Center for Hospice Care
choices to make the most of life

Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
May 16, 2018
7:15 a.m.

BOARD BRIEFING BOOK

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Center for Hospice Care
choices to make the most of life

CHAPTER ONE

AGENDA

Center for Hospice Care

BOARD OF DIRECTORS MEETING
Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
May 16, 2018
7:15 a.m.

A G E N D A

1. Consent Agenda (10 minutes):
   A. Approval of February 21, 2018 Minutes *(action)*
   B. Patient Care Policies *(action)* – Included in your board packet. Sue Morgan available to answer questions.
   C. Revised and new Human Resources Policies *(action)* – Included in your board packet. Karl Holderman is available to answer questions.
   D. QI Committee *(action)* – Meeting Minutes included in your board packet. Carol Walker is available to answer questions.

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

3. Finance Committee *(action)* – Jesse Hsieh (15 minutes)
   A. 2017 Combined Audit *(action)*
   B. Year to Date April 2018 Financial Statements *(action)*

4. Hospice Foundation Update *(information)* – Amy Kuhar Mauro (15 minutes)

5. Board Education *(information)* – "CHC Electronic Data: Connectivity, Security, Redundancy, and Recovery" – Josh Gregory, IT Director (15 minutes)

6. Chairman's Report – Wendell Walsh (5 minutes)

Next meeting August 15, 2018 at 7:15 a.m.

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Center for Hospice Care
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CHAPTER TWO

MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
February 21, 2018

Members Present:	Anna Milligan, Carol Walker, Jennifer Ewing, Jennifer Houin, Jesse Hsieh, Suzie Weirick, Tim Portolese, Tricia Luck, Wendell Walsh
Absent:	Amy Kuhar Mauro, Ann Firth, Mary Newbold
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 7:15 a.m.	
2. New Board Members	• New members Jennifer Houin and Tricia Luck were welcomed to the CHC Board of Directors.	
3. Minutes	• A motion was made to accept the minutes of the 12/20/17 meeting as presented. The motion was accepted unanimously.	T. Portolese motioned C. Walker seconded
4. Policies	• Ten new and revised policies were presented. The "Revocation" policy was reviewed. A revocation can occur when a patient may want to pursue a usually curative type of treatment outside of the hospice care plan, so they revoke their hospice service but are welcome to come back to us. We follow the CMS regulations very closely and track these patients. Patients can also get better on our services and no longer meet eligibility requirements of hospice. We review revocations with the patient/family at the time of admission and throughout service. This policy is more geared towards staff to help them accurately complete the required documentation. If the treatment the patient wants to pursue is not part of the hospice plan of care, the patient can either pay for it on their own or revoke the Hospice Medicare Benefit and go back to traditional Medicare. It is up to the patient/family to decide. We advise the patient/family on the financial implications of a revocation decision or not. We don't get paid for the day of the revocation. When the patient comes back, we have to do the entire admission process again. • A motion was made to approve the ten new and revised policies as published. The motion was accepted unanimously.	C. Walker motioned J. Hsieh seconded
5. President's	• Census is recovering from the low last September of 364. Through yesterday we are at	

Topic	Discussion	Action
Report	386. January had 155 original admissions, which was much higher than projected. • La Porte Office – We are still waiting for approval from CMS in Chicago and have left messages with them. ISDH didn't have the additional site application on its website and said we only needed to send a letter with the new address. Then they sent an application form to complete. We submitted the 855A form to Palmetto months ago. • A Community-Based Palliative Care Summit was held last week with 12 key staff members. At the meeting we talked about starting with our HeartWize and BreatheEasy programs, because those have been very successful. Over the past two years we have had 1,031 patients with CHF/COPD. Of those, 96.5% of CHF and 92.2% of COPD never went back to the hospital. This may be a product line we could market or sell to health systems, managed care companies, large employers, etc. We need to make it more formalized. We are supposedly in all of the local ACOs although there have never been any formal written agreements but we are a listed provider. These would be palliative care patients on a potential two year trajectory for hospice care. One in five patients age 65 and over that are in a hospital today will expire in six months or less. 20% of all Medicare patients in a hospital at this moment are eligible for hospice. We need to get them into hospice earlier and increase their length of stay. Our community liaisons made 761 visits to referral sources or potential referral sources. They have many long term relationships with these resources and are building relationships with new referral sources. They are informing them about our programs such as HeartWize and BreatheEasy. • In 2017 we had 94 goals and 87% were met or were in process by the end of the year. In 2018 we have 107 goals which include Milton Adult Day Services, Global Partners in Care, and other programs we have added. • Optum Pharmacy Services – We meeting with Optum monthly over the phone and review our current medications and our performance over a rolling 13 month period. We always get accolades from Optum on how low our costs are. Optum has 265 clients and the average cost per prescription per day is $23.25 and we are at $15.29. Dave H. meets weekly with the medical staff. He asked Optum to provide a weekly list of drugs that are non-formulary and brand name drugs. We look at each one and see if there are opportunities to lower the prescription to a generic or one less in price but just as effective. Optum often says their other clients would love to do what we are	

Topic	Discussion	Action
	doing. Their clients are other hospices across the country. • We are interviewing a potential physician candidate on Thursday. She is board certified in hospice and palliative medicine. When she was an undergrad at Notre Dame, she was a volunteer in our South Bend IPU. We will be interviewing another physician next month who is from the Chicago area. Dr. Jon Kubley plans to retire in May, but will stay on PRN. • A narrative status update of the 2016-2018 Strategic Plan is in the board packet as an attachment to the President's report. Strategic Plan status is reported annually and the plan itself is on the secure board website. • About a year ago we started using the "Experience Model" for Interdisciplinary Team (IDT) meetings. This was created by Mary Labyak, a social worker. CMS has been over-medicalizing the hospice experience. It used to be the RN, social work, and spiritual care as equals, but now it is more about the medical directors and nurse practitioners. The Experience Model focuses more on the patient/family's values and goals at the end of life. The IDT meets weekly and reviews 50% of hospice patients on census. The IDT consists of nursing, social work, spiritual care, and bereavement. In the Experience Model, the Nurse introduces the patient and diagnosis. Then the social worker presents their goals for the patient/ family, then spiritual care, and then back to the nurse. All medications are also reviewed. This model streamlines what is discussed. • Reminder to sign the Conflict of Interest form. This is to meet the requirements of our annual audit and answer specific questions on the IRS Form 990, the nonprofit "tax" return. • The NHERT had a presenter from a pharmacy manufacturer at their last meeting. He said there has not been a new oncology drug approved since 2015 that cost less than $100,000.	
6. Finance Committee	• YTD 2017 we served 2,091 patients which is down 1% from the prior year and 2% from budget. ADC was 384 which was down 3.8% compared to the prior year and 5% from budget. The breakeven ADC is 345. Operating revenue YTD was down 3% from the prior year and ties into the lower ADC. Expenses were up 3.4% from the prior year which is historically what we have done year over year—a 3-5% increase on an annual basis on actual expenses. Expense YTD were down 8.9% from budget. This was due to several different factors—positions not staffed, lower medication costs,	

Topic	Discussion	Action
	and a lower number of patients on census so lower direct patient care costs. The format of this report is to make it more clear where we are financially and where we stand compared to the budget. Total budgeted revenue was $22MM and we came in at $21MM. Total budgeted expenses came in $2MM below budget. This speaks highly of the fiscal management of Mark M. and his team and Karl H. and his team. We are doing about $1MM better than projected. The total overall drug costs per patient day were down 4% from the prior year. In terms of savings and based on the actual per diem, we saved $125,000 on this budget item alone. • YTD December 2017 Operating income $21MM, Milton ADS $450,000, beneficial interest in Hospice Foundation $3.1MM, total revenue $24.7MM, total expenses $19.7MM, overall net $4.9MM, without beneficial interest in Foundation $1.8MM. At the Finance Committee meeting we noted that the $1,888,081 combined net without factoring in investments by the Hospice Foundation is spectacular. • A motion was made to accept the December 2017 year end pre-audited financial statements as presented. The motion was accepted unanimously. • From a functional expenses standpoint, the percentage that goes towards program services in 2016 was 86.25% and in 2017 it was 86.8%. • When we purchased the Smith house next to the Center for Palliative Care, we paid a premium above what the City paid us for it. We had several conversations with our auditors regarding the purchase. When we initially bought it, the purchase was recorded as a loss on the sale of an asset. Our auditors researched it and based on the agreement with the City of Mishawaka for improvements and the city granting us easement of the use of the property, that is an asset so it can be capitalized as an asset and not a loss.	J. Hsieh motioned T. Portolese seconded
7. Foundation Update	• The Crossroads Campaign is a five-year fundraising campaign. It started in July 2014 with a goal to raise $10MM. Through the first three and a half years we have raised $10.2MM. We continue to have some underfunded priorities. We have raised more in endowment and programs than capital than we anticipated. One was a $1MM matching grant to establish a permanent endowment for a Fellowship in Hospice and Palliative Medicine. We now have to raise another $850,000 to get the match. In the capital area we raised $3.5MM towards construction of the Ernestine M. Raclin House, which will be the new Mishawaka Inpatient Unit. We need another $1.5MM to complete that goal.	

Topic	Discussion	Action
	• The number of donations and donors has seen a dramatic change since 2010; however, the average gift size has increased. A lot of it has to do with the fact that many of the people that give to organizations like ours are older. Our focus and emphasis has been to work with our donor base that has a tendency to give higher amounts of money. We are seeing more gifts at the campaign level than annual giving. Annual giving was up until 2016 when it decreased slightly, but has been up again in 2017. • In January we launched an improved version of the Hospice Foundation website at foundationforhospice.org. It is more interactive and simpler and easier to navigate. • The details and priorities about the Center for Education and Advance Care Planning are in our 2016-2018 Strategic Plan. We want to serve as the personal resource and leader in advance directives. We have been working closely with various health systems and institutions of higher learning like Notre Dame, IU School of Medicine, and IUSB. We've done a lot of community education like screening the FRONTLINE documentary "Being Mortal." We are also helping Honoring Choices Indiana-North Central get off the ground. For many years a group of people from various hospitals and faith communities have been coming together to talk about what end of life care looks like in our community and how to get people talking about it sooner rather than later. We have been involved for several years, but last year we became more involved to the point we are helping to develop a business plan and a job description for a position that Honoring Choices would pay for. This would come under our umbrella of services. We filed a DBA to have Honoring Choices Indiana-North Central be another DBA under the Hospice Foundation, so the group doesn't have to establish a separate entity. There will be a revenue line and offsetting expense line item related to this initiative. • Global Partners in Care – There are currently 59 hospices in the U.S. working in concert with 59 hospice entities in 13 different countries. We are also working with a number of other international hospice and palliative care organizations around the world. We are trying to figure out how to collaboratively improve access to hospice and palliative care where we know the needs are great but resources are few. We began the process in October to formalize a GPIC Strategic Plan over the next couple months. We have also done some rebranding including updating the logo so it shows more of the world and not just North America. • Mishawaka Campus – We will be purchasing the final house on Madison Street and will close on it on Monday. We have had conversations with City that since will now	

Topic	Discussion	Action
	own all of the property between here and Cedar Street, could we vacate Madison and part of Pine so we are able to create better parking. Then we would be able to have a parking lot in front of the IPU instead of across the street. During construction, we will use the house on Madison for the contractors instead of paying about $20,000 for several job site trailers. We are planning to break ground on 03/19. Construction on the Ernestine M. Raclin House will begin on 06/12 with a groundbreaking ceremony. • The upcoming Helping Hands Award Dinner honoring Sr. Carmel Marie Sallows will be held on 05/02. She still volunteers in the South Bend IPU and has been a volunteer for 20 years.	
8. Board Education	• Year in Review 2017. We served 2,091 patients, which puts us in the top 3% of hospices in the country. ADC was down 3.5% from the prior year. Referrals were down 5%, but the conversion rate from referral to admission was the highest. It increased from 71% in 2016 to 75% in 2017. Same/next day referrals increased from 53% in 2016 to 58%. DBAs were down from 7.4% of referrals to 6.8%. The percentage of Patient/POA refused admission was up from 2.3% to 2.9%. Deaths in seven days or less increased slightly from 41.36% to 41.72%. We continue to work to get earlier referrals. Diagnosis – Cancer was 35.29%, Cardiovascular 27.16%, Dementia/Neurological 13.34%, and COPD/Respiratory 11.29%. The Hospice ALOS was 74 days compared to 68 days in 2016. The HMB Lengths of Stay were ALOS 81.42 days compared to 72.94 days the prior year, a 12% increase. • As we convert over to fewer cancer patients, we have been focusing on our HeartWize and BreatheEasy programs for cardiac and COPD patients. The statistics we are presenting to referral sources has been a real tool for us, and we are poised to be able to take advantage of that. Rebecca Fear and Sue Morgan will be presenting on our HeartWize/BreatheEasy programs at the NHPCO Management & Leadership Conference in April. We will put a trademark on the logos for those programs. • Referrals – Hospitals 45%, patients/families 29%, doctors 15%, ECFs 7%, other 3%. The IPUs combined served 645 patients, ALOS 5.2 days, occupancy 65.79%. This was a 2% decrease in the number of patients from the prior year. It is getting more difficult to document patient eligibility for GIP. The OIG and MedPAC published concerns about it, so doctors are being very careful deciding whether a patient is eligible because have to have a symptom to manage in order to collect reimbursement for GIP. We are doing a good job and audit all documentation. Our patients are doing	

Topic	Discussion	Action
	fine because of the interventions we are providing. • Bereavement served 2,497 clients. 75.75% were hospice, 20.9% were from the community, and 3.4% were bereaved of DBA patients. There is no reimbursement from Medicare for bereavement. The bereavement department is averaging 144 deaths a month. We are also seeing more bereavement for deaths from opioid overdoses, so we have added a couple of support groups for that loss. • CAHPS Survey – 97.8% said they had a positive experience and 97.9% would recommend CHC to others. • Fundraising revenue was $2,754,988 in cash not pledges, which is up 36% from the prior year—the largest cash income year in our history. The value of unreimbursed services was $1,995,116. • The St. Joe Valley Street Rods hit the $100,000 mark in cumulative fundraising over the past several years. We get 50% of the proceeds from the sale of Barnaby's Pizza coupons for $10.00.	
9. Chairman's Report	• A motion was made to approve a new three-year contract for the President/CEO, Mark Murray, with the CHC Board's extreme thanks for his performance. The motion was accepted unanimously. • Long term plans and succession – The CEO Succession Planning Framework is posted on the CHC Board website under Documents. It is reviewed and updated every three years and the most recent update was December, 2016.	J. Hsieh motioned J. Ewing seconded
Adjournment	• The meeting adjourned at 8:40 a.m.	Next meeting 05/16

Prepared by Becky Kizer for approval by the Board of Directors on May 16, 2018

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Carol Walker, Secretary Becky Kizer, Recording Secretary

Center for Hospice Care
choices to make the most of life

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
Hospice Foundation
Global Partners in Care
President / CEO Report
May 16, 2018

(Report posted to Secure Board Website on May 10, 2018)

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:15 AM. This report includes event information from February 22 – May 16, 2018. The Hospice Foundation and GPIC Board meetings follow immediately in Conference Room C. ***Due to the new quarterly structure of the board meetings, the format of this President's Report has been slightly altered and presents only the most recent data in some areas.***

CENSUS

Beginning in March, the La Porte office census was broken out into its own "office." This is the reason the South Bend office census appears to drop month over month beginning in March. Previously, LaPorte County patients were seen out of the South Bend office. Overall, year-to-date (YTD) April 2018, referrals are down 3%, the conversion rate is down 2% at 69% of all referrals compared to last year. Number of patients served and new admissions is down 4% from YTD April 2017. While patients refusing admission is down 1% from a year ago, YTD April 2018 patients dying before admission has increased to 9% of all referrals compared to 6% a year ago with hospitals being the largest source. In April 2018, 47% of all admissions died in seven days or less.

APRIL 2018	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Patients Served	500	961	1,004	-4.28%
Original Admissions	142	593	618	-4.05%
ADC Hospice	373.07	370.15	362.53	2.10%
ADC Home Health	14.10	16.47	29.34	-43.87%
ADC CHC Total	387.17	386.62	391.87	-1.34%

HOSPICE INPATIENT UNITS

April 2018	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
SB House Pts Served	27	121	133	-9.02%
SB House ALOS	4.78	5.12	4.93	3.85%
SB House Occupancy	61.43%	73.81%	78.10%	-5.49%
Elk House Pts Served	26	96	105	-8.57%
Elk House ALOS	4.73	4.93	4.33	13.86%
Elk House Occupancy	58.57%	56.31%	54.17%	3.95%

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	217	202	191				203	213	215	216	221
Ply:	71	76	77	82				67	65	69	73	72
Elk:	77	85	96	91				88	77	78	77	79
Lap:			12	15								
SBH:	5	54	6	4				5	6	5	4	4
EKH:	4	4	4	4				3	3	4	4	4
Total:	380	387	392	387				366	364	371	373	380

PATIENTS IN FACILITIES

Of the 500 patients served in April 2018, 148 resided in facilities. The average daily census of patients served in nursing homes, assisted living facilities and group homes in April 2018 was 124 and year-to-date was also 124.

