

You will be asked to sign a conflict of interest policy statement for 2018. This is the same statement used in previous years. It is signed each year by every member of the board of directors to meet the requirements of our annual audit and answer specific questions on the IRS Form 990, the nonprofit "tax" return. The document is included as an attachment to this report for you to review prior to Wednesday's meeting. We will have hard copies available for you to sign at the board meeting.

BOARD COMMITTEE SERVICE OPPORTUNITIES

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 "Special Committees" section which is open to all board members. There is also a new committee, "Milton Adult Day Services Advisory Committee" which is required by the Indiana Medicaid Waiver program.

NO LOSS FOR CHC ON SALE OF SMITH HOUSE AFTER ALL

Craig Yahne from David Culp & Co., the CPA accounting firm that performs our annual audit has been researching the issue of potentially mitigating the loss of $97,123 on the sale of the Smith house / property on Cedar Street next to the Center for Palliative Care (outpatient clinic) at the Mishawaka Campus. You may remember this "story" was prominently featured on the front page of the South Bend Tribune on August 4, 2017. The story pointed out – not in full detail – that *"The Hospice Foundation, which owns the center, bought the house for $245,000 in June and is selling it to the city for $150,000."* In any case, there will be no loss on the purchase of the Smith House. Karl has spoken with Craig regarding the loss we had been showing on financials regarding the sale of the Smith house will go away. It will not be a loss, and it will not be a gift-in-kind. Since we will have use of the property (most likely extra parking) we can record the loss as an asset on our Balance Sheet. In essence, we paid for the right to use the property and that right-of-use is considered an asset. Craig has finalized the fixed asset journal entries for Karl and they are reflected in the December 2017 year end financials.

NATIONAL HOSPICE EXECUTIVE ROUNDTABLE JANUARY MEETING

The National Hospice Executive Roundtable (NHERT) is a collection of eleven hospice CEOs from leading legacy 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 usually rotate at member sites except for January when we meet in Miami, FL where our consultant lives and we do not have to pay his travel. You may remember that CHC hosted the group in June of last year. We began meeting Sunday night January 14 and continued through the evening of January 16. We had three

guest speakers who we do not pay for their time or travel. They are interested in meeting with us. They were: Jim Coccia: VP Market Access Takeda Oncology, a large pharmacy company who shared some big picture information about the oncology world, about drug reimbursement, working with managed care organizations and trends in oncology practice; Glenn Kaufhold, President of GKolaborative and Susan Galler, President of The GallerGroupLLC who both have development consulting companies and spoke on philanthropy, current trends, and future expectations; and, Ana Viamonte Ross, MD who was the Secretary for Health and Human Services in Florida under Governor Jeb Bush and now runs the palliative care program at Baptist Health System in south Florida who spoke about her current experiences in the health system world, interacting with Baptist's cancer care center and how to imagine getting approval in a state to expand the use of hospice beds when you need approval by the state legislature. While some of our members have recently retired, we have added some new members. The NHERT now is comprised of the CEOs form 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

MEDICARE PATIENT ACCESS TO HOSPICE ACT PASSES CONGRESS

In the early morning hours on February 9, the Senate voted on a major two-year deal that sets budget caps for FYI 2018 and FY 2019. The budget package included Medicare related policies, including The Medicare Patient Access to Hospice Act (H.R.1284) sponsored by Senator Mike Enzi (R-WY), Senator Tom Carper (D-DE) Congresswoman Lynn Jenkins (R-KS) and Congressman Mike Thompson (D-CA). The legislation will allow physician assistants to serve as the attending physician to hospice patients and perform other functions that are otherwise consistent with their scope of practice. The hospice community is facing a shortage of hospice attending physicians. Prior to the passage of this legislation, Medicare would only allow physicians and nurse practitioners to serve as a patient's hospice attending physician, creating a significant challenge for both hospice providers and the patients and families they serve. The Medicare Access to Hospice Act removes this barrier. Indiana co-sponsors included Rep. Todd Rokita. The new law also includes language from the Improving Access to Cardiac and Pulmonary Rehabilitation Act, which goes into effect Jan. 1, 2024, to allow PAs and other advanced practice providers to supervise cardiac and pulmonary rehabilitation programs for Medicare patients. PAs will be allowed to provide hospice care beginning Jan. 1, 2019. The legislation also includes a provision that reduces payments to hospitals upon transfer to hospice. While the cuts are to hospital payments, the hospice

industry raised concerns with policymakers that financially penalizing hospitals could result in delays to hospice admission. To assess the impact of the change, the legislation calls for the Medicare Payment Advisory Committee (MedPAC) to measure the policy's effect on hospital-hospice transfers, hospice length of stay, and overall spending. These healthcare provisions were part of a two-year budget agreement that includes stopgap government funding that runs through March 23, 2018.

OUT AND ABOUT

I attended the NHERT meeting in Miami, FL January 14-16.

Several staff attended the Rev. Dr. Martin Luther King, Jr. Community Service Breakfast at Century Center on January 15. CHC had a full-page ad in the 40-page program.

I attended the Hospice Action Network Board meeting and the all Boards Issues Session in San Antonio, TX on January 25.

I presented a lecture on "Hospice Care in America" as part of the Innovations in Healthcare Transformation MBA class at the Mendoza College of Business at the University of Notre Dame on February 13th. The course, which has become very popular, is taught by CHC Board Member Jesse Hsieh, MD.

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

Dave Haley's Census Charts

Karl Holderman's 2017 Summary Dashboard

2017 Goals Final Report

2018 Goals

Current Strategic Plan 2016-2018

Current Strategic Plan Status Update document

Conflict of Interest Policy / Form

Committees of the Board of Directors

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

December 2017 Financials

Hard copies of the Conflict of Interest Policy / Form for signatures at the Board Meeting

CHC Social Work brochure

CHC Spiritual Care brochure

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, May 16th at 7:15 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 .