FINANCES

Karl Holderman, CFO, reports the year-to-date April 2018 Financials will be posted to the Board website on Friday morning, May 11th following Finance Committee approval. For information purposes, the unapproved, year-to-date March 2018 financials, including a year-to-date summary are presented on the next page. On 3/31/18, at the HF, intermediate investments totaled $4,487,401. Long term investments totaled $19,595,835. The combined total assets of all organizations on March 31, 2018 totaled nearly $50.2MM on 3/31/18. Year-to-date investments showed a loss of -$51,421.

It should also be noted at the board meeting we will be concentrating only on year-to-date April 2018 financials as part of our new board format. To move things along, we will not be covering previous months in detail.

Year to Date March 2018

Year to Date Summary	Center for Hospice Care	Hospice Foundation	GPIC	Combined
CHC Operating Income	5,415,154			**5,415,154**
MADS Revenue	118,224			**118,224**
Development Income (Net)		212,824		**212,824**
Partnership Grants			119,818	**119,818**
Investment Income (Net)		(51,421)		**(51,421)**
Interest & Other	5,443	16,155	5,891	**27,489**
Beneficial Interest in Affiliate	(439,290)	744		
Total Revenue	**5,099,531**	**178,302**	**125,709**	**5,842,088**
Total Expenses	**4,818,990**	**617,592**	**124,964**	**5,561,546**
Net Gain	**280,541**	**(439,290)**	**744**	**280,541**
Net w/o Beneficial Interest	*719,831*	*(440,034)*		
Net w/o Investments				***331,962***

2018 CONSOLIDATED FINANCIAL AUDIT

The 2017 audited financial statements are on the Board Agenda. They are scheduled to be reviewed by the Finance Committee on Friday May 11th at an in-person extended Finance Committee meeting with the auditors from David Culp and Co., LLP. The audited financials will be posted to the board website on Friday morning following the Finance Committee meeting for those wishing to review the materials prior to Wednesday's board meeting. Hard copies of the 2017 audited financial statements will be distributed to all board members at the Wednesday board meeting. There were no deficiencies or significant findings again in this year's audit. As a result, there are no changes to the December 31, 2017 pre-audit financial statements presented to the Finance Committee and the Board. Once again, we congratulate Karl Holderman, VP/COO and his team for an outstanding job.

CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

When it comes to CHC pharmacy expenses, our total drug cost per patient day for 2017 was $5.10 per patient day, with the cost trend line declining throughout the year. For the first quarter of 2018, our total drug cost was $4.60 per patient day, as compared to $5.99 per patient day for the first quarter of 2017. This amounts to a 23% reduction in pharmacy cost when comparing the first quarter of 2017 with the same period in 2018. This quarterly 23% cost reduction in a year is attributable to better utilization of lower priced drugs by our medical staff. It is even more remarkable when one considers the general price of drugs is more expensive in 2018 than in 2017. When we had a per diem drug arrangement with Enclara Pharmacia three years ago, our total drug cost per patient day was $8.75. When comparing $8.75 per patient day to our 2017 performance of $5.10 per patient day, that is a 42% reduction in pharmacy expenses.

Jon Kubley, M.D., retired on May 4. He plans to rest for six weeks and wants to again work with CHC as a part-time independent contractor covering weekly Interdisciplinary Team meetings in Plymouth and some face-to-face visits in Marshall County.

Elaina DiOrio, M.D. and Johanna Coughlin, M.D., both Hospice and Palliative Medicine Fellows from Indiana University School of Medicine have just completed clinical rotations with our agency. Kayla Herget, M.D., started her clinical rotation on May 7. She is the first recipient of the Vera Z. Dwyer Fellowship and we will be holding a reception in her honor on May 24.

We have signed an Agreement with Company Mileage, Inc., which provides a product that automatically calculates mileage driven by employees. It is expected this will provide us with a more accurate record of mileage expenses and save significant money over time. Training is scheduled to begin in June.

DIRECTOR OF NURSING UPDATE

Sue Morgan, DON, reports…

Students from Saint Mary's College majoring in Social Work and Nursing were here on March 28 for a two-hour class on Hospice Care. Nursing, Social Work and Chaplaincy gave short presentations on their roles in the Interdisciplinary Team and they toured the inpatient hospice unit. There were 19 students in attendance.

"Organizing Teams and Implementing Projects" was offered to all the CHC Coordinators or anyone organizing and facilitating projects and teams for quality improvement. Those who completed the class received 1.0 CEU through the Ohio State Nurses Association. CHC has been approved by the Ohio State Nurses Association to offer Continuing Education units to our education program which meets the requirements for continuing education credits

"What's So Special About Special Care" was presented by the Institute for Excellence in Memory Care – an affiliate of Alzheimer's & Dementia Services of Northern Indiana -- to all the Clinical Staff on March 14. The lecture focused on the care of the patient with dementia.

Sue Morgan, DON and Rebecca Fear, Coordinator of Quality and Medical Records, presented a concurrent session at the NHPCO Management and Leadership Conference on April 24, 2018. The session was titled, "Good to Great: How to Improve a Specialty Program Designed to Decrease Hospitalizations of End Stage Cardiac and Pulmonary Disease in the Hospice Setting" and featured CHC's HeartWize and BreatheEazy specialty programs. The presentation was very well received and the session was also well attended.

We continue to be "survey ready" in preparation for Indiana State Department of Health Hospice Survey. We periodically remind the staff of the Conditions of Participation (COP's) in preparation of the survey. Hospice surveys are mandated by the Centers for Medicare and Medicaid Services (CMS) to take place at a minimum of every three years. Our three-year anniversary since our last survey was October 2017.

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 April 2018, the Development Department recorded the following calendar year cash gifts as compared with the same period during the previous four years:

	2014	2015	2016	2017	2018
January	51,685.37	82,400.05	65,460.71	46,552.99	37,015.96
February	109,724.36	150,006.82	101,643.17	199,939.17	93,912.90
March	176,641,04	257,463.89	178,212.01	282,326.61	220,485.17
April	356,772.11	419,610.76	341,637.10	431,871.55	310,043.61
May	427,057.81	635,004.26	579,888.08	574,854.27	
June	592,962.68	794,780.62	710,175.32	1,066,118.11	
July	679,253.96	956,351.88	1,072,579.84	1,277,609.56	
August	757,627.43	1,042,958.42	1,205,050.76	1,346,219.26	
September	935,826.45	1,267,659.12	1,297.009.78	1,466,460.27	
October	1,332,007.18	1,321,352.39	1,421,110.26	1,593,668.39	
November	1,376,246.01	1,469,386.01	1,494,702.09	2,443,869.12	
December	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)

	2014	2015	2016	2017	2018
January	51,685.37	57,971.60	52,156.98	31,552.99	31,847.64
February	43,038.99	67,572.77	36,182.46	35,125.58	46,258.33
March	66,916.68	107,457.07	73,667.84	79,387.44	113,969.42
April	180,156.07	162,146.87	163,425.09	149,569.94	87,978.32
May	100,285.70	160,178.34	93,318.98	142,982.72	
June	97,258.66	159,776.36	127,315.24	146,200.17	

July	38,243.88	93,586.27	52,394.52	61,505.45	
August	79,015.87	86,606.54	97,470.92	63,593.03	
September	84,011.71	99,931.45	92,459.02	120,261.01	
October	55,208.68	53,693.27	71,323.54	127,208.12	
November	44,238.83	46,870.62	66,490.16	75,809.56	
December	193,065.45	161,519.80	138,328.11	286,687.74	
Total	**1,033,125.99**	**1,257,310.96**	**1,064,532.86**	**1,319,883.75**	**280,053.71**

Cornerstones for Living: The Crossroads Campaign

Campaign-related work in February, March and April 2018 included meetings with donor prospects, donor stewardship meetings, additional donor cultivation, follow-up activities, and scheduling meetings with major gift donor prospects. As we move through the second year of the public phase of our comprehensive campaign, which is in its 45th month, (7/1/14 thru 4/30/18) cash, pledges and documented bequests now total $10,499,498. 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 $835,000 to match the $1 million challenge grant to fully endow the Vera Z. Dwyer Fellowship in Hospice & Palliative Medicine.

A recent Hospice Foundation grant request to the Community Foundation of Elkhart County (CFEC) resulted in an invitation to make a presentation to the Foundation's Key Initiatives Committee. This invitation is based upon our submission of a Letter of Intent last year and a full grant application this year. We made a presentation to the Quality of Life Committee on March 9th along with five other nonprofits that presented in-person that day. On May 16th three nonprofits have been asked to present in-person again and all are requesting $250,000 or more. We are requesting a $500,000 grant for the new inpatient unit. Tim Portolese will be joining us that morning at the CFEC presentation and has written a letter of support to each of the Key Initiatives committee members.

Planned Giving

Estate gifts received in March and April 2018 totaled $10,072.73. In addition, we have been receiving more requests than usual from financial advisors and attorneys asking for information about planned giving and bequests to Hospice Foundation.

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 newly created Sister Carmel Helping Hands Fund which will support charity care.

Special Events & Projects

The 2018 Helping Hands Award Dinner honoring Sister Carmel Marie Sallows, CSC for her lifetime of service was held on Wednesday, May 2, 2018. We had 406 registered guests and gross revenue was $194,300.

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, President & 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 program, will be on hand to make brief remarks.

We have several other events planned for this year because of several milestone anniversaries. Events include celebrations around the 25th anniversary of Camp Evergreen (8/9) and 10th anniversary of the Elkhart Campus (8/16).

PCAU

Planning for the Palliative Care Association of Uganda's (PCAU) staff exchange visit in July/August continues. We will be celebrating the 10th anniversary of our partnership with this year's edition of Okuyamba Fest on Tuesday, July 31st. Other activities for their visit include a staff meeting presentation on August 8th, presentation to the Hospice Foundation board on August 15th, meetings and training session at the University of Notre Dame for the joint mHealth project and other initiatives, visits and lunch with staff at each office, meetings at IU South Bend to discuss internships, and lunch with the Friends of Uganda Network (FUN).

Our 10th anniversary partnership report is being created and will include information about our shared successes in making palliative care accessible to all in Uganda. It will also include updates on the Road to Hope program.

Kaitlyn Siler, an MPH student at the Eck Institute for Global Health (ND) is currently in Uganda gathering data for her capstone project. This project will help PCAU in reporting palliative care access and morphine supply by mapping the location of nurses and clinical officers trained through the Diploma in Clinical Palliative Care program.

Road to Hope Program/Documentary

Roberta Spencer has returned to Uganda to participate in the 2018 Road to Hope Children's Camp. She will also develop an evaluation tool to use with the children who participated in the Empowerment Retreat this past February.

We are interviewing two students from Saint Mary's College for possible internship positions with the Road to Hope program. Ideally, at least one will be able to travel to Uganda this summer to assist with documenting children's' stories, including their academic progress.

Global Partners in Care

We are drafting our five-year strategic plan, which we plan to distribute to our partners and other stakeholders mid-year. We are making sufficient progress on our 2018 goals and will meet in June to assess where we are with our timeline for 2018. We are still working with individual partnerships to sign new partnership agreements, and consulting with each of them to strategically

plan for partnership activities and growth. Some partners are content with their partnership and are not currently asking for support from GPIC, while others are actively engaging our support for their partnership.

We have sent $12,000 in scholarship money to the African Palliative Care Association (APCA) for 2018, which should be sufficient to fund four scholarships for students in nursing and social work to advance their palliative care education. These have been donated specifically for this purpose. We have finalized a new MOU with the APCA and have set up a regular framework for interaction and communication as we seek to collaborate in three key areas: scholarships, national association support, and advancing research.

GPIC will attend the 22nd International Congress on Palliative Care, a well-known international conference in palliative care hosted by Palliative Care McGill (at McGill University). We are collaborating with the conference organizers to offer a 'Global Partners in Care travel scholarship' which will be awarded to one of our international GPIC partners who has a poster accepted at the conference. This is a good way for us to highlight GPIC at the conference through sponsorship and getting one of our international partners there to speak for us.

Center for Education and Advance Care Planning

We held our first "Death by Chocolate" event on National Healthcare Decisions Day, April 16th. There were 32 paid attendees. The feedback we received via survey was positive. Our thanks go to Kilwin's and Olympia Candy Kitchen for their delicious donations. A series of yoga sessions that feature end-of-life conversations is planned for this summer. We are working with the Mishawaka Parks Department to hold these at Central Park. The year will wrap up with "Cupcakes to Die for," which will be like "Death by Chocolate" in its focus – normalizing conversations about end-of-life in a relaxed, social environment.

The Honoring Choices® Indiana – North Central business plan has been completed and members of the coalition are meeting with each of the area hospitals to secure seed funding for the program. The Advance Care Planning Coordinator (ACP) job description has also been finalized; we have received one inquiry to date.

The first phase of the Center for Education & Advance Care Planning website has been developed and is being beta tested internally. We anticipate it will be launched in June.

Elleah Tooker, our Community Education Coordinator, presented on hospice and end-of-life planning for classes at IVY Tech and IU South Bend's Elkhart Campus. We are developing a flier that will be sent to area colleges and universities, particularly liberal arts departments, which will invite professors to contact us about making class presentations.

We are updating our one credit hour Introduction to Hospice and Palliative Care course, which will be offered again on September 22nd at the University of Notre Dame. This course was also discussed at a recent meeting with department heads of the Vera Z. Dwyer College of Health Sciences at IU South Bend. They would like to offer a similar course, as well as expanding the types and number of internship opportunities with CHC, HF and GPIC.

Cyndy Searfoss took part in a community breakfast hosted by another IU South Bend department which has been charged with orchestrating internships with area non-profit organizations. This department's focus is on internships that are not part of the student's degree requirements. Although an official kick-off date for internships hasn't been set, the department is anticipating they will be ready to place interns in the fall. A unique feature of this program is that the organizers anticipate they will be able to pay a stipend to students, which will allow those who are working to pay for college and the opportunity to gain valuable experience during their college career.

Mishawaka Campus

We completed the acquisition of the 612 Madison Street property on February 26th. DJ Construction is using 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.

Construction started on the new Clinical Staff Building in mid-March. The foundations have been installed and work is nearing completion on under-slab rough-ins for plumbing and electrical. Semi-monthly construction meetings are being held on the 2nd and 4th Thursday of each month.

Mike continues to meet regularly with Helman Sechrist Architecture (architect), Jones Petrie Rafinski (engineer), DJ Construction (builder), Office Interiors (interior designer) to put the finishing touches on design of our new 12-bed inpatient facility, the Ernestine M. Raclin House, with a ground-breaking ceremony scheduled to take place on Tuesday, June 12th.

The Board of Zoning Appeals and Mishawaka Plan Commission will hear our rezoning, sub-division and variances requests for the parcel located at the corner of Comfort Place and Cedar Street at their meeting on Tuesday evening, May 15th. Provided our plan is approved, we intend to begin construction on the first of two planned residential homes on that site this summer.

COMMUNICATIONS, MARKETING, AND ACCESS

Craig Harrell, Director of Marketing and Access, reports on marketing and access activities for February and March 2018…

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 February and March our four Liaisons completed 853 visits to current and potential referral sources within our service area.

Access

For the months of February & March, the Referral Specialists received 890 and 910 incoming phone calls respectively to the Admissions Department.

We continue to struggle with late referrals, particularly from hospitals. So far, this year through March, we have had 63 referrals that died prior to us being able to admit them. That's an increase of 57.5% over the same period in 2017.

Website

During the months of December and January, CHC's website hosted 5,473 new users, which is an 8.35% increase over the previous period. Also increased are the number of Sessions (+6.45%), Users (+8.62%) and Pageviews (+17.5%). Our most significant increase continues to be with users finding us organically through search engine optimization. In February and March 31.7% of visitors found us by entering our website address or through a search engine such as Google which is a 98.3% increase over the same period in 2017.

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 49,593 people for February and March, and had 143,414 paid and organic impressions, 283 shares, and 158 comments. We recently began adding more video with the intention of educating and focusing on what makes us different than competitors. In February and March our videos were viewed over 35,000 times for more than 8,000 minutes. To put that in perspective, during the same period in 2017 there was a total of 258 viewing minutes. Video interviews of the CHC Pres/CEO speaking on topics like, "Life on Your Terms" and "You have a right to choose which hospice you want" were viewed more than 2,600 times. We also continue to share content through Twitter, Instagram and LinkedIn.

Digital Overview

The digital campaign focuses on delivering our ad to the proper audience at the proper time. For the months of February and March it generated 144 telephone calls. Google industry benchmarks show an average click-through rate in the Health & Medical field of 3.27% and we continue to be extraordinarily high at 9.72%.

UPCOMING EVENTS AND DATES WHERE CHC BOARD MEMBERS ARE INVITED TO PARTICIPATE

- May 24 (5:30pm at CHC) – A Celebration of the Vera Z. Dwyer Transformational Gift for Hospice and Palliative Medicine. Attendees include David Kibbe from Indiana Trust Wealth Management, Dr. Lyle Fettig, director of the Hospice and Palliative Medicine Fellowship at IU School of Medicine, and Dr. Kayla Herget, MD, our first Vera Z. Dwyer Fellow who will be finishing her CHC rotation.

- June 5 (5:30pm at Elkhart Campus) – Annual Gardens of Remembrance and Renewal Program on the grounds of the Elkhart Campus

- June 12 (5:30pm at CHC) – Official Groundbreaking Ceremony for the new Mishawaka Campus Inpatient Care Facility (Ernestine M. Raclin House)

- July 17 (5:00pm at CHC) – Cocktail reception for NHPCO, National Hospice Foundation, and Hospice Action Network President/CEO Edo Banach

- July 31 (5:30 at CHC) – Okuyamba Fest, with special guests Rose Kiwanuka, Mark Mwesiga and Cynthia Kabagambe from the Palliative Care Association Uganda

- Aug. 16 (5:30pm at Elkhart Campus) – 10th Anniversary of Elkhart Campus, and rededication and naming of the inpatient unit as "Esther's House," named after Dick Strefling's mother. The Strefling Foundation gave a significant gift to the Elkhart campus capital campaign.

- Sept 23 (8:00am at CHC) – 10th Bike Michiana for Hospice and 34th Walk for Hospice (we will start and end at CHC, more details to follow)

- Oct. 16 (5:30pm at CHC) – Veterans Tribute Ceremony to dedicate donated bricks and plaques, and rededicate the veteran's memorial as the "Robert J. Hiler, Jr. Veterans Memorial"

A hard copy of this list will be distributed as a one-sheet at the board meeting.

RECENT OPERATIONS REPORT FROM MILTON ADULT DAY SERVICES

We get reports from Milton about every two weeks written my Nancy DeMaegd, RN the Director. I would like to share a couple recent reports with you.

We did it! April 17th we got our clients out into the community on their first field trip. Sprenger Health Care of Mishawaka invited us over to enjoy musical entertainment by a jazz trio. Those clients that stayed behind had a Chuck Berry dance party of their own.

On April 18th we hit another milestone when census hit 34 for the day. As you can imagine, we were running all day and we celebrated three client birthdays. Carl Mayfield came to do another springtime floral craft with our clients. Additionally, I was able to meet with Tricia Luck. She came by the day center for the grand tour. She had a lot of great questions. I look forward to working more with her in the future.

We celebrated our Milton volunteers on April 20th with our annual appreciation luncheon. We invited all our volunteers to come enjoy a pizza party. We celebrated and thanked our current interns as well. We will certainly miss them at the end of this semester.

I've tried to take some notes over the past couple of weeks on what we are doing over here. We've continued with marketing where and when we can. I've taken our brochure to a few physicians' offices. I have a friend that works for St. Joe County that was telling me about various coworkers caring for elderly parents, so I got copies of the Real Service Connections magazine with our advertisement along with our brochures to the break areas of some of the St. Joseph County road departments.

As for operations at the day center, we started off the month with children's book day. We brought in various children's books and reminisced about books we remember reading as children or to our own children. We did an activity called "Critic's Corner." We tell the clients that the library has sent over a book for them to review. We read the story and ask clients whether they think it would be a good story to read to children, what age child they think would enjoy this book, and how would they rate it. This way we are not just reading them a children's book for no reason, but rather we are giving them a purposeful activity. They are helping out the librarians in their community. We celebrated Guitar month by having Brian Eddington come in and play for us. We addressed community integration by having some of the South Bend fire fighters bring a truck and some equipment over. A few of our clients stated they had never seen a fire truck up close. We addressed intergeneration by having the Good Shepherd kids join us in making a craft. For crafting this month, Carl Mayfield came and made paper spring time tulips with our folks. We revisited "Cooking Club" by whipping up a few Cookies & Cream pies with our bakers. We even made one sugar-free for our diabetic friends. National Siblings day was this month. Clients and staff brought in photos of us in years gone by. We spent time guessing who's who. It was a great way to get the folks reminiscing about past fashions, hairdos, old cars, and other memories. We held our monthly Client Council and new officers were elected from among our clients.

We are always looking for some new art therapy projects. On Rainbow Day, April 3rd, we painted rainbow fish. We taped cut out shapes of tropical fish to the bottom of shallow pans. Then, we squirted paint around the fish shape and threw in some marbles and a golf ball. Our folks just tilt the pan to roll the balls through the paint and paint the fish. We have also been working on Radial Symmetry to create art. I found a design that is repetitive. Different clients color and decorate a single unique square. I then put them together like a quilt to form a creative collaborative project.

Some of the other holidays we celebrated were April 4th, National Walking Day. We were supposed to start up our "Walk & Roll Club" for the season, but the weather had other ideas. Our walk got snowed out. Instead, we talked about the importance of exercise in seniors and did some sit-down dance. Dandelion Day was April 5th. We painted dandelions with Q-tips and our fingertips. Then we wished on our dandelions. A popular wish that day was for the snow to stop and spring to finally start. April 11th was National Submarine Day. We celebrated by singing Beatles songs like "Yellow Submarine" and serving Subway for lunches.

POLICIES ON THE AGENDA FOR APPROVAL

There are 12 revised and two new Patient Care Policies on the Agenda for your approval. They are included in your board packet. Under the consent agenda, we will not be going through these one by one. However, after you review them, if you have questions, Sue Morgan, DON will be on hand to answer.

In preparation for the publication of the Human Resources Policies Manual 2018-2019, there are seven revised and one new policy on the Agenda. Under the consent agenda, we will not be going through these one by one. However, after you review them, if you have questions, Karl Holderman, VP/CFO will be on hand to answer.

NHPCO PRESIDENT / CEO TO VISIT CHC IN JULY

Edo Banach, President/CEO of the National Hospice and Palliative Care Organization, the National Hospice Foundation, and the Hospice Action Network will be visiting CHC in-person. We will have a reception here at the Mishawaka office beginning at 5 PM on July 17 in conference rooms A, B, and C. All of you will be invited to attend and Edo will be giving a brief presentation and answering any questions. The following morning at 8 AM, we will be having a special all staff meeting where he will make a longer presentation and answer questions. After that he will tour the Mishawaka Campus. We are very pleased to have him here at CHC. He previously was the Deputy Director of the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services and Associate General Counsel at the Visiting Nurse Service of New York. Prior to that, Banach was the General Counsel at the Medicare Rights Center. Banach holds a B.A. from Binghamton University and a J.D. from the University of Pennsylvania Law School. Prior to attending law school Banach worked for the New York City Department of Homeless Services and Mayor's Office of Operations under Rudy Guiliani.

NATIONAL HOSPICE EXECUTIVE ROUNDTABLE MAY 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 May 6 and continued through the evening of May 8 at Arkansas Hospice whose CEO is one of our newer members. Besides our own general program updates, topics included: advanced directives education and what each of our programs was doing in our local communities; Strategic Planning and its process (each NHERT member shared their current strategic plan with the group prior to the meeting); and guest speakers included The Advisory Board Company. We had an in-person presentation by Brooke Bumpers -- daughter of former Arkansas Governor and U.S. Senator Dale Bumpers -- who works with Hogan Lovells, the 11th largest law firm by revenue in the world, representing and lobbying on behalf of the National Hospice and Palliative Care Organization and the Hospice Action Network who presented on a "Hill Update" from our nation's capital. And, advance directives were discussed by presenter, Bernard J. Hammes, PhD, the Director of Medical Humanities and Respecting Choices® at Gundersen Health System and Gundersen Lutheran Medical Foundation. Hammes received his BA and PhD in philosophy from the University of Notre Dame. He is currently the VP of the International Society of Advance Care Planning and End of Life Care. He is also a Professor of Clinical Science at the University of Wisconsin-La Crosse, an Associate Adjunct Professor of the Institute for Health and Society at the Medical College of Wisconsin, and a Clinical Assistant Professor in the Department of Pediatrics at the University of Wisconsin School of Medicine and Public Health. As part of his position at Gundersen, he founded and helped develop the Respecting Choices program in the La Crosse region where 96% of the population has advance directives in place. This was particularly timely with Hospice Foundation's new affiliate, Honoring Choices Indiana – North Central.

The NHERT is comprised of the CEOs from the following programs:

- Care Synergy (The Denver Hospice, Halcyon Hospice, Pikes Peak Hospice and Palliative Care), Denver, CO.
- Empath Health (Suncoast Hospice, Tidewell Hospice), Clearwater, FL
- Ohio's Hospice (Hospice of Dayton, Hospice of Central Ohio, Hospice of Miami County, Community Mercy Hospice, Hospice of Butler and Warren Counties, Hospice of Fayette County, Hospice LifeCare, 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

NEW HOSPICE COMPETITOR OPENS OFFICE IN ROSELAND

Another for-profit hospice has opened less than a half a mile from our South Bend office. Called Comfort 1 Hospice, LLC, we understand it is owned by a local business person who also owns and operates a group home in the Roseland area, as well as a charitable program that raises funds for Malawi, Africa. We learned about it because of supplies they ordered which were delivered in error to us. We checked with the Indiana State Department of Health because they were not listed on the state directory of licensed programs. We understand they have a provisional license. A new program must be seeing some patients before they can have their initial survey. They cannot take Medicare or Medicaid until they are approved and licensed by the state. Comfort 1 Hospice is in the same building on US 933 that houses Two Men and a Truck.

MEDICARE HOSPICE REIMBURSEMENT WOULD INCREASE 1.8% in FY2019 UNDER NEW PAY RULE FROM CMS

On April 27th, CMS proposed to increase hospice reimbursement by 1.8% for federal in fiscal year 2019 which begins on October 1, 2018. CMS also took steps to implement a congressional requirement that physician assistants be recognized as attending physicians for hospice beneficiaries. The Bipartisan Budget Act of 2018 requires that, effective Jan. 1, 2019, physician assistants be recognized as attending physicians for Medicare hospice beneficiaries. According to CMS, this statutory change expands the definition of attending physician to include physician assistants in addition to physicians and nurse practitioners. The proposed rule also updates the quality reporting program for hospices, including a review of quality measures using the meaningful measures framework, and proposes updates to the public reporting of these measures on Hospice Compare.

OUT AND ABOUT

Mike Wargo, Chris Taelman, Catherine Hiler and I attended a donor event and met with donors in Naples and Tampa, FL on February 28 and March 1.

Several staff including members of the Administrative Team and CHC board attended the annual CHC Volunteer Recognition and Annual Report on April 17th.

Several staff and volunteers attended the REAL Services "Age of Excellence" luncheon on April 20.

I attended the HAN Board and NHPCO board issues session in Washington, DC on April 22nd.

Dave Haley, Sue Morgan, Karl Holderman, Craig Harrell, three additional staff members and I attended the NHPCO Management Leadership Conference in Washington, DC April 23-25.

I chaired the Indianapolis Hospice and Palliative Care Organization's board of directors meeting in Indianapolis on May 3.

I attended the National Hospice Executive Roundtable meeting in Little Rock, AR May 6-8.

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

Dave Haley's Census Charts.

Karl Holderman's Monthly dashboard summaries.

2018-2019 Human Resources Policy Manual changes and addition.

Patient Care policy changes and additions.

Thank you letters for our grief groups in schools from Adams High School and Holy Family Grade School

The press release for the 2018 Helping Hands Dinner honoring Sister Carmel.

Compliance Committee Minutes 02/20/18

QI Committee Minutes 02/27/18

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

Year to Date April 2018 Financials

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, August 15th 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

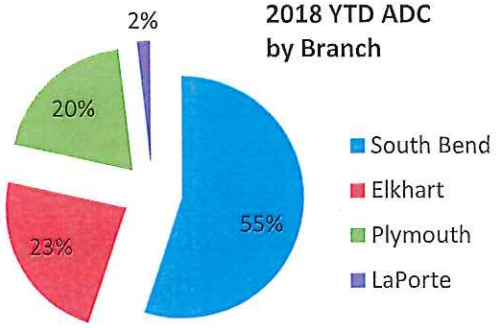
2018 YTD Average Daily Census (ADC)

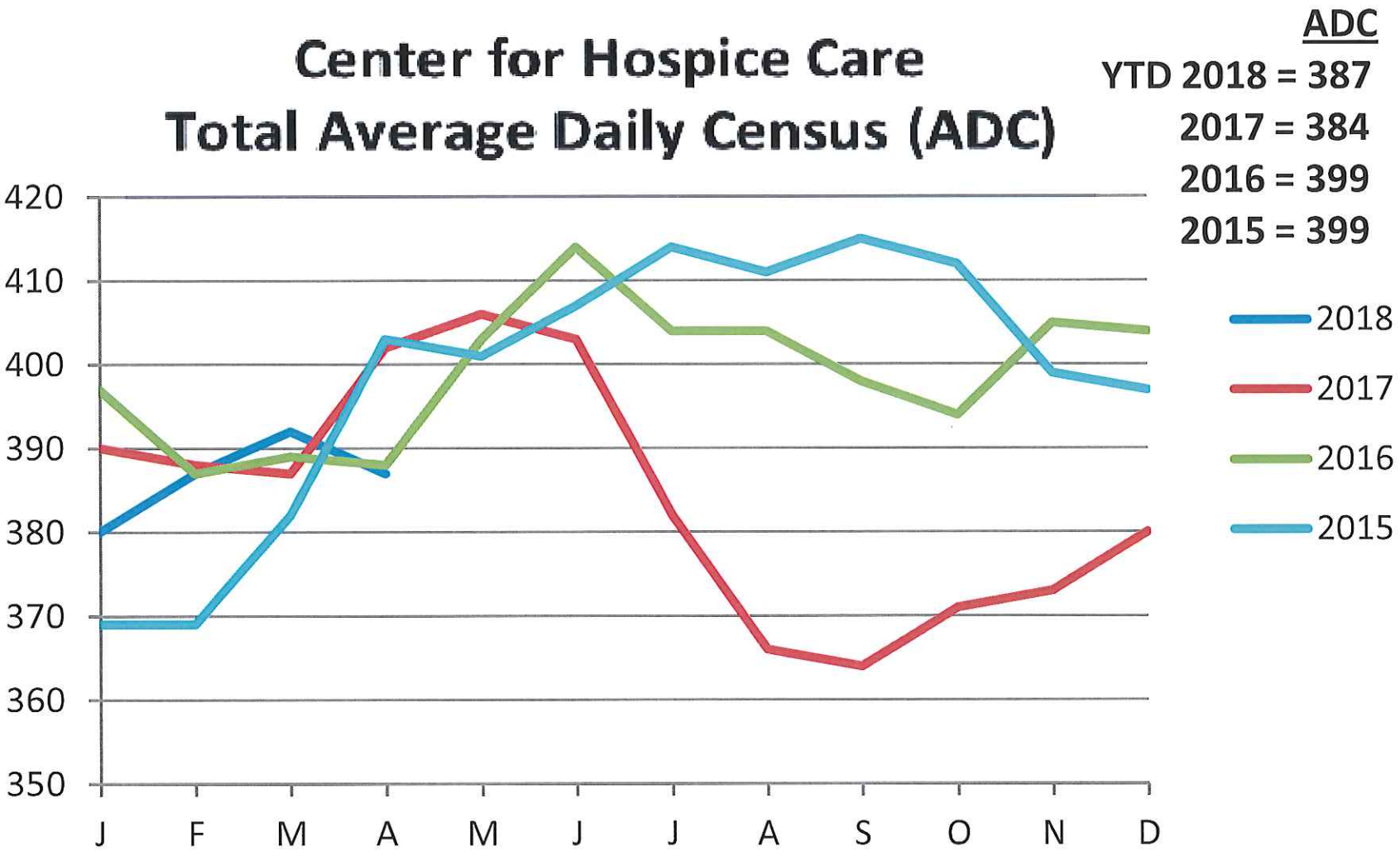
(includes Hospice House and Home Health)