# # #

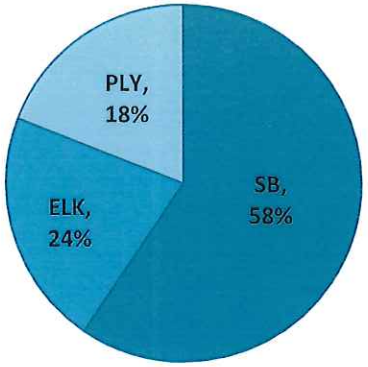
Center for Hospice Care

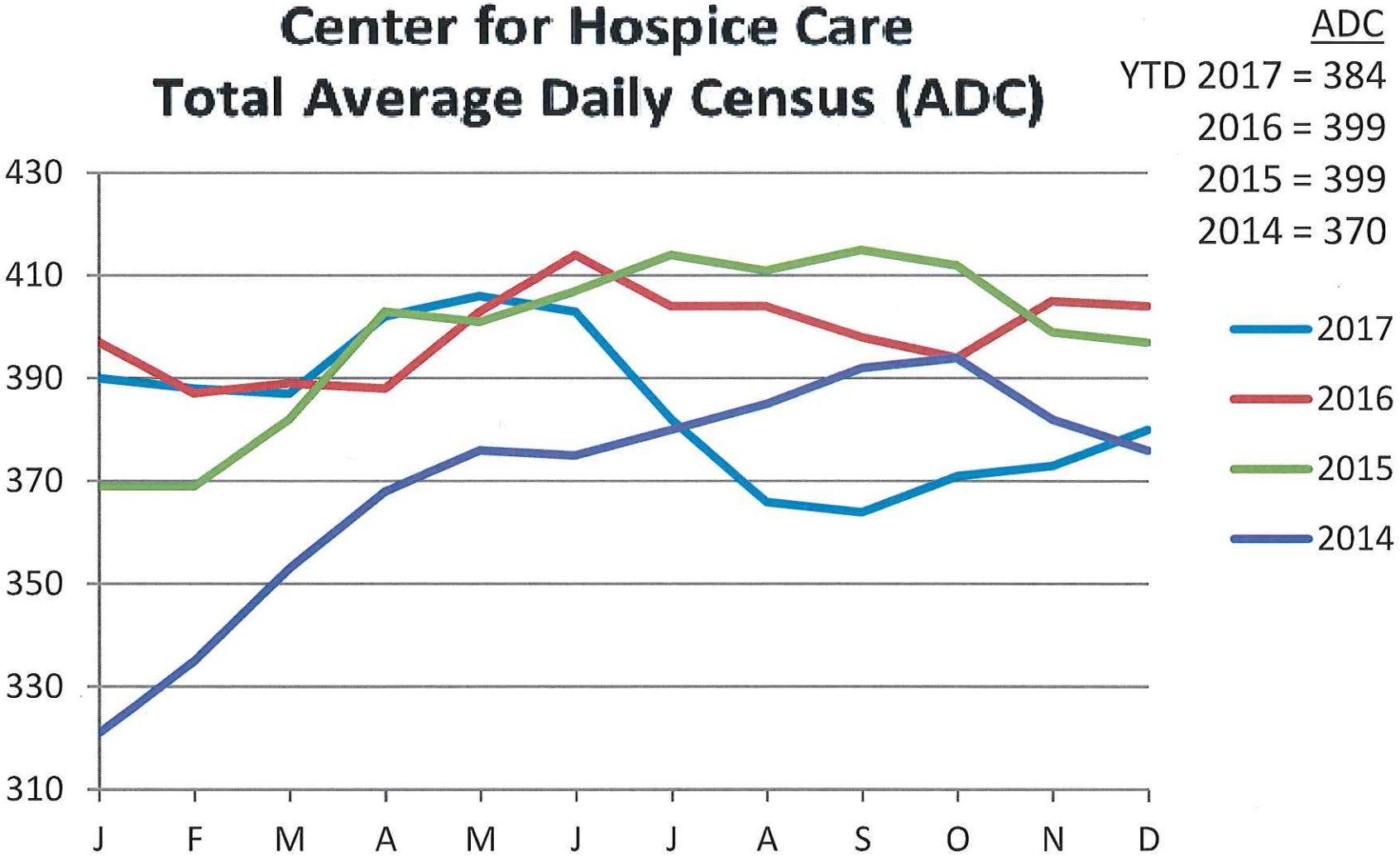
2017 YTD Average Daily Census (ADC)

(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	371	220	82	69
N	373	219	80	73
D	380	225	83	72
2017 YTD Totals	4612	2695	1088	828
2017 YTD ADC	**384**	**225**	**91**	**69**
2016 YTD ADC	398	228	96	75
YTD Change 2016 to 2017	-14	-3	-5	-6
YTD % Change 2016 to 2017	**-3.4%**	**-1.5%**	**-5.6%**	**-8.0%**