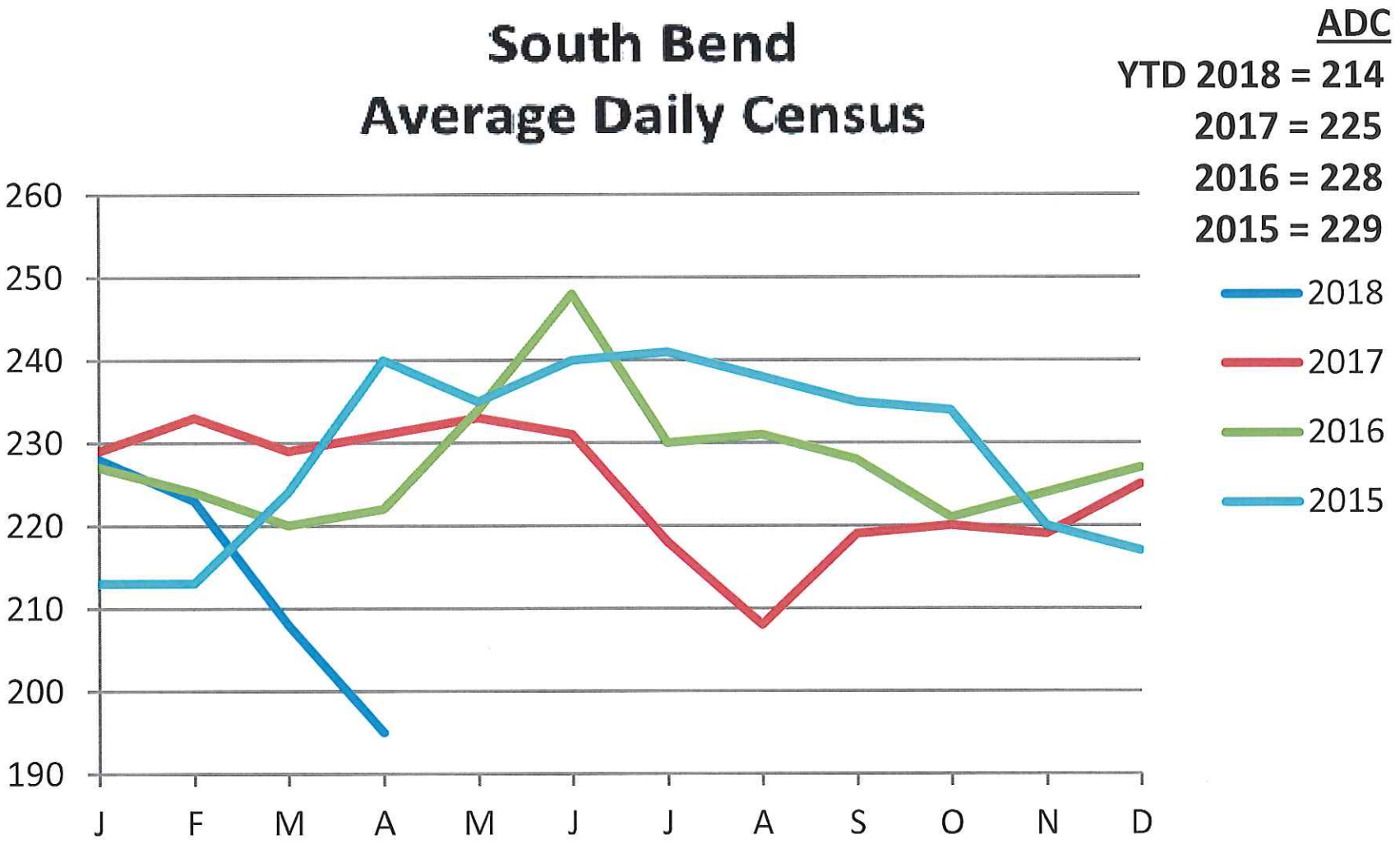
	All	South Bend	Elkhart	Plymouth	LaPorte
J	380	228	81	71	0
F	387	223	89	76	0
M	392	208	95	77	12
A	387	195	96	82	15
M					
J					
J					
A					
S					
O					
N					
D					
2018 YTD Totals	1546	854	361	306	27
2018 YTD ADC	**387**	**213**	**90**	**77**	**7**
2017 YTD ADC	392	230	90	68	0
YTD Change 2017 to 2018	-6	-17	0	9	7
YTD % Change 2017 to 2018	**-1.4%**	**-7.4%**	**0.0%**	**12.5%**	**NA**

2018 ADC by Branch

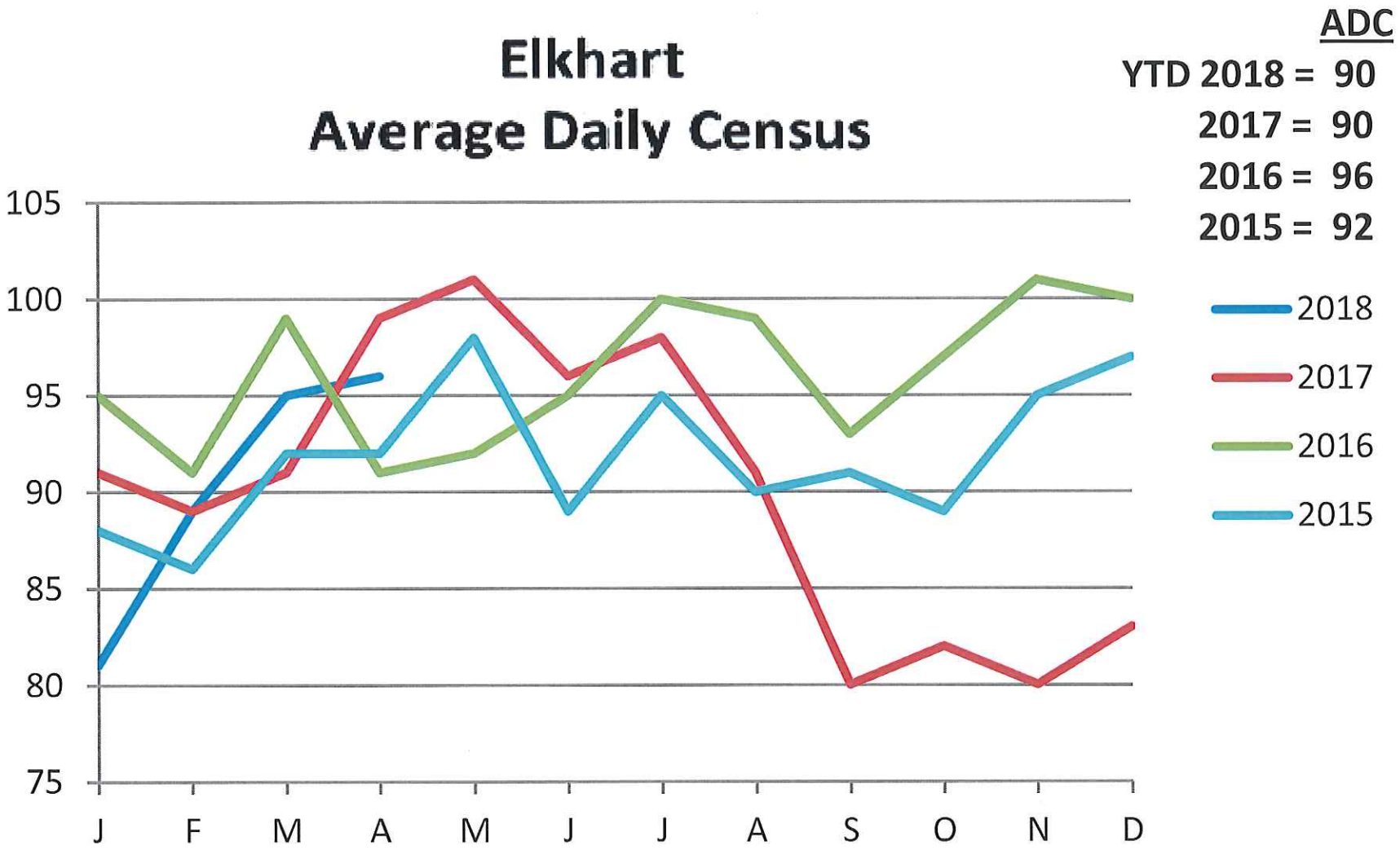
South Benc	55%
Elkhart	23%
Plymouth	20%
LaPorte	2%
All	100%



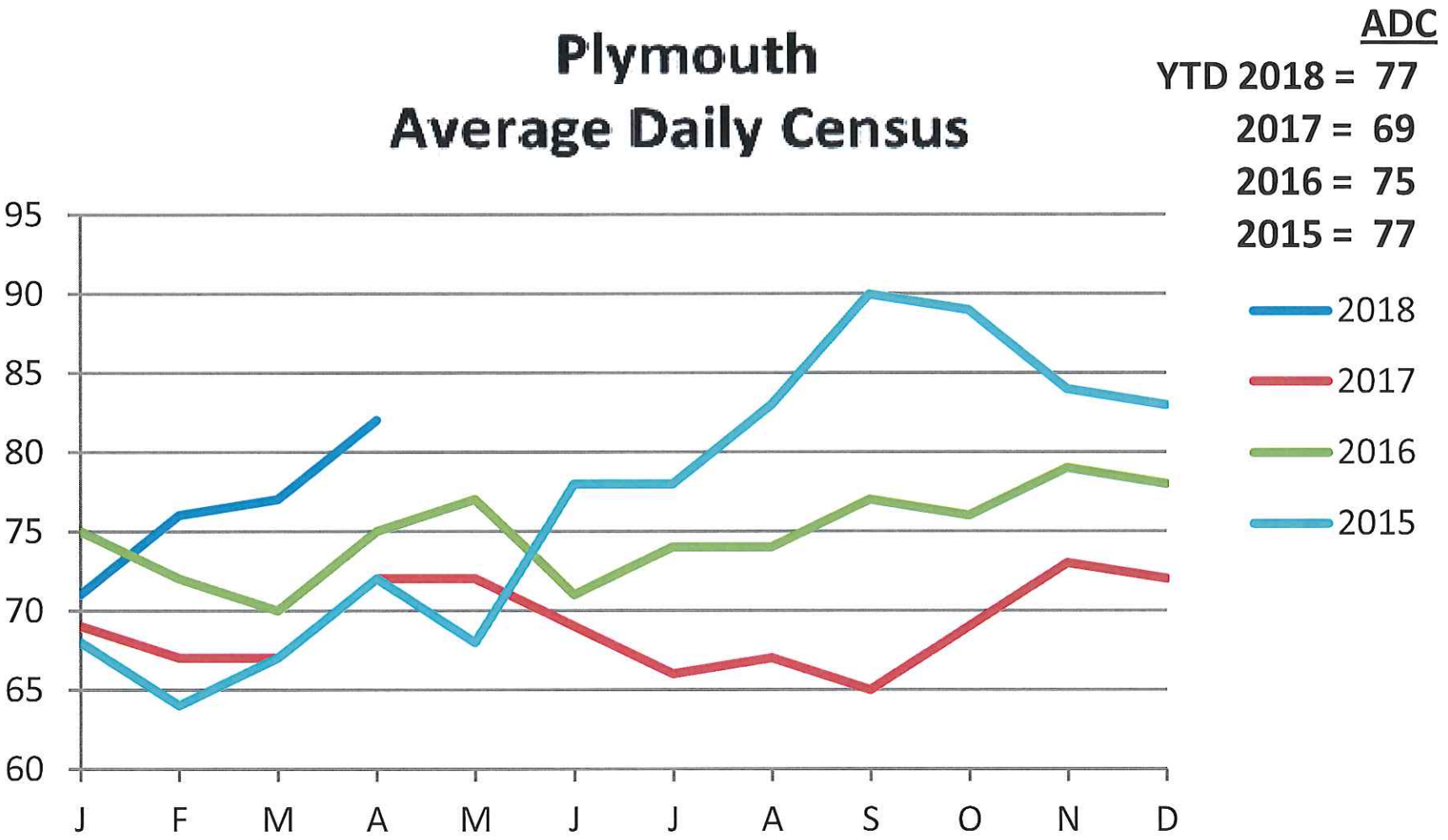

Center for Hospice Care
Total Average Daily Census (ADC)
ADC
YTD 2018 = 387
2017 = 384
2016 = 399
2015 = 399
420
410
400
390
380
370
360
350
J
F
M
A
M
J
J
A
S
O
N
D
2018
2017
2016
2015


South Bend
Average Daily Census
ADC
YTD 2018 = 214
2017 = 225
2016 = 228
2015 = 229
2018
2017
2016
2015
260
250
240
230
220
210
200
190
J
F
M
A
M
J
J
A
S
O
N
D

Elkhart
Average Daily Census

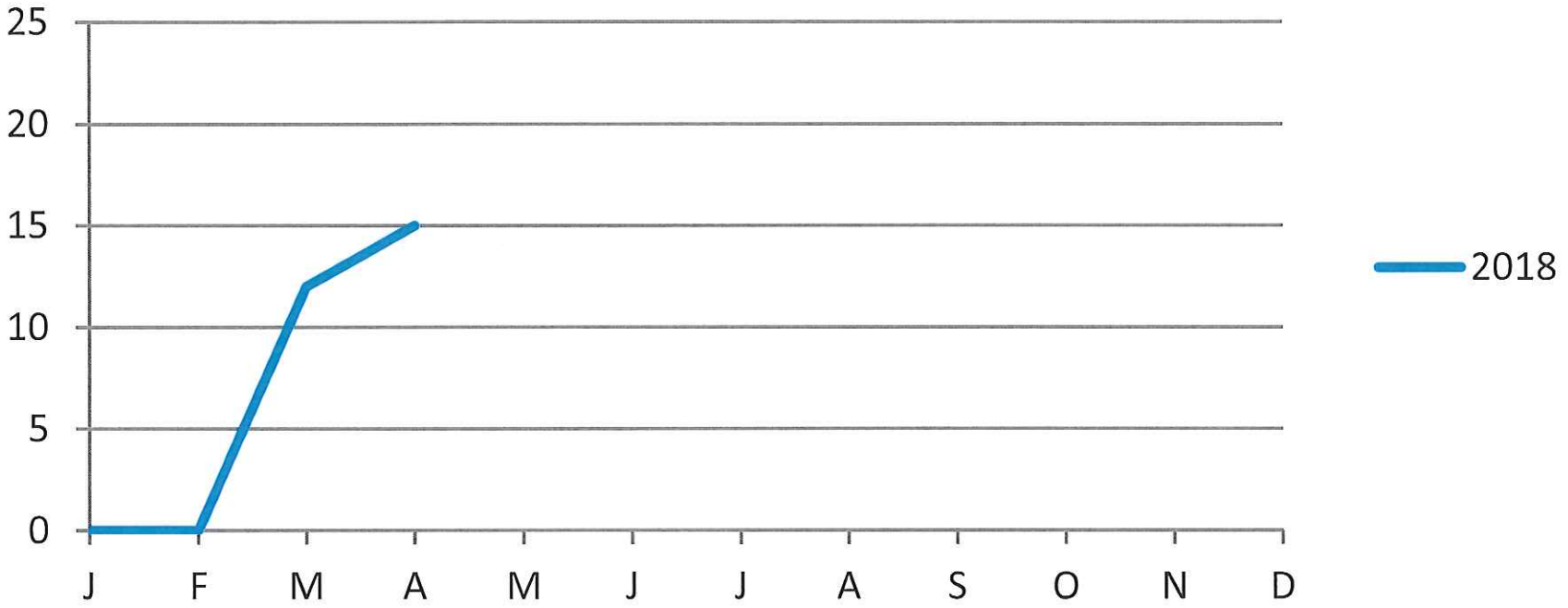


Plymouth
Average Daily Census



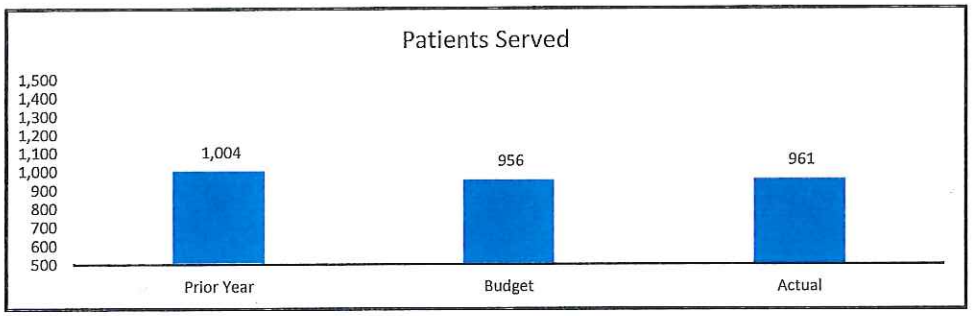
LaPorte
Average Daily Census

ADC
YTD 2018 = 7
2017 = 0

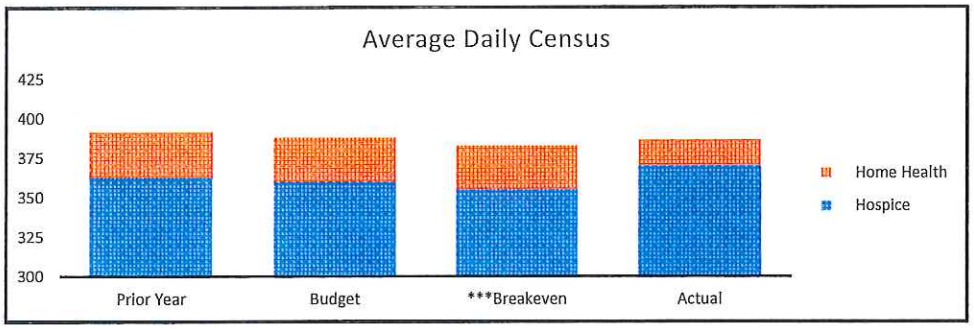


Center for Hospice Care
April 2018 Summary

	Prior Year	Budget	Actual
Patients Served	1,004	956	961

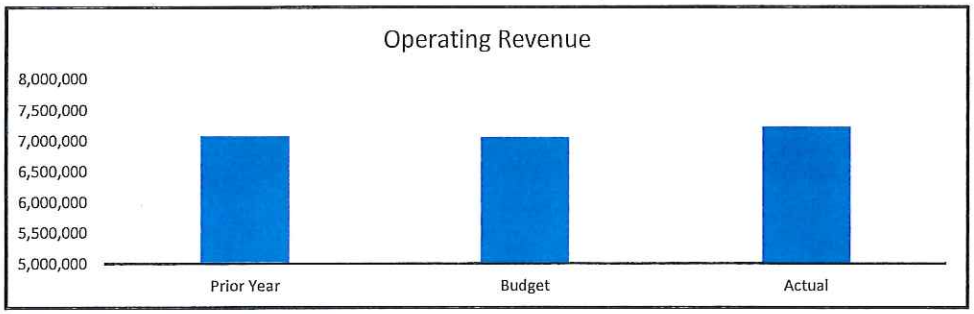


Average Daily Census	Prior Year	Budget	***Breakeven	Actual
Hospice	362.53	359.95	354.98	370.15
Home Health	29.34	28.29	27.90	16.47
Total Average Daily Census	391.87	388.24	382.88	386.62

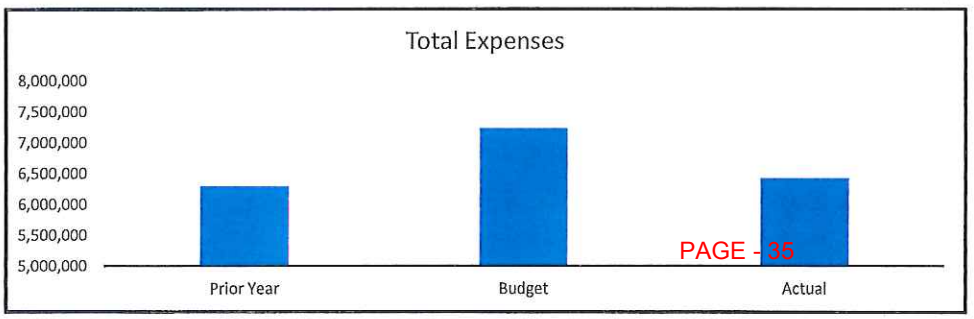


*** *Budgeted Breakeven*

	Prior Year	Budget	Actual
Operating Revenue	7,081,172	7,067,941	7,230,864



	Prior Year	Budget	Actual
Total Expenses	6,303,082	7,242,154	6,438,568



Center for Hospice Care
choices to make the most of life

CHAPTER FOUR

HUMAN RESOURCES POLICIES

Human Resources Policies Manual
July 20186 – June 202018

BUILDING AND GROUNDS

BUILDING ACCESS

- Normal business hours are defined as 8:00 a.m. to 5:00 p.m. Monday through Friday exclusive of Holidays.
  South Bend – unlocked 6:30 a.m. – 7:00 p.m.
  Elkhart – unlocked 7:00 a.m. – 7:00 p.m.
  Mishawaka – unlocked 7:30 a.m. – 5:00 p.m.
  Plymouth – unlocked 8:00 a.m. – 5:00 p.m.
  LaPorte – unlocked 8:00 a.m. – 5:00 p.m.
- Facility doors will be locked and the security alarm set, unless meetings or events are still in progress.
- Locked doors are not to be propped open.
- Access to other agency locations will be as designated by an Administrator.

USE OF CHC OWNED BUILDINGS BY OUTSIDE GROUPS AND ORGANIZATIONS

CHC does not seek outside organizations to use our facilities. CHC will occasionally grant permission to outside organizations to hold meetings or events at one of our owned facilities. Organizations requesting this approval must have a connection to CHC, which may include associations like a similar mission, a partnership with CHC in the community, a like-minded educational interest, or being a supporter of CHC/HF in some manner. CHC staff may request approval for use on behalf of outside organizations, and if approved, may be required to take on responsibility and accountability for the meeting and the facility use, including being personally present before, during and after the meeting/event.

All requests for use by outside groups and organizations require approval by a member of the CHC Administrative Team. It is the general intent that outside groups would only hold meetings or events during CHC's regular weekday business hours of 8 AM to 5 PM. Requests outside of these times are generally denied and require prior approval by the CHC President/CEO, and CHC staff must be present on a volunteer basis in numbers necessary to ensure the security of the CHC properties. CHC facilities are not available for rent or for use for personal functions and events by outside individuals or groups.

The CHC offices in Plymouth and La Porte are~~is~~ not owned by CHC and are~~is~~ not available for any meetings of any kind by any outside individuals or groups.

USE OF CHC OWNED FACILITIES FOR STAFF PERSONAL EVENTS

CHC will occasionally grant permission for staff to hold events for co-workers only such as baby showers, retirement parties, etc., at one of our facilities. All requests require approval by a member of the CHC Administrative Team. If approved, staff must be present on a volunteer basis and may be required to take on responsibility and accountability for the event and the facility use, including being personally present before, during and after the event, clean up, and ensure the security of the facility. It is the general intent that such events would only be held outside CHC's regular weekday business hours of 8 AM to 5 PM. No alcohol will be permitted at these events.

PARKING

- Staff parking is available for your private, licensed, passenger vehicle. Parking is not permitted for recreational vehicles, boats, trailers, etc.
- Parking in front of the entrance to the Inpatient Unit~~Hospice House~~ canopy is prohibited at all times.
- Overnight parking is prohibited without prior supervisory approval.
- The speed limit in the parking lots is 5 MPH. All posted traffic signs are to be obeyed.
- Any additional rules imposed by the landlords of rented facilities are also applicable.

GENERAL EXTERIOR RULES

- Decorating of the exterior of the building and/or grounds is prohibited. No additional plants, bushes, or grasses are permitted.
- No animal habitats are permitted (e.g., bird houses/baths, squirrel twirlers, etc.). Please do not feed the ducks, squirrels, etc.
- When weather permits, staff is welcome to use the outdoor spaces in owned facilities. The deck will have hours posted when it is available to patients and families.
- Any additional rules imposed by the landlords of rented facilities are also applicable.

GENERAL INTERIOR RULES

- All applicable Fire and Life Safety codes will be adhered to.
- **Tacking, taping, gluing, or using a sticky material on surfaces that are painted/stained or covered with wall fabric, or publically visible glass or windows, is not permitted.**
- Appropriateness of all personal decorations is subject to administrative approval.

- Thermostatic controls are not to be adjusted by staff. Requests for temperature adjustments should be made to the maintenance staff.
- The thermostatic controls in Inpatient Unit ~~Hospice House~~ patient rooms may be adjusted by staff only at the request of patients and/or family members.
- Space heaters are not permitted.
- Lit candles are not permitted inside any CHC rented or owned facility at any time.
- Never touch a sprinkler head. Never adjust a smoke alarm. Never adjust a glass-break monitor. Report any concerns with the alarm systems to the maintenance staff.
- Non-administrative and non-maintenance staff are never permitted on the roofs.
- The bathrooms and all restrooms/shower facilities in the Inpatient Unit~~Hospice House~~ are for the exclusive use of Inpatient Unit~~Hospice House~~ patients, their families or caregivers.
- Any additional rules imposed by the landlords of rented facilities are also applicable.

SPIRITUAL REFLECTION ROOMS

- Do not rearrange the room or place anything in the fountain and deter visitors from doing so.
- Remove religious literature which may have been left behind by visitors.
- At the South Bend facility, operate the Shoji screen with great care, as it is a fragile, artistic window covering and not intended to be operated like tracked closet doors.

STAFF BREAK ROOMS

- The staff refrigerator and microwave are located in the staff break rooms. Be respectful of space in the refrigerator and limit what you bring in.
- The staff break rooms are intended for use by all employees. Please be sensitive to others by cleaning up after yourself, wiping up any spills and splatters on counters, sinks, floor, microwave, and refrigerator. Please avoid leaving food in the refrigerator for extended periods of time, as they will eventually generate bacteria and foul odors.
- Do not post items on the refrigerator or any other appliances. In Elkhart, use the tack board provided.
- In Elkhart, put your own dirty dishes in the dishwasher, not in the sink. If the dishwasher is full of clean dishes, please empty the dishwasher prior to placing dirty dishes inside.

INPATIENT UNITS~~HOSPICE HOUSES~~

- Only those on staff or volunteers in the Inpatient Unit~~Hospice House~~, those who are making specific scheduled visits with Inpatient Unit~~Hospice House~~ patients or those staff with specific business should be inside the Inpatient Unit~~Hospice House~~.

INPATIENT UNIT~~HOSPICE HOUSE~~ KITCHEN

- The Inpatient Unit~~Hospice House~~ kitchen is intended for the storage and preparation of food for Inpatient Unit~~Hospice House~~ only.

INPATIENT UNIT~~HOSPICE HOUSE~~ FAMILY LOUNGE / KITCHEN

- The patient/family kitchen area located in the Inpatient Unit~~Hospice House~~, which includes the microwave, refrigerator, and cupboards, are for the exclusive use of patient families and the staff of the Inpatient Unit~~Hospice House~~ on all shifts, with the knowledge that patient and family needs are met first.
- The ice machine in the Inpatient Unit~~Hospice House~~ is for the exclusive use of Inpatient Unit~~Hospice House~~ patients and should be operated by Inpatient Unit~~Hospice House~~ staff for patient needs only.

RESERVING CONFERENCE AND MEETING ROOMS

- The training and conference rooms may be scheduled using the employee website and should be reserved in advance whenever possible.
- The training and conference rooms may be used for impromptu meetings provided they have not already been reserved for use by another staff member.
- After you sign out a conference room and then discover you will not need it for a meeting, please release the reservation as soon as you know it's not going to be used to allow others to use the space.

PERSONAL WORK AREAS

In keeping with the spirit of collaborative environments, strive to keep your work area open, clean, functional, and personalized:

- Work areas should be kept as absolutely neat as possible.
- Display of awards and personal photographs are acceptable, and encouraged, provided they are tastefully framed and coordinated to match your personal workspace.
- Only CHC provided artwork may be displayed on walls without prior approval.
- Personal heaters are not allowed.
- Post-its and other notes are not allowed to be posted on computers or monitors.
- The number of papers and folders on your work surface should be limited to those on which you are working at the time. Papers and files on which you are not presently working should be stored in your in-box, drawer, or filing cabinet.
- Desks should be cleared of papers and files and put away at the end of the business day.

Privacy Panels

- Nothing should extend above panel height.
- Items tacked to panels need to be limited to work related and only at "belt line" panel height (one panel above work surface) or on tack boards.

Overheads/File Cabinets

- Nothing is allowed on the fronts or tops of overheads.
- Keep overheads/file cabinets neatly arranged and closed at all times when not accessing.
- Binders and folders must be stored in overheads, upright on shelves, or in file cabinets. These should not extend above panel height.
- Intermediate and long-term storage should be in the storage areas (Elkhart – second floor; South Bend – records room).

Wire Management

- All wires on the floor need to be hidden from view.
- Computer wires need to be hidden from view where possible.

Floor

- Do not store boxes on the floor of your workstation. Dispose of empty boxes immediately.
- Place laptop bags, etc., in a drawer or in an inconspicuous area in your workstation.

MISCELLANEOUS

- Nothing should lean against the walls of the workstations or pedestals, etc.
- Only approved calendars are acceptable.

TRAINING AND CONFERENCE ROOMS

- Care should be taken for the protection of surfaces.
- Blinds should be reopened at the conclusion of meetings.
- The space should be cleaned after serving food and returned to original set up. Each person should dispose of his/her own trash when attending a meeting.
- Be sure to remove any extra handouts and other papers before you leave.
- Put away all equipment as soon as the meeting is over. Do not leave equipment sitting on the table.
- Return chairs to the correct position before leaving.
- All flip charts are to be stored in the proper place when the meeting is over.

COPY AND MAIL ROOM AREA

- These areas should be kept neat at all times. By the end of the day, all printing, faxes, and all mail should be picked up.
- Keep cabinet doors closed.
- No papers should be placed on top of the copier, fax, or workstation. These should remain in the printer/fax bin or distributed in the mailboxes or inbox.
- When sending a fax, wait for the confirmation that the fax has been successfully transmitted. This will take less time than finding out later that your fax did not go through. If it is not possible, then remember to collect your confirmation as quickly as possible.
- Do not place boxes next to the trash can in the copy area. Please dispose of any empty boxes in designated areas.

COMMUNICATION

Obviously, we don't want to avoid communication, but a few simple considerations will really help out:

Consider your neighbors

- Avoid interrupting someone who is using the telephone. Refrain from using sign language to attract the attention of someone who is on the phone. The more polite approach is to wait until the call is finished before approaching.
- A quick call to ask if "now might be an okay time to walk over to have a quick chat" is a great way to show consideration to others.
- Keep your phone ringer low, as well as your voice.
- When you're on the phone, remember to face into your work area so you are not projecting across the entire area.
- Avoid conversations in the aisles and main walkways near occupied workstations.
- Avoid the speakerphone unless in a private office or in a conference room. Use conference room for conference calls.

SECURITY

- The protection of the organization's assets and information is everyone's business. The last person to leave in the evening should turn off the lights and lock the door after setting the alarm and ensure that all other doors are also locked.
- It is a good practice to lock down your computer when you leave your area for any length of time—use a screensaver with password or a network logoff.
- Please do not leave your workstation unprotected with active logins to information systems.
- If you see someone you do not know walking through unaccompanied, say "hello" and ask if you can help him/her. We need to be gracious hosts to our guests and vigilant about recognizing people who have no official business here.
- By following a few simple guidelines, CHC will maintain the high standards it has set for its services and staff.

Revised 05/18; Reviewed 04/14

CLASSIFICATION OF EMPLOYEES

CHC makes no promises with regard to the number of hours available for work on any particular day, day of the week, week, month, or year. Employees are categorized as follows based on their regularly scheduled hours and/or their exempt or non-exempt status.

EXEMPT EMPLOYEE

Exempt employees are executive, administrative and professional employees as defined under the Fair Labor Standards Act (FLSA). These employees are paid for the job they perform rather than the hours worked.

NON-EXEMPT EMPLOYEE

Non-Exempt employees, as defined under FLSA, are paid at an hourly rate and will receive overtime pay of time-and-a-half for all hours worked over 40 each week, unless state regulations dictate otherwise.

FULL-TIME EMPLOYEE

An ~~non-exempt~~ employee who is regularly scheduled to work thirty (30)~~forty (40)~~ hours per week. Group health insurance, long-term disability, and life insurance are available to employees who work "power weekends" or a minimum of thirty (30) hours per week.

~~**HALF-TIME EMPLOYEE**~~

~~A non-exempt employee who is regularly scheduled to work twenty (20) hours or more per week but less than forty (40) hours.~~

PART-TIME EMPLOYEE

An ~~non-exempt~~ employee who is regularly scheduled to work less than thirty (30)~~20~~ hours per week.

POWER WEEKEND EMPLOYEE

Designated employees regularly scheduled to work twelve (12) hour shifts on two consecutive days.

PRN EMPLOYEE

Employees who work on an "as needed" basis. PRN employees do not have regularly scheduled hours (see PRN Employees).

Revised 05/18; Reviewed 03/16

Motor Vehicle Check - Verifies validity of driver's license and driving record of individual for last seven years.