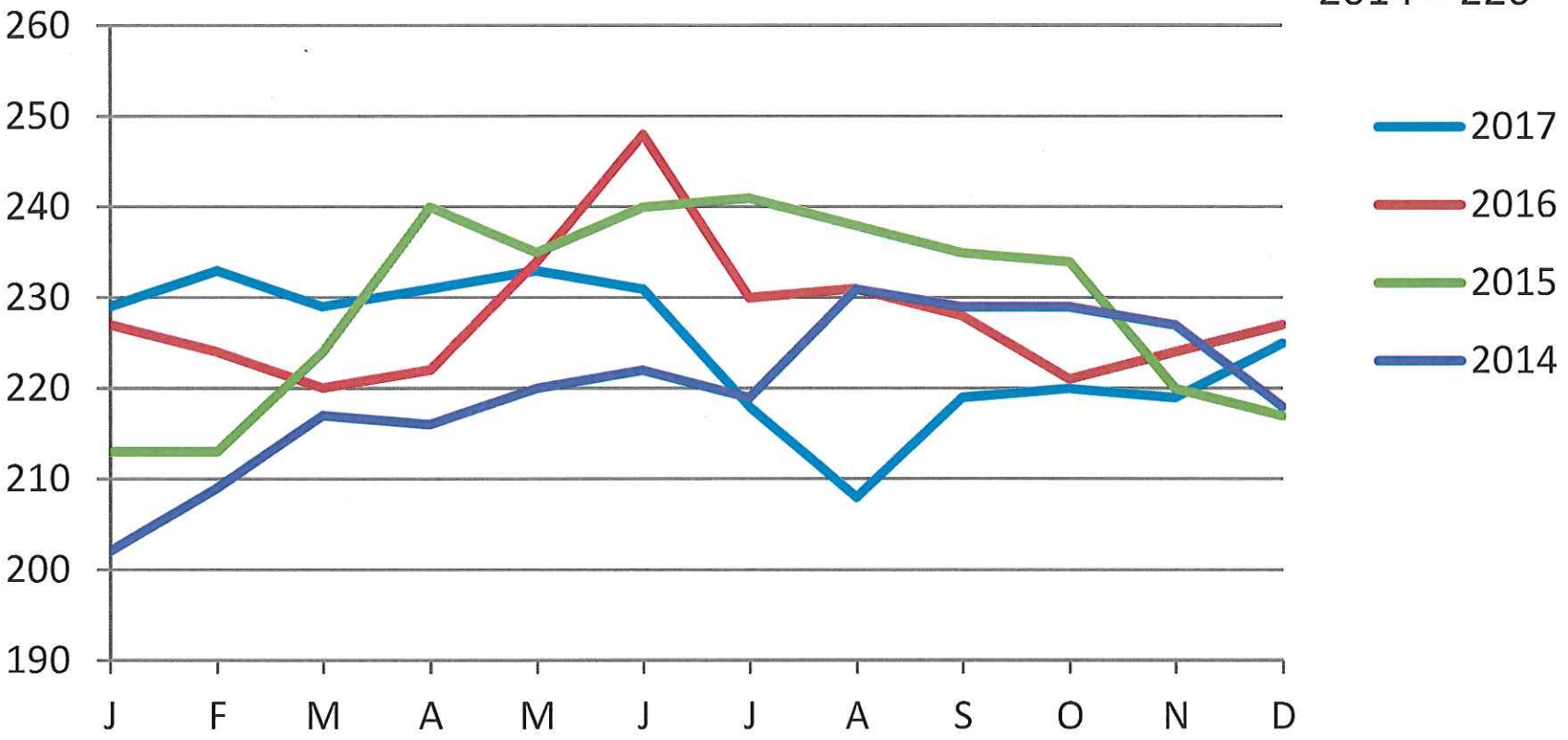
2017 YTD ADC by Branch



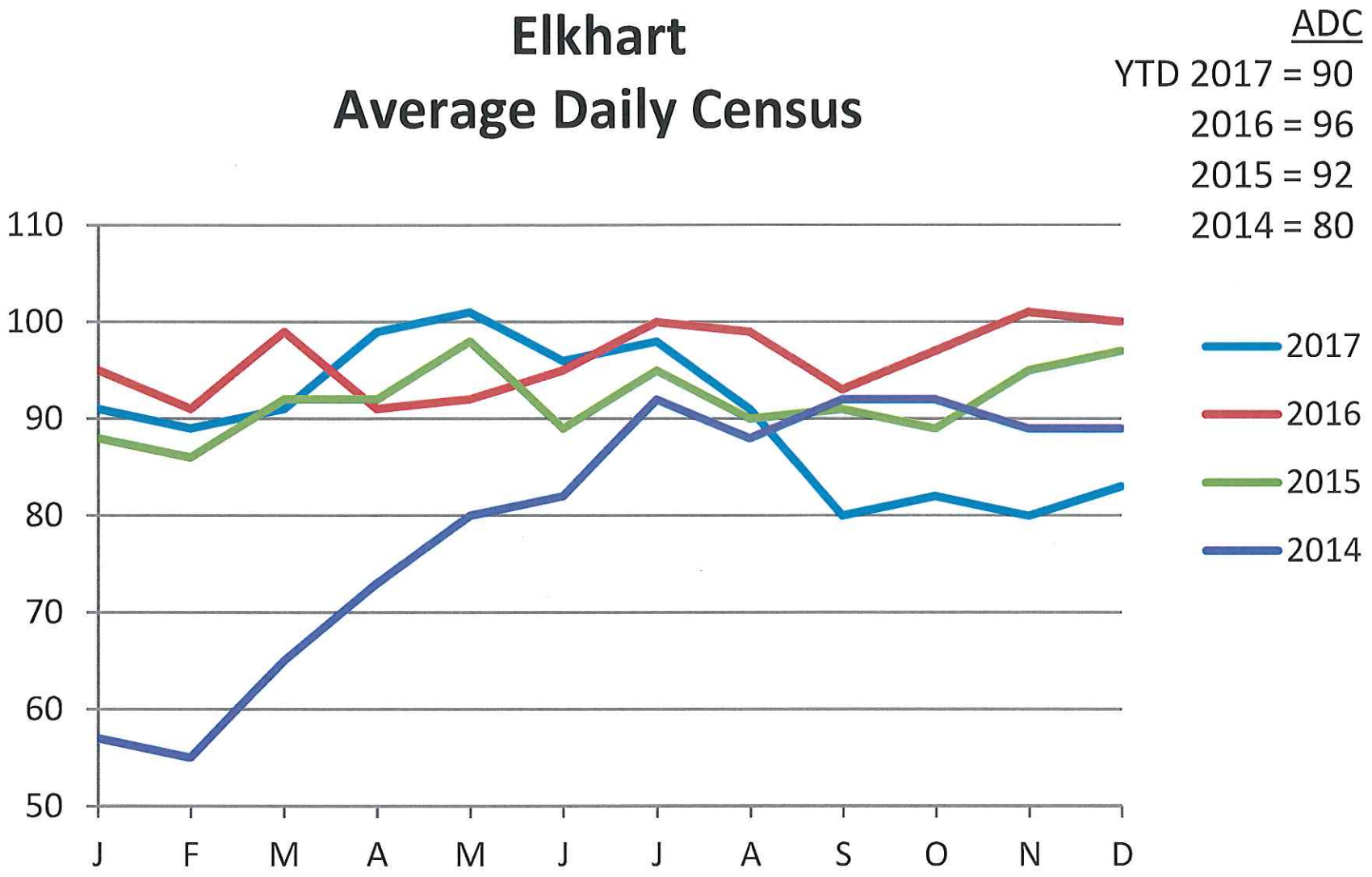

Center for Hospice Care
Total Average Daily Census (ADC)
ADC
YTD 2017 = 384
2016 = 399
2015 = 399
2014 = 370
430
410
390
370
350
330
310
J
F
M
A
M
J
J
A
S
O
N
D
2017
2016
2015
2014

South Bend
Average Daily Census

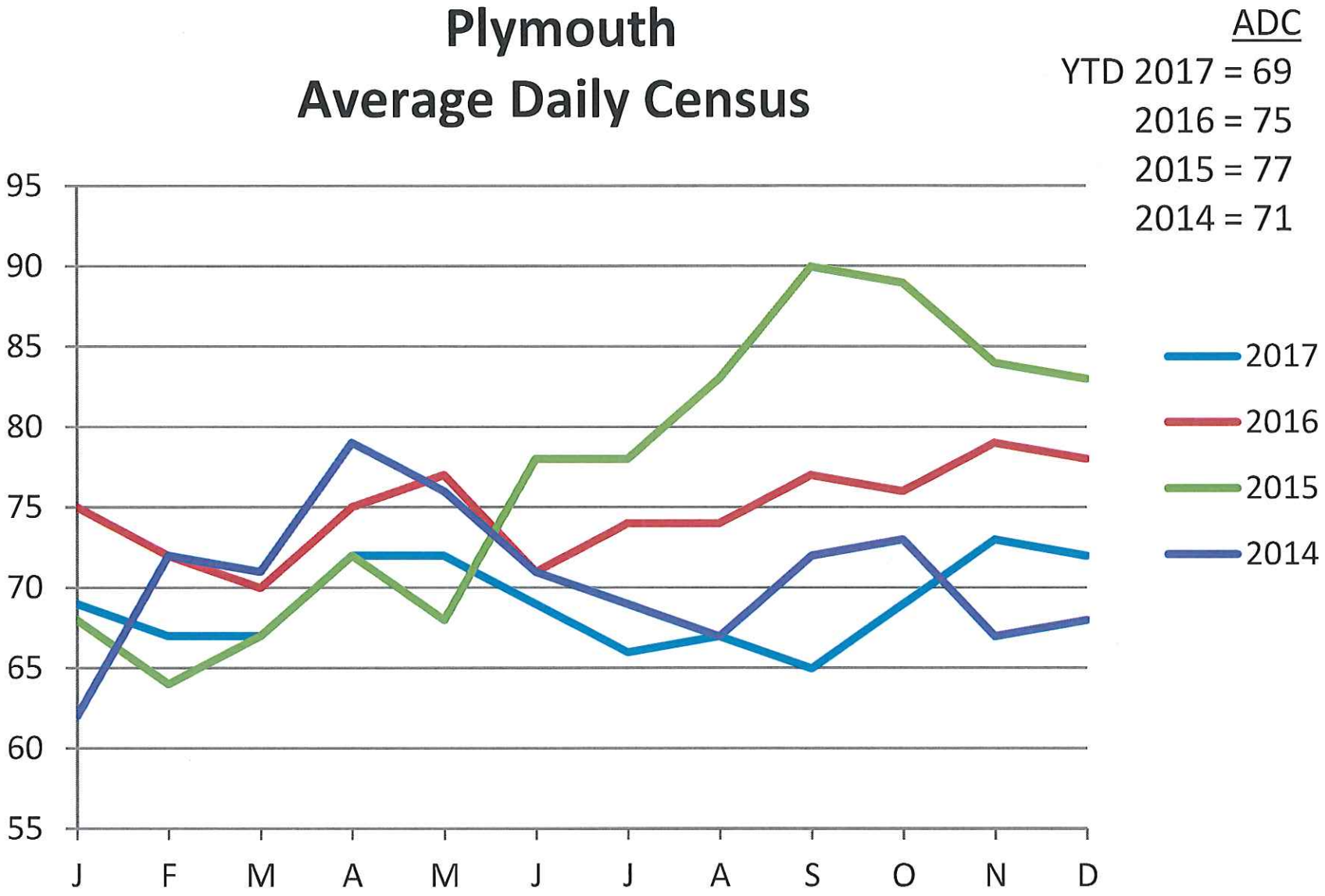
ADC
YTD 2017 = 225
2016 = 228
2015 = 229
2014 = 220