Professional License Verification - All professional licenses, i.e., nursing, social work, counseling, are verified through the Indiana State Department of Health.

Education Verification - Degrees are verified as part of the professional license verification.

Nurse Aide Registry - The Indiana Nurse Aide Registry is checked prior to employment of any home health aide. The registry provides verification of certification and that the home health aide is "in good standing."

IRCA Verification (I-9 form) - New employees are required to provide proof of their identity and work authorization.

Previous Employment - A minimum of two references are checked for employment candidates.

Social Security Number Verification - This is done indirectly by using the social security number to perform the driver's license and professional license search.

Medicare Sanction Check - Verifying employee has not been sanctioned by the federal Medicare program.

Criminal History Check – A State and/or National Criminal History Check will be done via finger printing within three days of initial employment on all employees.~~will be performed on all employees prior to hire. Employment will not commence until the results of a limited Criminal History Check obtained from the Indiana State Policy repository have been obtained~~.

CHC/HF/CADS prohibits the hiring (or contracting with) a person convicted of crimes including, but not limited to, a sex crime (IC 35-42-4); exploitation of an endangered adult (IC 35-46-1-12); abuse or neglect of a child (IC 35-42-2-1); failure to report battery, neglect, or exploitation of an endangered adult or dependent (IC 35-46-1-13); theft (IC 35-43-4 {except as provided in IC 16-27-2-5(a)(5)}); murder (IC 35-42-1-1); voluntary manslaughter (IC 35-42-1-3); involuntary manslaughter (IC 35-42-1-4); battery (IC 35-42-2).

~~***State Criminal History Check*** - This is performed in either Indiana or Michigan depending on current residence of individual being checked. Limited criminal history information is defined as all arrest, indictment, information or other formal criminal charges less than one year old, but only those arrest, indictment, information or formal criminal charges over one year old that include a final disposition.~~

~~***National Criminal History Check*** - A national criminal history check, done via fingerprinting, is completed on employees if they lived outside the states of Indiana or Michigan during the two year period prior to their hire date.~~

Pre-Home Placement Physical – According to Indiana State Department of Health guidelines, prior to beginning work with CHC/HF/CADS, all direct patient care employees must submit documentation showing their status regarding infectious and communicable disease.

Revised 05/18; Reviewed 03/16

DRESS CODE

Our organization's image is reflected by our employees. We ask that all employees take pride in their professional appearance, and that everyone is clean, well groomed, and appropriately dressed for their position.

Employees who come in contact with patients and families should be aware as professionals that attention to details in appearance will help instill confidence in patients and families. Projecting a professional appearance projects professional care.

CHC has established the following guidelines, which include, but are not limited to:

1. Agency photo identification must be worn at all times by patient care staff.
2. Fingernails should be clean, well-trimmed, and not interfere with duties. Based on CDC and OSHA guidelines to reduce the risk of healthcare acquired infection, artificial nails (including acrylics, gels, wraps, overlays, etc.) are not to be worn by anyone with patient contact or patient food preparation. Nail polish may be worn on natural nails by patient care staff, but it should not be chipped.
3. Perfume/cologne should not be worn by patient care staff.
4. Hair should be clean and neatly fashioned. Patient care staff must keep long hair tied back when performing patient care. Inpatient Unit~~Hospice House~~ staff must do so at all times.
5. Jewelry can be worn sparingly, for example, rings, watches, short necklaces, and small earrings. Jewelry may not be worn on visible pierced body parts (excluding ears).
6. Clothing should not be form fitting (leggings, spandex, Lycra) or reveal lines/color of undergarments.
7. Clothing cannot display questionable graphics or any wording. This includes, but is not limited to, alcohol or tobacco logos.
8. Non-canvas athletic shoes may be worn by direct patient care staff, if they are appropriate to dress. They must also be solid in color. Nurses and Aides providing patient care must wear closed toe shoes.
9. Bib overalls, sweat pants, shorts, and denim pants are not permitted.
10. Business Capri pants must be of a length to cover the calf portion of the leg. Individual supervisors will be responsible for ensuring that staff who wear Capri pants meet agency expectations for professional appearance.
11. Skirts or dresses should not be more than two inches above the knee.
12. Patient care staff is required to wear Agency issued career wear when making patient visits. All Nurses and Aides are required to wear Agency issued scrubs when providing patient care. Additional Agency issued career wear and scrubs will be available for purchases on the CHC website.

Individual supervisors are responsible for ensuring that the appearance of their employee is appropriate, and may, at his/her discretion, in consultation with the Director of Human Resources, implement and define appearance standards which are more restrictive than those listed above, but never less restrictive. Employees who appear for work inappropriately dressed may be sent home and directed to return to work in proper attire. Under such circumstances, non-exempt employees will not be compensated for the time away from work. Dress Code policy violations will be handled in accordance with the Progressive Discipline policy.

Revised 05/18

EMPLOYEE BENEFITS

Contact Human Resources for specific enrollment and coverage details regarding the benefits listed below. Open enrollment is held December 1st through December 15th each year. Elections made at that time are effective January 1st. Deductions for benefits are taken for 24 pay periods. This is the only time that changes can be made to benefits outside of a COBRA qualifying event as defined by the summary plan description.

Life Insurance – Effective the first day of employment, CHC automatically provides life insurance equal to 1x the employee's annual salary or a minimum of $20,000 for power weekend employees and all staff with weekly scheduled hours of 32 or more.

Accidental Death and Dismemberment Insurance – CHC provides 1x annual earnings in AD&D insurance for staff with weekly scheduled hours of 32 or more as well as power weekend employees. This is also effective the first day of employment.

Long Term Disability Insurance – CHC provides a long term disability insurance benefit equivalent to 60% of the employee's base salary at time of disability and begins 90 days following the date of disability. It will continue until the employee reaches the age of 65 or is no longer disabled. Power weekend employees and staff with scheduled hours of 32 or more receive this benefit automatically upon hire.

Group Health Insurance and Health Savings Account – Group health insurance is available to staff with weekly scheduled hours of 32 or more as well as power weekend employees. Coverage is effective the first day of the month following employment or January 1st if elected during CHC's open enrollment period. CHC will establish a Health Savings Account (HSA) and provide an annual contribution for all employees that elect its group health insurance. New employees will receive a pro-rated contribution following completion of their 90 day probationary period.

Dental Insurance – Dental insurance is available the first day of the month following employment to staff with weekly scheduled hours of 32 or more as well as power weekend employees.

Flex Spending – Following completion of the 90 day probationary period non-prn staff is eligible to deduct up to $2,000 of their salary each calendar year for reimbursement of non-insured medical, dental or vision expenses or substantiated childcare costs. In accordance with government regulations, any withholdings not claimed for reimbursement by the CHC specified date will be forfeited.

403B/Roth 403B – Non-PRN employees regularly scheduled to work 20 hours or more per week~~Full-time, half-time, and power weekend employees~~ are eligible to participate in CHC's retirement plan following completion of their 90 day probationary period. Vesting is 100% upon enrollment. ~~CHC matches 25% of the employee's contribution up to a maximum annualized match of $4,000.~~ CHC will match at 25% the first $16,000 of the employee's contribution.

AFLAC – Short-term disability insurance, supplemental life insurance, personal recovery insurance and cancer insurance are available through AFLAC to non-PRN employees upon completion of their 90 day probationary period.

Employee Assistance Program (EAP) – CHC provides an Employee Assistance Program to help non-prn employees, their spouses and eligible children in coping with personal problems and stress. CHC will pay the cost of four counseling sessions per employee and eligible family members each calendar year. This is effective immediately upon employment. Employees may contact the EAP provider directly to schedule confidential appointments. The number of employees participating is the only information shared with CHC.

Continuing Education – Non-prn employees are eligible to attend seminars/conferences on job-related topics with the approval of their supervisor. Employees interested in obtaining a job-related certification, may be eligible for some financial assistance as part of their continuing education.

Professional Membership Dues – CHC will pay for/reimburse staff for some professional memberships/dues with prior Administrator approval. The expense must be relevant to the employee's position and should provide benefit to both CHC and the employee.

FUNERAL LEAVE

Immediate Family Member - When a death occurs in an employee's immediate family, full-time employees may take up to three days off with pay to attend the funeral or make funeral arrangements. Time off is pro-rated for part-time employees. Immediate family member is defined as an employee's spouse or domestic partner, children, stepchildren, parent/stepparent, brother/stepbrother, sister/stepsister, in-laws, grandparent, or grandchild.

Non-Immediate Family Member - Employees may take up to one day off with pay to attend the funeral of a close friend or non-immediate family member. This time off will be considered by the employee's supervisor on a case-by-case basis. CHC may require verification of the need for the leave time.

Additional Time Off - CHC recognizes the impact that death can have on an individual or a family. Employees may request to use their accrued vacation or personal days to extend their funeral leave time. This is subject to supervisory approval.

Holidays – CHC recognizes the following as paid holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. Substitutes for these days can be arranged by contacting Human Resources. Full-time employees are paid eight hours for each holiday. Half-time and power weekend employees are paid four hours and part-time employees are paid for two hours. When the holiday falls on a regularly scheduled day of work for an employee, he/she will be compensated for the number of hours normally worked. When a holiday falls on a Saturday, the observed holiday will be Friday and when it falls on Sunday, the observed holiday will be Monday. For Inpatient Unit~~Hospice House~~ staff, the holiday will be considered the actual calendar date beginning at 7:00 a.m.~~12:01am~~ and ending at 7:00 a.m.~~12:00 a.m.~~

VACATION

Accrued Vacation Time – Vacation time is accrued each pay period and can be used by staff after completion of six months of employment and with approval from their supervisor. Caps are established limiting the number of days that can be accrued. The cap is equivalent to twice the number of vacation days an employee would accrue based on the table below. When employees hit their cap, they will stop accruing vacation days until they once again fall below it. Accrual rates and cap numbers will be adjusted due to a status change or an increase in vacation time based on years of service.

Employees who have completed six months of service will be paid for any accrued vacation time upon termination of their employment as long as appropriate notice is given.

Hourly employees can request vacation time in half or whole day increments. Exempt employees can take only whole days.

Employees who have changed employment status may not qualify immediately for the increased accrual associated with specific years of service. A certain number of years of consecutive service at a particular status level may be necessary first. This will be reviewed on a case-by-case basis.

Employees will accrue vacation days based on their years of service and the number of days they are regularly scheduled to work each week.

Vacation days will be accumulated according to the following table:

Scheduled Days Per Week	Yrs 1-2	Yrs 3-6	Yrs 7-9	Yrs 10+
5	10	15	20	25
4	8	12	16	20
3	6	9	12	12
2	4	6	8	8
Power Weekend	5	7.5	10	10

Vacation Exchange – Employees have the option of receiving the cash value for a portion of this benefit instead of taking paid time off. Employees electing to use this option must submit an email request to Human Resources. The request will be processed as part of the normal payroll cycle and the employee will receive the cash equivalent of the vacation hours on their paycheck.

PERSONAL DAYS

Employees receive the following paid personal days each January 1st to be used during that specific calendar year. Compensation is based on the number of hours staff is regularly scheduled to work. Only non-exempt employees have the option of requesting personal days in half or whole day increments. Personal days are not considered an earned benefit and as such, employees will not be paid for any unused personal days upon termination of employment.

Scheduled Days Per Week	Yearly Personal Days
5	4
4	3
3	2
2	1
Power Weekend	2

New Employees hired between the following dates will receive the designated number of personal days to be used during their first calendar year of employment and **after completion of their 90 day probationary period**:

Scheduled Days Per Week	01/01 – 02/28	03/01 – 04/30	05/01 – 07/31	08/01 – 08/31	09/01 – 12/31
5	4	3	2	1	0
4	3	3	2	1	0
3	2	2	1	1	0
2	1	1	1	0	0
Power Weekend	2	2	1	0	0

SICK DAYS

Upon completion of their 90 day probationary period, new employees hired between the following dates will receive the designated number of sick days to use for their own personal injury/illness.

Scheduled Days Per Week	01/01 – 04/30	05/01 – 08/31	09/01 – 12/31
5	5	3	0
4	4	2	0
3	3	2	0
2	2	1	0
Power Weekend	2	1	0

Each January 1st, additional sick days will be added to the number remaining from the previous year. Only non-exempt employees can use sick time in either half or whole day increments. Since sick days are not considered an earned benefit, employees will not be paid for any unused sick time upon termination of employment.

A change in employment status from half-time to full-time will not affect the number of sick days available to an employee during the calendar year, unless the employee has worked full-time for six consecutive months. Employees who change from half-time to full-time status after June 30th will not receive any additional sick days until the next calendar year. Employees changing from full-time to half-time status will retain any unused sick days still remaining.

Employees must provide a doctor's note indicating their ability to return to work if absent due to illness/injury for three (3) or more consecutive work days.

Employees will receive the following designated sick days each January 1st based on their regularly scheduled days each week. The maximum number of days which can be accrued is also listed.

Scheduled Days Per Week	Sick Days	Maximum Day Accrual
5	5	90
4	4	60
3	3	30
2	2	30
Power Weekend	2	30

Revised 05/18

COMPENSATION FOR WORKED HOLIDAYS

The following guidelines will be used to determine compensation for employees scheduled to work or who provide "on call" coverage for the actual holiday or CHC observed holiday. Differentials will not be included in holiday compensation.

Exempt~~Salaried~~ Home Care Nurses:

- Nurses **scheduled to work** for specific periods of time will be paid a holiday premium based on the number of hours scheduled.

- Nurses providing On Call or Backup On Call coverage will receive holiday beeper pay for hours covered plus one-and-one-half times the designated visit rate for each visit made.

Non-Exempt~~Hourly~~ Home Care Nurses:

- Nurses **scheduled to work** for specified periods of time will be paid time-and-one-half their base rate for a minimum of the number of hours they are scheduled to work.
- Nurses providing On Call or Backup On Call coverage will receive holiday beeper pay for hours covered plus one-and-one-half times their base rate for actual hours worked.

Exempt Support Services Staff:

- Staff providing On Call coverage will receive holiday beeper pay for hours covered plus one-and-one-half times the designated visit rate for each visit made.

Non-Exempt Support Services Staff:

- Staff providing On Call coverage will receive holiday beeper pay for hours covered plus one-and-one-half times their base rate for actual hours worked.

Inpatient Unit~~Hospice House~~ staff compensation for holidays:

- **On Call Nurse** – will be paid $5.00/ hour beeper pay plus time-and-one-half times their base rate for actual hours worked on the holiday.
- **Power Weekend staff that work on a holiday that falls on Saturday or Sunday** will be paid at time-and-one-half their base rate for actual hours worked. Additionally, they will receive eight hours of holiday pay at their base rate.
- **Power Weekend staff that work** a holiday that does not fall on Saturday or Sunday will be paid at time-and-one-half their base rate for actual hours worked. Additionally, they will receive four hours of holiday pay at their base rate.
- **Full-time staff that works on a holiday that falls on Saturday or Sunday** will be paid at time-and-one-half their base rate for actual hours worked, plus eight hours of holiday pay at their base rate. Additionally, they will be given an eight hour paid day off to be used within six months of the worked holiday. Requested time off must be approved by the employee's supervisor.

Revised 05/18 ; Reviewed 05/12

EDUCATION TRAVEL PROCEDURE AND GENERAL EXPENSE REIMBURSEMENT

This policy is intended to ensure that employee education travel is consistent with the objectives of CHC. It also defines procedures for authorized business travel and guidelines for general expense reimbursement.

CHC encourages employees to continue their education and advance their skills by attaining certain certifications, attending conferences, seminars, and workshops outside of the inservices and training sessions provided in-house. Registration fees for education and other events, and the employee travel expenses associated with it, will be authorized only in circumstances which are clearly consistent with the mission of CHC.

Supervisor and Director Responsibilities:

1. Supervisors and Directors must know CHC's current travel policy and inform their departmental staff of company policy and procedures when questions arise.
2. Determine if registration and travel is actually necessary to achieve a particular goal.
3. Approve expenses in accordance with this policy.

CHC will pay or reimburse certain charges related to registration and round-trip travel. Prior approval must be obtained from your supervisor. Education travel must also be approved in advance of attending. Budget considerations, staffing requirements, appropriateness of the educational experience, and other factors will be taken into consideration before approval is granted. CHC strongly encourages using any available "early bird" discounts for registration. Requests for registration after discount deadlines have passed may influence the approval.

For travel by personal car, employees will be reimbursed for mileage at a rate established by CHC. Tolls and parking at the site will be reimbursed. Reimbursable mileage is always based on miles to and from the CHC office. The exception to this is when you must leave or return from your home and your residence is closer to your destination than the CHC office. Always use the lesser amount for calculating mileage. Mileage claimed must be substantiated using *MapQuest* (or similar program) showing starting point, ending point, and calculated mileage; a printout must be attached to the prescribed expense report form. CHC never reimburses commuting mileage or miles not actually traveled.