Elkhart
Average Daily Census

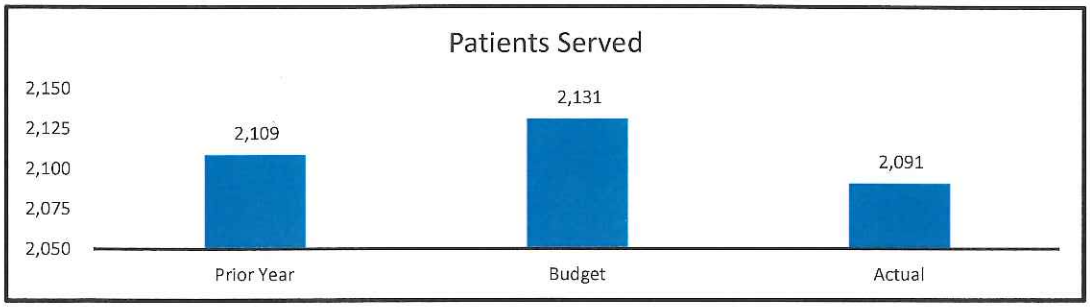


Plymouth
Average Daily Census

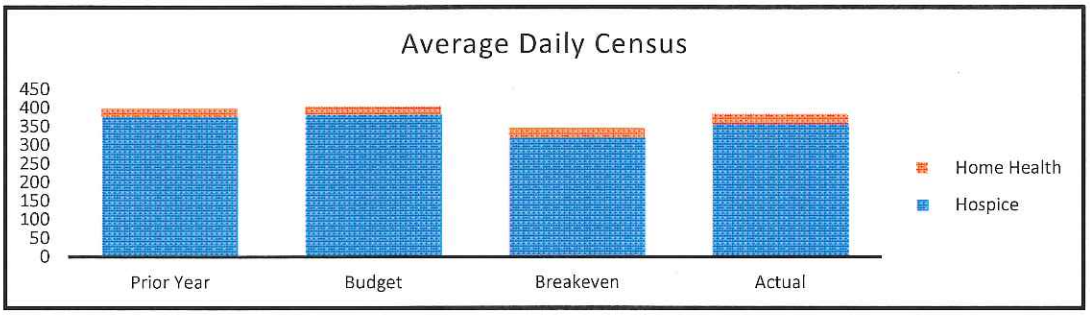


Center for Hospice Care
2017 Summary

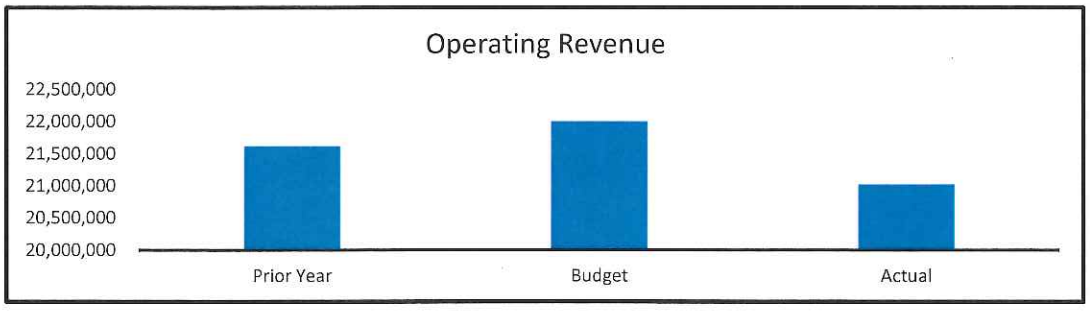
	Prior Year	Budget	Actual
Patients Served	**2,109**	**2,131**	**2,091**



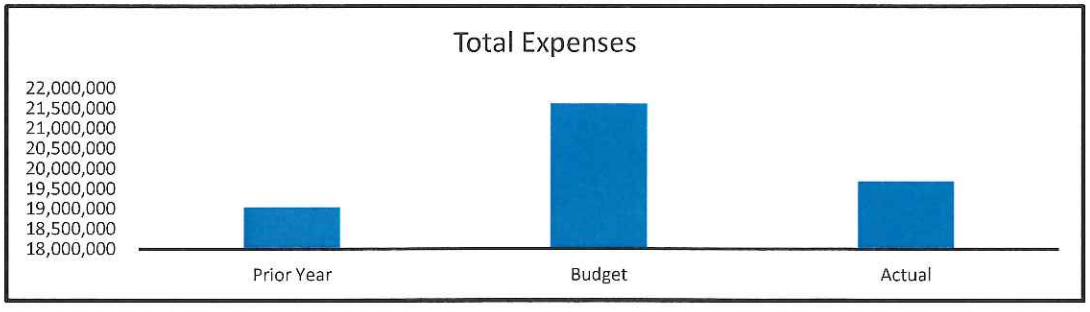
Average Daily Census	**Prior Year**	**Budget**	**Breakeven**	**Actual**
Hospice	376.26	382.50	320.18	356.34
Home Health	22.63	22.50	25.14	27.98
Total Average Daily Census	**398.89**	**405.00**	**345.32**	**384.32**



	Prior Year	Budget	Actual
Operating Revenue	**21,617,242**	**22,004,415**	**21,024,411**



	Prior Year	Budget	Actual
Total Expenses	**19,040,408**	**21,621,607**	**19,688,050**



Center for Hospice Care

Goals for Calendar Year 2017

Updated 01/23/18

Goal A: Enhance Patient Care

Category	Status	Goal
Administration	Not Met	1. Develop a specific pediatric palliative care program along with the marketing materials to support it with an emphasis on CHC clinical staff having been trained in the ELNEC Pediatric Palliative Care education modules.
	Met	2. Begin the project for CHC to be the convener to design what end-of-life care looks like in our community.
	Not Met	3. Begin customization and implementation of the "Every Person. Every Time" model of patient care.
	Not Met	4. Begin exploring and implementing new ways to engage front line staff into CHC.
	Met	5. Begin the processes needed for opening an office in LaPorte County.
	Met	6. Begin designing a new staff orientation program.
	In Process	7. Formally offer to bring an FTE in-house to coordinate the efforts of the Michiana Coalition on End-of-Life Wishes.
	In Process	8. Adopt the PPS scale (or another approach to predictive analysis) to determine at admissions which patients have the greatest chances of expiring in seven days or less, and increase the immediate scheduling of the number of RN and social work visits to those patients.
	Met	9. Prepare for implementation and compliance of the new Emergency Preparedness CoP prior to 11/15/17.
	Met	10. Investigate and implement methods to reduce the use of "cut and paste" within the Cerner EMR across all clinical disciplines.
	Met	11. Quantify the number of incorrect, unnecessary, and inappropriate uses of "Revocation" during 2016 and reduce that number by at least 90% by the end of 2017 via staff education and accountability.
	In Process	12. Begin to quietly market the availability of private pay room and board residential care in Hospice House with a two week up front and refundable daily fee based upon the average area nursing home daily rate.
	In Process	13. Increase ECF census by utilizing data from the HealthPivots tool.
Admissions	Met	1. Increase same day referral/admissions to 33%.
	Met	2. Begin process for tracking the percentage of Palliative Care Consults that convert to hospice admissions, as well as the location where the consultation took place, along with the number of days between consult and hospice admission.
	Met	3. Have 75% of admission nurses either have their CHPN or are working towards it.
	Met	4. Have 100% of admission nurses working on or completed ELNEC.

Goals for Calendar Year 2017

Updated 01/23/18

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

Goals for Calendar Year 2017

Updated 01/23/18

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

Category	Status	Goal
	Not Met	2. Enroll Dr. Cohen in the I.U. School of Medicine HPM Fellowship.
	Not Met	3. Complete original COTIs within seven calendar days.
	Met	4. Decrease the backlog of COTIs to less than three months.

Goal B: Position for Future Growth

Category	Status	Goal
Administration	Not Met	1. Develop a dashboard for the CHC Board of Directors.
	Met	2. Review and revise Hospice Foundation Policies and Procedures Manual.
	Met	3. Secure a seat on the Michiana End-of-Life Wishes Coalition and chair the business development subcommittee.
Mishawaka Campus & Regional Expansion	In Process	1. Design and construct new residential housing at northeast corner of Mishawaka Campus.
	Met	2. Secure and build-out new LaPorte office.
Global Partners in Care	Met	1. Successfully transition GPIC from NHPCO to Hospice Foundation.
	Met	2. Evaluate the viability of existing 75 international partnerships.
	Met	3. Work with APCA to establish framework for the identification and coordination of African GPIC partners.
	Met	4. Establish relationships with major international organizations engaged in hospice and palliative care initiatives, e.g., IAHPC, WHPCA, WHO, HCPA, IU/AMPATH, NASW, True Colors, various ND programs, etc.
	Met	5. Host the GPIC luncheon and create and staff an exhibitor booth at the NHPCO MLC.
Uganda	In Process	1. Work with the University of Notre Dame's Initiative for Global Development to establish strategic global partnership opportunities to promote palliative care in Uganda.
	Met	2. Work with Eck Institute for Global Health to ramp up third year of mHealth initiative.
	Met	3. Co-sponsor and facilitate two staff members to teach at the 6th Biennial PCAU conference.
	Met	4. Work with PCAU to explore possibility of establishing a PC diploma program at the Mulago School of Nursing.
Education	In Process	1. Develop and launch Institute for Hospice/Advance Care Planning website.
	Met	2. Develop comprehensive end-of-life planning curriculum, which can be delivered through local area

Category	Status	Goal
		professionals and faith communities.
	Met	3. Work with local college(s) to develop programs to offer CEU awarding seminars for local area professionals about end-of-life issues relevant to their profession.
	In Process	4. Develop initial online courses, e.g., how to choose a healthcare representative, how to effectively document advance directives, etc.
	Not Met	5. Develop online video education series about end-of-life planning matters using various local area professionals.
	In Process	6. Review existing local college/university internship opportunities and initiate new domestic and international programs where possible.
	Met	7. Establish Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine.
	In Process	8. Offer the IU Talk program to local area physicians.
	Met	9. Establish educational program with Forever Learning Institute.
	Met	10. Establish Speaker's Bureau.
	Met	11. Explore the possibility of creating the "Life Lessons" television series or documentary film with WNIT as a means to raise awareness of the importance of making end-of-life wishes known to family and loved ones.