For travel that requires air transportation, CHC will pay round-trip airfare for the lowest published Third Class or Coach rate as researched by the designated CHC internal travel planner. The designated travel planner may not choose a more expensive flight on an alternate airline to gain personal super-saver miles or any other airline/credit card perks. Employees may retain all benefits from frequent flyer club memberships. All dues for such clubs must be paid by the employee. All air travel arrangements must be made with prior approval of your supervisor and by the designated CHC internal travel planner. The CHC designated travel planner will attempt to ensure whenever possible that no more than six company employees, four Coordinators or Directors, and three Administrators are booked on the same flight.

Employees choosing to use alternate modes of travel between cities serviced by regularly scheduled airlines must request the travel planner to research the cost of the lowest flight at the time of travel approval. CHC will only reimburse the lesser of the previously researched airfare costs or the actual expenses of the alternate mode of travel. Documentation of this research must be submitted with the prescribed expense report form.

CHC will pay for charges for overnight accommodations related to a room on-site at a conference. When on-site accommodations are sold out, CHC may pay for a close by hotel facility or major chain, as available.

CHC will reimburse an employee for reasonable charges for meals while attending an educational experience, with the approval of your supervisor. Meals eligible for reimbursement on days of travel are as follows:

Day of Departure:

- Before 6:30 a.m. – all meals eligible for reimbursement
- After 6:30 a.m. – before 11:00 a.m. – lunch and dinner eligible for reimbursement
- After 11:00 a.m. – before 5:30 p.m. – dinner eligible for reimbursement

Day of Return:

- After 6:30 a.m. – before 1:30 p.m.– breakfast eligible for reimbursement
- After 1:30 p.m. – before 7:30 p.m. – breakfast and lunch eligible for reimbursement
- After 7:30 p.m. – all meals eligible for reimbursement

For conferences or educational meetings in other cities where air travel is required, CHC will pay for ground transportation to and from the airport of destination and the conference site. CHC will reimburse employees for the lesser of ground transportation to and from the airport of origination, or the cost of long term parking at the airport of origination. CHC will pay for the use of a rental car when necessary and with prior approval. Automobiles should be rented only when the cost advantages are clearly justified (i.e., the cost of the rental car would be less than using taxis, etc.) and prior approval is required. Employees can request either compact or intermediate size cars. Rentals for other types of cars are not permitted except with manager approval for large

groups of employees traveling to the same destination. Luxury, premium, and specialty car rentals will be reimbursed only at the intermediate car rate. Whenever possible, employees must refill gasoline prior to returning the rental car for drop off. Gas charges at the rental location average 50% more than independent filling stations.

If less than full-time employees voluntarily attend an education experience on a day they are not normally scheduled to work, they will not be paid wages. If the supervisor has determined their attendance necessary on a day the employee does not normally work, they will receive their normal hourly wage up to their normal working hours. Full-time employees are not paid wages for attending an educational experience outside of their normal working hours.
When day of departure travel takes place in the last half of a regular workday, CHC staff is expected to work some portion of the travel day. For example, CHC would not expect a staff person to not report at all on a regular business day when their departure time can be estimated during the afternoon.

With advance notice of at least three weeks, cash advances for travel expenses may be available on an as needed basis prior to departure. Contact your supervisor for further information. Receipts are still required upon return and any unused funds, or incurred expenses without proof of receipt, must be returned to CHC.

In the event of an accident while traveling, you must notify Human Resources immediately.

The following <u>are</u> <u>not</u> reimbursed as business expenses by CHC:

- Commuting mileage costs to and from the airport of origination, unless the airport is located outside the CHC service area, and the cost is more economical to drive than other available transportation.
- Any and all incidental charges.
- While on overnight travel, incidental charges beyond the cost of the hotel room and applicable taxes.
- Personal long distance telephone calls and hotel telephone surcharges.
- Personal use and/or mileage of rental cars or personal cars, shuttles, taxis, and all ground transportation, unless included in the registration fee for the conference.
- Personal entertainment or recreational expenses and expenses for “optional" special events that may be offered to conference attendees for an additional fee.
- Unapproved conference or seminar educational purchases.
- Any portion of any expenses that are a direct result of any person traveling or attending a meeting or event with you.
- Childcare expenses for a traveling employee.
- Substitute food expenses for meals that are already covered within a registration fee paid for by CHC.
- First class travel, and upgrades to air travel, car rentals, or hotel rooms.
- Purchase of clothing, luggage, toiletries, and other miscellaneous personal items.
- Supplemental travel or car rental insurance.
- Fines, penalties, or legal fees.

While CHC will not reimburse you for the expenses listed above, you may qualify for a tax deduction on some of the expenses listed. Please consult a professional tax preparer for more information.

In all cases, for all expense reimbursement to be considered, employees must provide bona fide receipts, attached to the prescribed expenses report form, to their supervisor for approval of payment by CHC. Employees will not be reimbursed for expenses without proof of receipt. In order for reimbursement to take place, all receipts and requests for reimbursement, including mileage reimbursement, must take place within 45 days of incurring the expense.

CHC generally does not reimburse dues unless there are subscriptions or other educational materials and/or educational benefits (for example, reduced fees [not to exceed the cost of the dues] for conference attendance) that accompany dues structure, with supervisor approval. This occurs on a case-by-case basis.

CHC generally does not reimburse individual CME or CEU expenses which are required to maintain certification or licensures.

Revised 05/18; Reviewed 03/16

WE BELIEVE PROGRAM – (NEW)

The We Believe Program is an employee driven and maintained fund to benefit the needs of current Agency patients when no other source of reimbursement or acquisition is available. The committee will consist of Agency employees who donate to the WB Program. The WB Committee oversees the operation of the funds and makes decisions regarding the approval and disbursement of those funds.

1. Annually during Open Enrollment a presentation will be made on the purpose of the WB Program and to solicit employee donations to maintain the fund. Donations to the WB Program can be made by cash, check, or payroll deduction. Employees can only sign up to make donations to the WB Program during Open Enrollment.

2. Requests for funds must be for current Agency patients, directly benefit the patient, all other options for payment or acquisition have been exhausted, and the employee submitting the request has researched the item or service for best possible pricing.

3. All requests for disbursement of WB funds must be submitted using the e-form on the staff website. The request goes to the committee to review. Any employee can submit a WB request. A majority vote of the committee is needed for approval with a goal to respond with 24 hours.

4. Once a majority vote is obtained, the employee making the request will be contacted by a designated member of the committee to relay the decision. If the request was approved, the employee and committee will determine the best way to obtain and pay for the item/service.

5. Reimbursement is by check only from the WB checking account. A designated member of the committee will have the authority to sign checks. The Executive Officer Manager and CFO will also have authority to sign checks as backup.

6. The requesting employee may pay for the item/service in advance with approval from the WB committee, and be reimbursed by the WB fund after submitting a receipt. A WB check can also be made out to the place of purchase for the exact amount. Checks will not be written to a patient or patient's family member. Payment can also be made from invoices such as Meals-On-Wheels, Guardian, etc. Depending upon the situation, any pre-approved request for an item or service that the patient has been informed was approved and scheduled to be done will still be fulfilled even if the patient has died.

7. A We Believe Amazon account has also been established to expedite the purchase and delivery of items. Such items can be shipped directly to the patient. Contact the WB Committee for the Amazon Account information.

8. Generally requests will only be processed during regular business hours, M-F, 8-5. Some committee members have agreed to be contacted after business hours on their personal phones for urgent requests requiring a quick response.

9. If the WB fund is paying for a rental service such as Meals-On-Wheels, Guardian, or DME from Alicks, the social worker must follow up monthly with the patient to determine whether the service is still needed. The committee must be notified immediately when a patient dies or is discharged so the service can be discontinued.

10. Employees will be kept informed of WB activities in the Weekly Announcements at least quarterly.

11. Interesting WB stories can be shared with the Director of Marketing & Access with the permission of the patient/family to be used in Choices or on the Agency's social media. A CHC Promotion Agreement and

Publicity Release form will need to be signed by the patient or patient representative if a story is selected for publication.

Committee Members

Committee members must be active employee donors to the WB program. Any employee donor to the WB program can request to be a member of the committee by contacting any existing committee member. The existing committee members will vote on the request every December. The committee shall consist of no fewer than five (5) and no more than seven (7) members to ensure a majority vote and a quick response to WB requests within 24 hours. If the committee is full, the employee's name may be put on a waiting list for the next vacancy.

Members will serve for two consecutive years from January to December with the option to renew for an additional two consecutive years. Members will serve for no more than two consecutive terms. If a committee member leaves Agency employment during their term, an attempt will be made to replace the member with an employee from the same discipline, department or office. No more than one representative from a particular department, discipline, or office will serve on the committee at any time to ensure there is diversity on the committee.

Revised 05/18

Center for Hospice Care
choices to make the most of life

CHAPTER FIVE

PATIENT CARE POLICIES

REGULATIONS: 42 CFR 484.48 – Clinical Records

PURPOSE: To ensure a timely, accurate written record of the patient/family encounter, care, and coordination of contacts and services provided by the Agency.

POLICY: A medical record is established and maintained for every patient receiving care and services from the Agency. The record is complete, promptly and accurately documented, readily accessible, and systematically organized to facilitate retrieval.

PROCEDURE:

1. Entries are made in the medical record for all services provided. Services provided directly and through contracted providers will be entered in a standardized format and are legible, clear and complete, and signed and dated by the person providing the services.

2. Only authorized individuals are allowed to make entries in patient medical records and all signatures are authenticated with name and title or a secured computer entry by a unique identifier to ensure the author is who he/she claims to be.
   - ~~2.~~ Authentication must include date and time that an event occurred, not the time the documentation was entered into the record.

3. Each patient's medical record includes, at a minimum, the following:
   - Identification data, including contact information for the patient, the patient's representative (if any), and the patient's primary caregiver(s).
   - Referral information and pertinent medical history.
   - Contact information for the primary care physician or other health care professional who will be responsible for providing care and services to the patient after discharge from the home health agency.
   - The initial plan of care, updated plans of care, ~~initial~~comprehensive assessment, clinical notes.
   - Signed copies of the General Consent form.
   - Documentation of all interventions including ~~the patient's responses to~~ medications, symptom management, treatment and services, and responses to those interventions.
   - Goals and patient's progress toward achieving them.
   - Signed physician orders.
   - Copies of advance directives (if applicable)~~;~~.

4. Access to patient medical records is restricted to members of the Interdisciplinary Team (IDT) and employees who require such access to perform their jobs effectively.

Signature: President/CEO

5. A patient's entire medical record may only be used or disclosed in accordance with the Agency's policies and procedures related to uses and disclosures of protected health information.

6. The Agency has a zero tolerance policy for falsification of medical records.

7. The medical record contains a discharge summary, and medical records of discharged patients are completed upon discharge from the Agency.
   - A completed discharge summary is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the home health agency within five (5) business days of the patient discharge,
   - A completed transfer summary that is sent within two (2) business days of a planned transfer, if the patient's care will be immediately continued in a health care facility, or,
   - A completed transfer summary that is sent within two (2) business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the home health agency becomes aware of transfer.

8. When an error is made in the medical record, it may only be corrected by drawing a single line through the error with the initials of the individual making the correction. Correction liquid or tape, erasure, or obliteration of the error by multiple cross-outs and/or write-over's is not allowed. An addendum to the electronic medical record may be made, but never changed, using the date of the addendum in a memo attached to the date of the contact being addended.

9. Electronic medical records are safeguarded against loss or destruction by a backup process of the Agency's computer server each day.

10. Medical records are retained and protected for seven (7) years after the death or discharge of a patient.

11. Records of any patient who is a minor will be maintained for three (3) years after the person's 18th birthday or until the age of 21 years.

12. Records in the satellite offices will be maintained after discharge for a period of one year and/or up to the time of the next survey. Following this time period, the medical record will be sent to the South Bend office for incorporation into the Agency's official record and/or transfer to permanent storage.

Signature:  President/CEO

13. If the record is not on site in the records room, it will be stored at Two Men and a Truck~~Michiana Moving and Storage~~, 903 S. Main Street, South Bend.

14. Documents that no longer serve a purpose will be placed in a certified document destruction bin for shredding, or shredded.

15. In the event the Center for Hospice Care closes, medical records will continue to be stored at Two Men and a Truck~~Michiana Moving and Storage~~.

REGULATION: 42 CFR 484.48(b) – Protection of Records

PURPOSE: To ensure protection and confidentiality of medical records.

POLICY: All requests for copies of medical records outside of the course of providing care to a CHC patient must be directed to the Executive Office Manager (EOM). Requests from physician offices, medical equipment companies, or other health care agencies directly involved with the patient's care do not need to be directed to the EOM. Staff should also refer to the "Decision Tree – Medical records" on the staff website under Files.

Patient – The clinical record must be made available to a patient, free of charge, upon request at the next home visit, or within four (4) business days (whichever comes first).

Family Members – Requests from family members of active or discharged patients for copies of medical records must be directed to the EOM, who will ascertain whether the family member has the legal authority to request the records. If the EOM cannot make that determination, he/she will contact the agency attorney for direction. If it is determined that the family member does have the authority, a "Consent to Release Medical Records" form will be sent to the patient or family member. No records will be released until the signed form is returned. A fee may be charged for the copying of the medical records. The EOM will also keep the President/CEO informed of the requests and results.

Attorneys – Requests from attorneys for copies of medical records do not require the "Consent to Release Medical Records" form. If the EOM cannot ascertain whether the request meets Indiana law, he/she will contact the agency attorney for direction. A fee will be charged the requesting attorney for the copying of the medical records.

Subpoena – Any CHC employee that receives a subpoena on any subject involving CHC or a current or past CHC patient or family member, should immediately contact their supervisor and the EOM, or in his/her absence the President/CEO. Do not communicate with any attorneys on the matter. A copy of the subpoena should be sent to the EOM, who will then contact the agency attorney for direction. The EOM will keep the employee, their supervisor, and the President/CEO informed of the response from the agency attorney. A copy of the subpoena will be kept in the employee's personnel file.

Insurance Companies – Requests from life insurance, long-term care insurance, and other supplemental insurance companies for copies of medical records of active or discharged patients should be directed to the EOM.

PURPOSE: To facilitate Do Not Resuscitate (DNR) decisions for the patient.

PROCEDURE:

1. At admission if applicable, the RN will initiate conversation with the patient regarding current DNR status. If the patient has verbally or in a previous doctor's order designated their advance directives, then enter the DNR order on the 485 for the physician to sign.

2. Document the conversation that the agency staff person had with the patient or their designated health care representative, or significant family members present.

3. If the patient has a DNR, obtain a copy for our records. If none is available or the patient has not signed a DNR, provide an Out of Hospital Do Not Resuscitate Order.

4. If the patient or health care representative is unable or unwilling to make DNR decisions at this time, the RN will make a referral to the appropriate social worker for follow up.

5. The social worker will continue to explore the patient's DNR status and keep the Interdisciplinary Team (IDT) advised.

6. The signed form will be given to the QA Department. The white copy~~and yellow copies~~ will be marked for physician signature. Upon return, the white original copy will be scanned into the patient's chart.~~, and the yellow copy will be returned to the patient.~~

   The patient/primary caregiver must be educated to keep the yellow copy, in the handbook, ~~this form~~ available in the event should it be needed.

DIAGNOSIS ADDITIONS OR CHANGES

REGULATIONS: 42 CFR 484.18(a) – Plan of Care

PURPOSE: To provide up-to-date information on the patient's medical condition and diagnosis.

POLICY: When a new diagnosis is identified, or a change in the diagnosis is necessary due to an exacerbation of an illness, it is necessary to have the appropriate documentation to verify. The following procedure needs to be followed to ensure proper documentation.

PROCEDURE:

1. Identify the need for a new or change in diagnosis. This is accomplished by working with the attending physician:
   - lab work
   - diagnostic testing
   - medication regime/changes
   - change in patient status

2. ~~2.~~ Once the diagnosis is identified by the physician, a physician's order must be obtained to add or change a diagnosis. ~~(For changes, a "Diagnosis Change" form may be used.)~~
   - Change of diagnosis is written in the plan of care and is marked to generate an order for the attending to sign.
   - Obtain a physician's order stating what the new diagnosis is or that there has been an exacerbation of the diagnosis.
   - Mail the order to the physician for signature.

3. Enter the change in a QA Changes email for the QA Nurse to make the appropriate computer changes and print a new Patient Face Sheet.