Goal C: Maintain Economic Strength

Category	Status	Goal
Fund Raising and Stewardship	In Process	1. Develop and implement planned giving program and materials.
	Met	2. Create Helping Hands Award Wall of Fame.
	Met	3. Create and produce public phase campaign website and print materials.
	Not Doing	4. Finish creation and production of Crossroads Campaign video.
	Not Met	5. Initiate fundraising campaign to build the endowment at the Community Foundation of Elkhart County.
	Not Met	6. Initiate fundraising campaign to secure gap funding for costs of scaling up new LaPorte office.

Goal D: Continue Building Brand Identification

Category	Status	Goal
Marketing	Met	1. Explore ways to promote our pediatric palliative care initiative.
	Met	2. Explore ways to promote our Center for Palliative Care.
	Met	3. Develop basic marketing tools for MADS.
	Not Doing	4. Host National Healthcare Decision Day "Hello" events in Mishawaka, Elkhart and Plymouth.
	In Process	5. Post monthly President's blog.
	In Process	6. Post monthly Medical Director's blog.
	Not Met	7. With support of The Advisory Board Company materials and toolkits, increase ECF referrals by 5%.
	Met	8. Create new commercials for broadcast and digital advertising purposes.

Center for Hospice Care

Goals for Calendar Year 2018

Updated 02/13/18

Goal A: Enhance Patient Care

Category	Status	Goal
Administration		1. Develop a specific pediatric palliative care program along with the marketing materials to support it with an emphasis on CHC clinical staff having been trained in the ELNEC Pediatric Palliative Care education modules. 2. Begin customization and implementation of the "Every Person. Every Time" model of patient care. 3. Formally offer to bring an FTE in-house to coordinate the efforts of Honoring Choices Indiana-North Central on End-of-Life Wishes. 4. Adopt the PPS scale (or another approach to predictive analysis) to determine at admissions which patients have the greatest chances of expiring in seven days or less, and increase the immediate scheduling of the number of RN and social work visits to those patients. 5. Begin to quietly market the availability of private pay room and board residential care in Hospice House with a two week up front and refundable daily fee based upon the average area nursing home daily rate. 6. Develop a dashboard for the CHC Board of Directors. 7. Establish a CHC new orientation program including all departments in conjunction with Nursing, Human Resources, Hospice Foundation, and Administration. 8. Develop a community-based palliative care program.
Admissions		1. Increase same day/next day referral admissions to 58%. 2. Increase admission representative PA to Admission conversion rate to 70%. 3. Continue tracking palliative care consults and patients that admit by location of consultation, number of days between consult and hospice admission. 4. Have 100% of admission nurses working on or complete the Pediatric ELNEC. 5. Have 75% of admission nurses either have their CHPN or working towards it. This is going to be a house-wide initiative for the education—all nurses are to have their CHPN within two years of working at CHC. 6. PA to admission conversion rate to 75% for nurses. 7. Medication charting compliance to 97%. 8. Begin tracking PA to admission time, as well as continue to track referral to PA time tracking. 9. Start tracking live discharges, reason for discharge, and if the patient gets readmitted.

Category	Status	Goal
		10. Evaluate admission process in order to help increase efficiency.
Volunteers		1. Complete revision of the Volunteer Department Policies and Procedures Manual. 2. Explore the use of electronic time sheets. 3. Expand recruitment efforts to include Spanish speaking volunteers. 4. Continue focus on acquiring home visit patient care volunteers. 5. Pursue new volunteer opportunities, i.e., Peace of Mind – Celebration. 6. Offer volunteer orientation to current volunteers to refresh skills and rejuvenate. 7. Develop new training options for current volunteers, i.e., communication and Dementia classes. 8. Offer targeted orientation classes for specific groups, i.e., veterans, hair dressers, teens. 9. Recruitment, training, and placement of La Porte area volunteers.
Nursing		1. Establish a revised Nurse Preceptor Program. 2. Design and implement education, resources, and tools on Live Discharges for all staff. 3. Create and implement Home Health Quality Improvement Projects. 4. Establish a program for educational resources and trainings for nurses seeking CHPN Certification. 5. Identify strategies for ongoing clinical education and competency assessment for all nurses and nurse aides. 6. Identify and implement other clinical education programs and courses.
Bereavement		1. Implement addition of basic grief information provided by CHC Bereavement staff on the grief support page of the CHC website. 2. Continue to improve bereavement counseling support for Veterans by having bereavement counselors complete the Tier One, Tier Two, and Tier Three Star Behavioral Health Providers Trainings. 3. Utilize a satisfaction survey for individual and family counseling clients.
Social Work		1. Explore possible risk stratification and assessment for patient problems related to caregiving. 2. Improve quality of care for veterans by having all social workers who have been employed for at least one year as of 01/01/17 complete the Star Behavioral Health Providers Tier One Veterans Training. 3. All social workers will complete Pediatric ELNEC training in hospice care. 4. Veteran pinnings will be attended by social workers assigned to patients and social workers will

Category	Status	Goal
		encourage other staff to attend.
Spiritual Care		1. Each SCC will organize and conduct four hospice educational presentations for local ministerial-type associations or faith communities. 2. Develop an educational training plan for other CHC disciplines to increase awareness of the scope of spiritual care for hospice patients and families. 3. Evaluate the ongoing effectiveness of the Spiritual Comfort Measure (SCM) and Spiritual Health Assessment (SHA) by SCCs for CHC patients and their primary caregivers. 4. Advertise and implement a Clinical Pastoral Education (CPE) program through the HealthCare Chaplaincy Network (HCCN) at CHC.
Medical Directors		1. Assist in recruitment of one or two more HPM physicians. 2. Assist in recruitment of more MD, DO, and NPs to assist with face-to-face visits. 3. Complete original COTIs within seven calendar days. 4. Decrease the backlog of COTIs to less than two months. 5. Assist in development of Hospital 30-day Readmission Reduction program. 6. Assist in development of High-Cost Insureds Home Care program.

Goal B: Position for Future Growth

Category	Status	Goal
Mishawaka Campus & Regional Expansion		1. Begin construction on Clinical Staff Building. 2. Begin construction on Ernestine M. Raclin House. 3. Acquire final Madison Street home. 4. Construct first Cedar Street home to be sold (two-story). 5. Complete rezoning and Mishawaka Campus replat as needed. 6. Work with City of Mishawaka in an effort to vacate Madison and Pine Streets.
Global Partners in Care		1. Develop a five year pro forma. 2. Identify external sources of funding. 3. Release five-year Strategic Plan. 4. Develop a plan to recruit U.S. partners. 5. Launch new partner application process. 6. Develop new partnership materials. 7. Establish at least one new university relationship. 8. Establish student internship with GPIC. 9. Establish relationship with at least one other AAHPM Fellowship program to facilitate four-week rotations with collaborative GPIC partners in Sub-Saharan Africa.
Uganda		1. Facilitate Biennial PCAU Exchange Visit. 2. Review and revise Road to Hope sponsorship guidelines. 3. Identify funding sources for next phase of mHealth project. 4. Obtain distribution for Road to Hope documentary. 5. Publish 10-year PCAU Report.
Education		1. Hire Education Coordinator. 2. Certify at least two Hospice Foundation staff members as facilitators and integrate Honoring Choices Indiana-North Central into community education curriculum. 3. Leverage the Leighton Foundation challenge grant for palliative care to support CHC's palliative care priorities.

Category	Status	Goal
		4. Develop online video education series about end-of-life planning using various local area professionals. 5. Work with IU South Bend to establish Palliative Care Certification Program. 6. Develop branded recruiting materials to market the Vera Z. Dwyer Fellowship to area physicians. 7. Bring IUSM-Indianapolis' IU Talk to the region. 8. Develop an internship program with IUSM-South Bend.

Goal C: Maintain Economic Strength

Category	Status	Goal
Fund Raising and Stewardship		1. Develop a ROI methodology to determine financial success of fundraising events. 2. Develop a Raclin House brochure for use in fundraising activities. 3. Pursue Healthcare Foundation of LaPorte County opportunities. 4. Launch campaign to build fund at Community Foundation of Elkhart County to $1MM. 5. Initiate a targeted Physician component to support the Crossroads Campaign. 6. Kamm Society roll out. 7. Host two donor events in Florida. 8. Host Dwyer Fellowship event to publicly announce the gift and challenge grant. 9. Raise remaining $850,000 to complete Dwyer match for HPM Fellowship. 10. Complete $5MM Crossroads Campaign capital fundraising goal. 11. Begin working to secure funding to create and endow CHC's Community Diversity Outreach positions. 12. Host an event to celebrate the 10th Anniversary of the Elkhart Campus. 13. Host an event in honor of Camp Evergreen's 25th Anniversary. 14. Rededicate the Veteran's Memorial as the Robert E. Hiler, Jr., Veteran's Memorial. 15. Groundbreaking ceremony and reception for the Ernestine M. Raclin House.

Goal D: Continue Building Brand Identification

Category	Status	Goal
HF Marketing		1. Introduce new Hospice Foundation website. 2. Develop a comprehensive PR and communication plan for the Hospice Foundation. 3. Complete Hospice Foundation branding documents.
CHC Marketing		1. Increase market share in the following counties (all settings): Elkhart 38%, LaPorte 9%, Marshall 58%, St. Joseph 54%. 2. Increase referrals by 5%. 3. Focus on non-cancer physicians and illnesses to increase the MLOS by 7% (MLOS of 14 days) utilizing statistics and data from HeartWize, BreatheEasy, Dementia Program, Pain Assessment, Response Time. 4. Conduct customer service training for intake department and admission representatives. 5. Re-emphasize WHV and actively recruit community partners. 6. Convert CHC and MADS websites to Wordpress with branding similar to FoundationForHospice.org. 7. Increase ECF admissions by 5%. 8. Help establish and promote Pet Peace of Mind. 9. Create marketing materials for MADS. 10. Incorporate Marketing component into existing orientation for new employees. 11. Develop standard responses for common objections, i.e., *Every Patient Every Time.*

The Envisioned Future

Center for Hospice Care
Hospice Foundation

Strategic Plan (2016 - 2018)

Overview

Incorporated as a not-for-profit on June 16, 1978 under the name Hospice of St. Joseph County, Inc., the first patient was admitted in January 1980. Today, and 30,672 patients later, Center for Hospice Care (CHC) is a premier, nationally recognized, and award-winning agency dedicated to improving the quality of living through hospice, home health, grief counseling, and community education. With care offices in South Bend, Plymouth, and Elkhart, CHC serves St. Joseph, Marshall, Elkhart, Fulton, Kosciusko, LaGrange, LaPorte, and Starke Counties in northern Indiana. Caring exclusively for persons with life-limiting illnesses and their families / caregivers, the corporation also operates two Medicare certified seven-bed inpatient units, known as Hospice House, at its South Bend and Elkhart locations. The agency also operates a community bereavement facility called the Life Transition Center, Administrative and Foundation offices, and very soon an outpatient clinic called Center for Palliative Care all located at its expanding Mishawaka Campus. CHC currently has an average daily census of 400 patients and expects to serve over 2,200 patients during calendar year 2016. CHC is licensed as both a hospice and a home health agency by the Indiana State Department of Health. CHC is also Medicare Certified for both hospice and home health care. CHC is a member of the National Hospice and Palliative Care Organization, the National Association for Home and Hospice Care, The Advisory Board Company, and the Indiana Hospice and Palliative Care Organization. Development / fundraising activities to benefit CHC are provided by a separate 501 (c) (3) corporation -- an IRS Type II Supporting Foundation -- known simply as Hospice Foundation (HF). Together, CHC / HF have a professional staff of 228 and over 500 volunteers.

Envisioned Future

As we prepare for the year 2020 and beyond, we are taking measurable steps to create a future that will provide a seamless delivery model from referral through bereavement with the ultimate goal of providing the right care at the right time. This envisioned future unifies CHC hospice and palliative care programming.

To assist us in realizing our plan, we envision increased collaboration with other organizations addressing end-of-life care and enhanced quality and availability of CHC hospice and palliative care services to patients and their families.

CHC will continue to have four overarching goals:

A. Enhance Patient Care
B. Position for Future Growth
C. Maintain Economic Strength
D. Continue Building Brand Identification

CHC's Annual Goals will continue to be categorized under these headings.

For the next three years, CHC has identified specific Strategic Priorities. These priorities have been developed to provide direction to the Boards and Staff of CHC / HF throughout 2016-2018.

Strategic Priorities 2016 -2018:

1. Serve as the principle resource, leader and voice of hospice and palliative care by being the convener to engage key community stakeholders in the design of what end-of-life care looks like in our community.

2. Promote and enhance consistency in the delivery of CHC interdisciplinary clinical services.

3. Fully integrate palliative care into CHC programming and provide resources, innovations, education, and communication on palliative care to the community.

4. Organize and/or participate in building collaborative alliances of like-minded organizations and providers.

5. Optimize engagement of diverse and underserved consumers.

6. Create intentional strategic opportunities for further engagement of CHC staff.

Strategic Priorities: Plans and Objectives

The Strategic Priorities provide the framework for the 2016-2018 Strategic Plan. The plans and objectives are adapted yearly in the form of the annual goals and provide the overall descriptions of what is to be accomplished.

2016 - 2018 Plans and Objectives

1.) ***Serve as the principle resource, leader and voice of hospice and palliative care by being the convener to engage key community stakeholders in the design of what end-of-life care looks like in our community.***

Strategic Plans:

- Convene key stakeholders throughout the community to design what end-of-life care should look like in this community.
- Seek opportunities to serve as the principle and expert resource for hospice and palliative medicine and serve as the primary resource to media regarding hospice/palliative care through a proactive media campaign.
- Explore examples of previous successes like LaCrosse, WI where 96% of the residents who die do so with a completed advance directive in place.
- Create programming where anyone in the community can come to CHC offices and receive expert assistance from trained individuals on how to complete an advance directive.
- Develop and launch the Institute for Hospice / Advance Care Planning website.
- Develop a comprehensive end-of-life planning curriculum, which can be delivered through local area professionals and faith communities.
- Work with local college(s) to develop programs to offer CEU awarding seminars for local area professionals about end-of-life issues relevant to their profession.
- Develop initial online courses, e.g., how to choose a healthcare representative, how to effectively document advance directives, etc.
- Develop online video education series about end-of-life planning matters using various local area professionals.

2.) Promote and enhance consistency in the delivery of the CHC interdisciplinary clinical services.

Strategic Plans:

- Adopt and customize the "Every Person. Every Time" visit model.
- Create an intentionally designed visit model to promote a predictable, high quality experience for every person (patient / family), every time.
- Decrease variability in care from clinician to clinician across all disciplines.
- Enable patients and families to expect a highly predictable experience at a non-predictable time in life.
- Make visits easier to perform especially when clinical staff is busy or tired.
- Measure increased productivity through implementation of the model visits.

3.) Fully integrate palliative care into CHC programming and provide resources, innovations, education, and communication on palliative care to the community.

Strategic Plans:

- Promote internal culture change to fully integrate palliative care into CHC programming.
- Leverage the Leighton Foundation challenge grant for palliative care to support C H C palliative care priorities
- Test innovative ways to offer palliative care educational materials to the community.
- Foster ongoing collaborative relationships with other organizations interested in palliative care services.
- Create a fully realized marketing campaign for the Center for Palliative Care.
- Create a fully realized marketing campaign for the Center for Pediatric Palliative Care that additionally educates and leverages the concurrent care for children aspect of Medicaid.

4.) Organize and/or participate in building collaborative alliances of like-minded organizations and providers

Strategic Plans:

- Foster ongoing collaborative relationships with other local providers who provide end-of-life services or programs.
- Create opportunities to collaborate with organizations whose work is related to, but who are not directly involved in hospice and palliative care.
- Explore new potential partnership funding opportunities to secure funding / resources for shared CHC organizational and programming priorities.
- Seek opportunities to form alliances with other like hospice programs. Examples could be in the areas of Next Practices, Quality, Education, Intake, Admissions, IT, EMR, and Billing, and/or other back office functions that could lead to increased productivity and reduced expenses by not duplicating potentially shared services.

5.) Optimize engagement of diverse and traditionally underserved consumers of hospice and palliative care services

Strategic Plans:

- Recognize there are patient populations with a set of circumstances which may cause them to experience greater challenges in terms of healthcare and access, hospice and palliative care included.
- Fund, via the Crossroads Campaign, a permanently endowed staff position to coordinate CHC's Community Diversity Outreach efforts.
- Promote diversity and inclusion within the CHC organization and throughout our service area.
- Increase access to hospice and palliative care services by raising awareness among traditionally underserved populations, which could include: low income children, LGBT, substance abuse, elderly disabled, HIV/AIDS, and those with chronic health conditions, including mental illness.
- Explore funding opportunities and grants to create a sustainable and growing capacity to reach new populations.
- Seek opportunities for CHC program collaboration with other area healthcare agencies and local human services institutions to raise awareness within these populations.

- Using strategic, outcome and evidenced-based outreach activities, CHC will raise the bar for awareness of CHC services for our local underserved populations.

6.) Create intentional strategic opportunities for further engagement of CHC staff.

Strategic Plans:

- Begin designing a new New Staff Orientation Onboarding program.
- Recognize the importance of highly-engaged staff. Engaged staff have lower turnover rates, perform better, and tend to promote higher levels of patient satisfaction.
- Discover the percent of staff that are Engaged, Content, Ambivalent, and Disengaged by using the Advisory Board Company's survey tools.
- Ensure CHC's mission is reinforced regularly, with input from employees.
- Keep engagement drivers in mind in communications and day-to-day interactions with staff.
- Identify and act upon discrete areas of improvement.
- Create opportunities for career growth, and publically acknowledge the numbers of staff promoted from within on a regular, systematic, and scheduled basis.

Respectfully submitted,

Mark M Murray
President / CEO

Center for Hospice Care
Hospice Foundation

February 2016

# # #

Center for Hospice Care / Hospice Foundation

Strategic Plan 2016 – 2018

UPDATE

From Mark Murray, President/CEO

February 2018

The current Strategic Plan was approved by the CHC Board in February of 2016. The Plan has six specific Strategic Priorities, with each having multiple suggested plans to achieve the priorities over the course of three years. For space saving purposes, these suggested plans are not reproduced below. For clarity and continuity purposes, it is highly suggested that board members review the Plan itself -- which is attached immediately before this document -- prior to reviewing this Update.

Strategic Priority 1.) – Serve as principle resource, leader and voice of hospice and palliative care by being the convener to engage key community stakeholders in the design of what end-of-life care looks like in our community.

Under the banner of Center for Education and Advance Care Planning, which is a component of the Hospice Foundation, we are working with many key stakeholders such as Saint Joseph Health System, Beacon Health System, members of the various faith communities, physicians, IU South Bend, IUSM – South Bend and the University of Notre Dame to help create a community culture that talks openly about health care choices, including end of life, and respects/honors those choices. The consortium has adopted the name Honoring Choices™ Indiana - North Central and is operating as a d/b/a of our Hospice Foundation. The organization will be housed in the Foundation offices. Honoring Choices is a national initiative committed to promoting and sustaining advance care planning (ACP) to ensure individuals' future health care preferences are discussed, documented, and honored. It is currently a 13-state network that shares information, resources, and best practices. Indiana has chosen this model to educate citizens statewide about end-of-life issues. Several organizations throughout Indiana have joined together to accelerate awareness, systems changes, and policy related to ACP. A group of local hospitals, physician and other interested parties have been meeting for years to get this initiative going. CHC has been at the table for some time now and currently has several staff members on committees and sub-committees along with one staff member who serves on the steering committee. Honoring Choices Indiana – North Central is charged with delivering quality ACP education in North Central Indiana. 2018 goals for CHC/HF in this area include: Formally offer to bring an FTE in-house to coordinate the efforts of Honoring Choices Indiana-North Central on end-of-life wishes (the position will be funded by the various stakeholders who will have the opportunity to underwrite the programming). By mid-2018 we will have CHC/HF staff members who are trained in completing advance directives. In addition, we will have staff who will also be able to train facilitators through Honoring Choices™ Indiana - North Central which will work in tandem with our Center for Education and Advance Care Planning to

facilitate similar objectives. We are beginning this work in St. Joseph, Elkhart and Marshall counties with an eye toward expansion into the other counties in which CHC operates. We will begin by training facilitators throughout the community who will work directly with individuals to assist them in completing advance directives. A website sitemap and copy for our Center for Education and Advance Care Planning has been developed. It will include information for three primary audiences: the community, trusted advisors and clinical professionals. The website will be launched in the second quarter of 2018. We are currently offering several programs developed by the Hospice Foundation of America that provides continuing education units for social workers, counselors (particularly around bereavement), spiritual care providers, nurses and other clinical staff. We began offering these CEU-awarding courses in 2017 and this effort will be expanded in 2018 through collaborative efforts with IU South Bend to include offerings for trusted advisors. We are also working with the IU School of Medicine to offer a program called "IU Talk," which provides physicians a facilitative environment in which to practice high-yield skills to better navigate difficult conversations around end-of-life issues with their patients. The first offering will take place in Fall 2018.

Strategic Priority 2.) – Promote and enhance consistency in the delivery of CHC interdisciplinary clinical services.

This is being accomplished through the customization and implementation of "Every Patient, Every Time" which was originally developed by National Hospice Executive Roundtable Member, Hospice of Northwest Ohio based in Toledo. A 2018 Administration Annual Goal is "Begin customization and implementation of the 'Every Person. Every Time' model of patient care.

Strategic Priority 3.) – Fully integrate palliative care into CHC programming and provide resources, innovations, education, and communication on palliative care to the community.

Thanks to the generosity of the Judd Leighton Foundation, we completed the build-out of our new Center for Palliative Care outpatient clinic on CHC's Mishawaka Campus in 2016. Once completed, we hosted an open house for medical providers, community leaders and centers of influence so they could see the facility and learn about our program. In addition, we have developed a series of educational materials and targeted communications designed to raise awareness of the palliative care services that we are now able to offer to the community. Because of the Leighton challenge grant, we have been able to generate additional funds to assist us in getting our palliative care program off the ground. We are currently working on developing a formal business plan and beginning to identify future potential funding sources to make the Center for Palliative Care self-sustaining in the future. As part of this effort, we will test various market approaches to heightening awareness of the need for palliative care services. An internal "Palliative Care Summit" was held on February 7, 2018 with key CHC staffers to kick-off development of a Community-Based Palliative Care program. CHC has also become members of the national Center to Advance Palliative Care and has access to their resources. Additional resources are available to CHC

as members of NHPCO, The Advisory Board Company, the NHERT, and HealthPivots LLC. Through the new education component of the Hospice Foundation, palliative care educational materials, video, and website materials are in development. Goals for 2018 include: Develop a specific pediatric palliative care program along with the marketing materials to support it with an emphasis on CHC clinical staff having been trained in the ELNEC Pediatric Palliative Care education modules; Leverage the Leighton Foundation challenge grant for palliative care to support CHC's palliative care priorities; Work with IU South Bend to establish Palliative Care Certification Program; Create brochures and webpage content for Pediatric Palliative Care; Create brochures and webpage content for our existing Perinatal Palliative Care Services programming; and Create clear and distinct marketing materials and plan for community-based palliative care program. During the past two years we've made great strides in fostering ongoing collaborative relationships with other organizations interested in palliative care services, including area hospitals and physician offices.

Strategic Priority 4.) – Organize and/or participate in building collaborative alliances of like-minded organizations and providers.

Over the last two years, we have been able to deepen our relationships with higher education institutions such as IU South Bend, Indiana University School of Medicine, the University of Notre Dame as well as several other organizations both through our Center for Education and Advance Care Planning and Global Partners in Care. We worked with the Vera Z. Dwyer College of Health Sciences at IU South Bend to secure $1.68 Million in funding to establish an endowed chair in palliative medicine as well as palliative care certification programs for students studying to become nurses, nurse practitioners and social workers. These students will rotate through CHC as part of their education which may give us another pool of potential future employees to draw from. As this relationship evolves, we will have the opportunity to engage other organizations, including healthcare providers, physicians and other key stakeholders. In addition, we secured $1.5 Million to establish the Vera Z. Dwyer Fellowship in Hospice & Palliative Medicine in the IU School of Medicine's Hospice & Palliative Medicine Fellowship program. We have agreements and contracts to provide training for students with the following institutions in these discipline specialties: Physician Education -- Mayo Clinic, Indiana University School of Medicine, Residency Programs of Memorial Hospital and Saint Joseph Regional Medical Center, Midwestern University (Glendale, AZ), and Lincoln Memorial University-DeBusk College of Osteopathic Medicine (Harrogate, TN); Nursing -- Ball State, Bethel College, Grace College, Indiana University South Bend, Saint Mary's College, and Indiana Wesleyan; Social Work -- Indiana University South Bend; Spiritual Care -- Moreau Seminary; Bereavement -- Andrews University; Health and Human Services -- Western Michigan University; and we continue to have collaborative activities with Holy Cross College, Goshen College, and the University of Notre Dame. CHC staff has taught a one credit class "Introduction to Hospice and Palliative Care" every third semester drawing upwards of 100+ undergraduate students. The next class is scheduled for this year on September 22nd. Additionally, since 2016, the CHC Pres/CEO has presented a lecture annually on Hospice Care in America as part of an MBA class entitled "Innovations in Healthcare Transformation" at the Mendoza College of Business at the University of Notre Dame.

Strategic Plan 5 – Optimize engagement of diverse and underserved consumers.

One of the goals of our Cornerstones for Living: The Crossroads Campaign is to secure endowment funding to establish a fulltime staff position for Diversity and Community Outreach. We will continue to work on identifying funding sources throughout the remainder of the campaign. In the meantime, during 2016: CHC attended the African American Women Breast Cancer Awareness Conference in Michigan; attended the HIV Conference at Logan Center; and updated our Spanish Family Handbook and forms. During 2017: CHC attended the Monthly Diversity Committee Teleconference with the National Hospice and Palliative Care Organization; sponsored lunch and provided a presentation about advance directives at the Martin Luther King Center; met with Cherri Peat, Director of Community Outreach for the South Bend Mayor's office discussing diversity and inclusions; met with Christina Brooks, the Diversity and Inclusion Officer for the City of South Bend; attended the Human Rights Awareness Workshop and Luncheon at Century Center; attended NHPCO Management Leadership Conference in Washington, DC and attended a lunch meeting with the national Diversity Committee; arranged a meeting with key Staff and Cory Gathright, Director of the Interdenominational Ministerial Alliance of St. Joseph County discussing more ways of outreach; sponsored lunch at the Martin Luther King Center where CHC social work staff did presentation about caregiver tips on self-care; sponsored lunch at the Martin Luther King Center where a CHC RN presented to attendees about recent experience on losing mother, being a care-giver, and battling cancer herself; had Eric Ivory, the Diversity Manager for Kem Krest in Elkhart, speak to all employees at an All Staff meeting regarding Diversity and Inclusion; and CHC staff attended the Diversity and Inclusion Seminar in Westville at Purdue University Northwest that was presented by Human Resource Association and Greater LaPorte Chamber. So far, this year: CHC sponsored a table and attended MLK Breakfast at Century Center; CHC is currently participating in a six-week "Diversity Dialogue" with the Near Northwest Neighborhood members which is being facilitated by staff from the University of Notre Dame staff and the City of South Bend to discuss experiences and ways to better communicate and relate. Near future goals include: Arrange for Diversity and Competency training with CHC staff by LGBT Resource Center of St. Joseph County; have a presenter from La Casa de Amistad to come in-house to discuss barriers regarding hospice with the Hispanic community. As to seeking funding opportunities to reach new populations, we are continually seeking new funding / grant opportunities to grow our capacity to reach new populations and have been successful in obtaining multiple grants, including $500,000 from the Leighton Foundation to fund our expanding palliative care program, $500,000 from the Asante Foundation to fund a new inpatient unit to meet growing future demand, $1.75 Million from the Vera Z. Dwyer Trust to expand our community education initiatives as well as hospice and palliative medicine fellowship training to educate our future workforce and $1 Million from Ernie Raclin to establish the Ernestine M. Raclin House on our Mishawaka Campus.

Strategic Plan 6.) – Create intentional strategic opportunities for further engagement of CHC staff.\

When a CHC employee observes a co-worker, who is exemplifying CHC's core values (Compassion, Dignity, Innovation, Integrity, Quality, Service & Stewardship) that creates a memorable experience for a patient, family, volunteer, vendor or partner, that person can be recognized. The WOW card, available for completion on the staff website / Intranet is the

instrument that does that. The card is then submitted. Those that are outstanding are recognized and the WOW is read at bi-monthly All Staff meetings. Both the recipients and submitters receive a certificate to be redeemed for CHC logo wear. To receive a WOW, staff must differentiate themselves, which means do something a little unconventional and innovative. They must do something that's beyond their job description. And whatever they do must have an emotional impact on the receiver. Center for Hospice Care is not an average hospice, our service is not average, and we don't want our employees to be average. We expect every employee to deliver WOW. And they are recognized by their peers for doing so. Whether internally with co-workers or externally with our customers and partners, delivering WOW results in word of mouth. Our philosophy at CHC is to WOW with service and experience. We seek to WOW our patients, their families, our co-workers, our vendors & our partners. As to The Advisory Board Company's staff engagement tool, we were under the impression that our membership was all inclusive. Apparently, this Staff Engagement survey tool is outside of the membership benefits. Because they outsource the online component and include follow-up and analysis (which we didn't particularly want) they were going to charge us $20,000. After complaining they came down to $17,000. I offered $12,000 and they didn't budge. Therefore, we declined. During 2018 we will be using the online Best Places to Work in Healthcare tool at a cost of less than $2,000. A 2018 Goal is "Establish a CHC new orientation program including all departments in conjunction with Nursing, Human Resources, Hospice Foundation, and Administration" and we plan on meeting that goal this year. Other engagement practices include recognition of staff who are promoted from within. They are prominently featured in the published Weekly Announcements. New staff at all offices are introduced at the bi-monthly All Staff meetings with a warm welcome and applause. Each year we recognize staff longevity at the January All Staff meeting and staff receive Visa Gift Cards in amounts commensurate with their longevity at intervals of 5, 10, 15, 20, 25, and 30 years. CHC also allows staff and their family members to enjoy the Mishawaka 4th of July fireworks display on the private, gated south lawn of the Mishawaka Campus. Annually we also host CHC night at the South Bend Cubs for staff and their families to enjoy.

# # #

Center for Hospice Care

Conflict of Interest Policy

Article 1

Purpose

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

Article II

Definitions

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

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

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

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

Article III

Procedures

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

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

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

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

Article IV
Records of Proceedings

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

Article V
Compensation

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

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

Article VI

Annual Statements

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

Article VII

Periodic Reviews

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

Article VIII

Use of Outside Experts

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

_____ _____

Signature **Date**

_____

Print Name

2010

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.

Milton Adult Day Services Advisory Committee
The MADS Advisory Committee shall consist of appointees by the Chair of the Board of Directors and include caregiver and community representation. It shall have the responsibility to review the scope of services, quality of services, policies and procedures, service reports, evaluation findings, public relations/information materials, marketing/fundraising activities, and grant opportunities. The committee meets twice a year.

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.

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.