4. Document in an IDT note that order was obtained and reason for the changes or additions (lab work, diagnostics, change in medications, or change in patient status, and be specific).
   - Obtain copies of pertinent diagnostic work-up reports to place on patient's chart.

REGULATION: 42 CFR 484.55(c) – Drug Regimen Review

PURPOSE: To ensure quality, safe prescribing, dispensing, and ordering of patient medications.

POLICY: Medications may only be administered that have been ordered by the patient's physician or CHC medical director.

PROCEDURES:

1. Both telephone and written orders for medications are documented in the patient's medical record and include:
   - Date of the order
   - Time of the order
   - Name of medication
   - Dose
   - Route
   - Frequency
   - Purpose (if PRN and/or antibiotic)

2. Telephone orders for medications may only be accepted by a registered nurse or a licensed practical nurse under the direction of the registered nurse. The registered nurse will read back and verify every telephone/verbal order given by the physician by repeating the patient's name, and the name, dosage, route, and time of the medication to the ordering physician.

3. A copy of telephone orders is sent to the ordering physician for return with signature and included in the patient's medical record.

4. Orders for medications are documented in the patient's current medication profile.
   ~~4.~~ • All medications will be marked as non-covered in the EMR.

5. The registered nurse contacts the pharmacy to fulfill the order.

6. No change may be made to the medication dosage or route without a physician's order.

7. A physician's order is needed to discontinue medications.

Center for Hospice Care

PHYSICIAN NOTIFICATION OF MISSED SCHEDULED VISIT

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

REGULATION: 42 CFR 484.18(a) – Plan of Care

PURPOSE: To comply with state and federal regulations. The attending physician will be notified if the number of visits varies from the patient's plan of care.

POLICY: Each discipline is responsible for notifying the physician by fax of visits that are not within the visit strings as designated on the plan of care. The Patient Care Coordinator will be responsible for the Home Health Aide visits.

PROCEDURE:

1. Notify the physician when the visit frequency is not met as ordered.
2. Document notification in a demographics memo.
3. ~~Complete the "Physicians Notification of Refusal" form and fax to the physician.~~
4. 3. Staff must document why the visit was missed in the patient chart.
5. 4. Any questions or problems regarding scheduled visits or physician notification of visits should be forwarded to the Patient Care Coordinator.

Effective Date: 07/93	Revised Date: 04/18~~03/17~~	Board Approved: 06/28/17
Reviewed Date: 03/13		Signature Date: 06/28/17

Signature: President/CEO

Center for Hospice Care

CARE PLAN ESTABLISHMENT AND REVIEW

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

REGULATION: 42 CFR 484.6018(b) – Periodic Review of Plan of Care

PURPOSE: To provide a written care plan for each individual admitted to the Agency and to ensure that the care provided to an individual is in accordance with the plan. The care plan shall be reviewed and updated accordingly. The home health agency (HHA) must provide a written individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by the attending physician acting within the scope of his or her state license.

POLICY: The interdisciplinary team (IDT Team) is responsible for formulating the patient/ PCG care plan; this formulation occurs after the initial assessment by the team members, and occurs with the collaboration of these team members, patient and family. The IDT Team will be notified prior to the initiation of patient care.

The IDT Team works together in contributing information, identifying of patient/ family problems, and planning appropriate responses to patient and family needs inclusive of goals and interventions.

PROCEDURE:

1. A registered nurse will conduct the initial physical assessment of each patient and contact members of the IDT to initiate the care plan.
2. Care plan will include an assessment of patient/family/ PCG needs including medical, nursing, functional psycho-social and spiritual issues.
3. Care plans shall be reviewed and updated every 60 days for all patients and as needed as changes occur.
4. An updated Plan of Treatment will be sent to the physician every certification period, and progress notes will be sent every two weeks.
5. Upon signing the plan of Treatment, the physician is confirming he/she has seen the summaries in addition to the care plan.
6. Review of the patient's plan of care, inclusive of changes, occur as needed in addition to a review every two weeks at the IDT Supervisory Meeting.

Effective Date: 12/95	Revised Date: 04/18 ~~01/05~~	Board Approved: 01/18/05
Reviewed Date: 03/17		Signature Date: 01/18/05

Signature: President/CEO

10. Attend to the family, friends, and ECF staff (if applicable) and explain that bereavement services are available to anyone in the family and contact will be made to the family member identified by the patient care team. If a family member at the death visit asks to be contacted by bereavement, CHC staff will gather complete name, address and phone number.

11. Be sensitive to public locations (Inpatient Unit) when a body is being removed, and offer an explanation that the funeral home representative is arriving soon and they may want to move to another location.

12. If the death is unexpected or there is suspected foul play, notify the police.

13. After permission is obtained from the family, notify the funeral home as designated by the family for transport of the patient's body. Inform the funeral home who will be signing the death certificate.

~~13.~~14. For IPU patients: When the funeral home arrives, verify the correct funeral home and correct patient before releasing the body.

~~14.~~15. Contact all appropriate agencies, DME, contracted pharmacy, volunteer, contracted providers (IV, therapies, etc.), private duty providers, etc., of the patient's death.

~~15.~~16. Complete a Death/Discharge Note in Patient Note and transfer note to patient note summary. Include where death occurred, date and time of death, and that all agencies listed on #14 above were contacted. If death occurs in an ECF, document this information in the facility chart also.

16. Enter the patient's name, attending staff, funeral home, and date of death into the Secure Messaging.

17. Staff will notify the triage nurse of all patient discharges or deaths. The nurse making the death visit with discharge in Cerner. This is inclusive of all shifts and agency locations.

18. See policy for Medication Disposal for disposal of medications. Medical disposal must be documented in this note.

3. The case manager/visit nurse notifies the facility nursing staff when the transfer will occur, initiates the completion of the appropriate TB protocol before arrival, and obtains a copy of facility MAR (medication administration record).

4. ~~If the patient does not bring the ECF medications, the Inpatient Unit nurse will call the medications in to contracted pharmacy and a local pharmacy at the time of transfer. The prescriptions are given to the family to give to the pharmacy when picking up the medication.~~

CURRENT PATIENT TRANSFER TO INPATIENT UNIT

1. Follow the Inpatient Unit Direct Transfer Flow Sheet.

ARRIVAL AT INPATIENT UNIT

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

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

REGULATION: 42 CFR Part 418.56 – Interdisciplinary Team, care planning, and coordination of services.

PURPOSE: The agency will use an interdisciplinary approach to assessing the medical, physical, social, emotional, and spiritual initial and ongoing needs of the patient and family to determine the best placement for patient.

POLICY:

GIP for New Admissions

- Admissions will set up conference call from their iPhone. (See CHC knowledge base for directions).
- GIP patients should have an MD (on call if available), rounding Nurse Practitioner, Inpatient Unit (IPU) RN, Social Worker, and Admission RN for all IDT's.
- If IPU nurse too busy to participate in IDT at requested time:
  - The IPU nurse will ask the coordinator, if she is not available then the ADON during business hours.
  - If after business hours, staff member requesting the IDT will conference in the nurse leader on call.
- Staff facilitating GIP transfer should mutually decide with IPU best time for transfer.
- GIP patients should go to the IPU of family choice, if there is a reason to divert to the other IPU, the coordinator or nurse leadership on call should be included in the decision.
- Communicable disease form will be completed by Admission RN.
- Admissions will complete IDT note.

Transfers of Current Patients

- CM/Visit nurse will set up conference call from their iPhone.
- Transfer patients should have an MD (on call for the IPU if available), rounding NP, Case Manager/Visit Nurse, IPU RN, and Social Worker for all IDT's.
- If IPU nurse too busy to participate in IDT at requested time:
  - The IPU nurse will ask the coordinator, if she is not available then the ADON during business hours.
  - If after business hours, staff member requesting the IDT will conference in the nurse leader on call.
- Staff facilitating GIP transfer should mutually decide with IPU best time for transfer.
- GIP transfer patients should go to the IPU of family choice, if there is a reason to divert to the other IPU, the coordinator or nurse leadership on call should be included in the decision.
- Communicable disease form will be completed by CM/Visit nurse.
- CM/Visit nurse will complete IDT note.

Signature:  President/CEO

Respite

- Case Manager/Social Worker will set up conference call from their iPhone.
- If CM is unable to be on the call, CM should call IPU RN with report on patient.
- Respite patients IDT's are done within 24 hours of requested date.
  - SW should call unit day of transfer to confirm bed availability.
- Respite patients should have included in their IDT: MD, SW, CM/VN, IPU staff, and Coordinator, if Coordinator not available, nurse leadership on call.
- SW is responsible for entering respite information in both IPU green books.
- The IPU coordinator or nurse leadership on call can divert to the other IPU or delay transfer of respite patient if the respite patient will occupy the last bed at that IPU.
- All respite patients will have a fee assessment completed by SW either before transfer or same day as transfer.
- TB tests and Communicable disease questionnaire will be completed prior to transfer to IPU. TB tests are valid for 1 year.
- SW will complete IDT note.

Center for Hospice Care

INPATIENT UNIT – DOCUMENTATION

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

REGULATION: 42 CFR 418.104 – Clinical Record
42 CFR 418.54 – Initial and comprehensive assessment of the patient

PURPOSE: To ensure accurate documentation of the patient's stay in Inpatient Unit.

PROCEDURE:

1. A patient~~comprehensive~~ assessment will be completed every shift~~weekly~~ and PRN on all patients. The Inpatient Nurse Assessment form reflecting the patient's medical status and reason for the level of care will be documented each shift.

2. Documentation in the electronic medical record will reflect the level of care as determined by the IDT.

Effective Date: 03/01	Revised Date:02/18~~05/16~~	Board Approved: 10/19/16
Reviewed Date: 09/14		Signature Date: 10/19/16

Signature: President/CEO

REGULATION: 42 CFR 418.108(b) - Short-term Inpatient Care

PURPOSE: To ensure patients who need respite care are cared for in the same manner as at home.

PROCEDURE: Patients will go to the Inpatient Unit (IPU) of their choice. If the IPU cannot accommodate them, they will be given the option of going to the other IPU or delaying respite stay.

Before a patient is scheduled for Respite stay:

- Case Manager/Visit nurse will complete a TB test and the Communicable Disease form before transfer. Exception on TB test will only be made for emergency respites.
- As soon as the family has made the request for respite, the Social Worker will fill out the IPU Request List form at both IPUs.
- An IDT will be scheduled within 24 hours of start of Respite by the Social Worker.
- The Case Manager will be included in the IDT to ensure all needed information is shared with IPU staff.

Day of Respite:

- Social Work will call the IPU and verify with the IPU Coordinator that a bed is available bed before scheduling transportation.
- If there are any changes to the patient since the IDT, the Case Manager will call the IPU with an update.

Admission to IPU:

- Upon arrival the patient and the caregiver, if present, will be oriented to the IPU including the following:
  - Inventory of patient belongings
  - Questionnaire on patient preferences will be completed by the RN
- Copy of questionnaire will be kept in CNA book for reference
- RN will call family prior to admission to complete
- Questionnaire will be utilized for the patient plan of care while in the IPU
  - Family preference on who to call first if there is more then one family member

Daily Care while in the IPU:

- Any changes in the patient's condition will immediately be reported to the family.
  - If patient becomes combative or increasingly agitated, the family will be notified.

Signature:  President/CEO

- Any changes in medications from what the patient normally takes at home will be discussed with the family before initiating.
  - The nurse will document the reason for any medication changes or additions.
- If the patient does not have a Foley, the nurse will discuss with the family BEFORE anchoring.
  - The nurse will document the need for a Foley and family approval.
- The plan of care will follow the home routine to the best of the IPU's ability. This includes:
  - Dressing
  - Bathing
  - Activity
  - Meals
  - Medication schedule

Transfer from Respite Back to Home:

- Social Work will coordinate transfer time and transportation.
- IPU nurse will call the Case Manager with an update on the patient.
- Medications and belongings will be packed and made ready for transportation.
  - Belongings will be double checked against the inventory sheet to make sure all of the patient's belongings are returned with the patient.
- If the family is not present at the discharge from the IPU, the IPU nurse will call the family with an update on the patient's respite stay.

PURPOSE: To ensure appropriate discharge from Inpatient Unit~~.~~ (IPU).

PROCEDURE: The Hospice IDT will monitor the patient's care for discharge to the appropriate setting when:

- Specific symptoms are controlled and there is no further decline in condition
- Goals have been met
- Patient elects discharge
- Patient expires
- Patient is no longer eligible for Hospice services by virtue of prognosis
- Respite stay is completed

The social worker will initiate the discharge process with the patient/family in consultation with Inpatient Unit staff. .

The Hospice IDT will determine the appropriate discharge process.

Inpatient Unit staff will do the following before patient leaves the unit:

- Check patient orientation personal inventory list to make sure all belongings go with the patient.
- If patient came from home and patient is going back home/facility:
  - Send all medications and care kit brought with the patient.
  - If patient is going from home to a facility, do not send care kit.
  - Order any medications that home patient has less than a three day supply of to be delivered to the home.
  - Destroy according to policy all medications removed from the EDK for the patient.

- If the patient is a new admit and is going home/facility:
  - Send any medications labeled by pharmacy with patient name and directions with patient.
  - Destroy according to policy all medications removed from the EDK for patient.
  - Order any medications that home patient has less than a three day supply of to be delivered to the home.
  - Call report to the CHC case manager/hospital nurse/ECF nurse.

- Complete the Inpatient Unit Patient Discharge Instructions and send with patient.
- If patient is going from the IPU to the emergency department (ER), an IDT must be done and triage notified to send a nurse to the ER.

PURPOSE: To establish a procedure on using the blanket warmer in the Inpatient Unit.

POLICY: Inpatient Unit staff will be knowledgeable in the temperature monitoring and use of the blanket warmer.

PROCEDURE:

1. Blanket warmer will always be kept at the manufacturer suggested temperature.
2. Blanket warmer is to be the only item plugged into the outlet.
3. Only clean bath blankets will be kept in the warmer.
4. Warm blankets may be given to patients or families.
5. Inpatient Unit staff should test temperature of blanket before lying over patient to make sure it is not too hot.
6. Blanket warmer should be cleansed according to manufacturer recommendation and/or it becomes visibly soiled.
7. Blanket warmer will be turned off when the Inpatient Unit is closed.

Effective Date: 04/18	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

Signature:  President/CEO

SOUTH BEND COMMUNITY SCHOOL CORPORATION

ADAMS HIGH SCHOOL
808 S. TWYCKENHAM DR. SOUTH BEND, INDIANA 46615
TELEPHONE (574) 393-5300 • FAX (574) 283-7704

Mr. Mark Murray
Center for Hospice Care
Life Transition Center
501 Comfort Pl.
Mishawaka, IN 46545

April 18, 2018

Mr. Murray,

On behalf of John Adams High School, I want to express our sincere thanks to the Center for Hospice Care for the services of one of your bereavement counselors, Ms. Annette Deguch, who conducted and recently completed an annual grief and loss group with our students.

We have a number of students who have experienced the death of a family member or close friend. As you know, these losses, if not addressed, can lead to a host of negative responses, such as poor attendance, a drop in grades, and emotional/behavioral problems.

By partnering with Hospice to provide this grief and loss group, we are able to provide our students with the tools they need to cope with their significant loss and to encourage their growth and resilience in the process.

Once again, thank you for the professional support Hospice continues to provide for our students. These services are greatly needed and sincerely appreciated.

Best Regards,

Mark Geissler

Mark Geissler LCSW
John Adams Social Worker

Jim Seitz

Jim Seitz
John Adams Principal

Dear Lisa + Holly,

Thank you for taking time to spend with us. Juan

THANK YOU SO MUCH for....

Thank you for your time and knowledge!
Carol Lee

All your insight + thoughtfulness! Appreciated your time + energy.
- KarinaPalcs

Thank you for spending time with us!
Kethayn

taking time to share with us! appreciated your insight + info on complex grief
-Hanna

Social Work Senior Seminar

Holy Family Grade School

Guiding Families to Pursue the Truth and Live it.

April 9, 2018

Mr. Mark Murray
Center for Hospice Care
Mishawaka, IN 46544

RE: School Bereavement Group

Mr. Murray,

Please allow me to share my gratitude for the services of Mrs. Annette Deguch to our school community. Mrs. Deguch prepared and facilitated a student bereavement group for students from grades K-6. She came to the school each Monday, sharing a lesson and activity designed to engage each student. These lessons and activities encouraged members to talk about their unique experiences with loss. She initiated many conversations and asked students thoughtful questions to encourage their participation.

Mrs. Deguch easily established rapport with the students, who looked forward to group each week. Her program was highly interactive and had a strong impact. Mrs. Deguch was able to successfully tailor the meetings to the diverse ages and needs of the group. She arrived early to insure everything was set and she was very flexible with the arrangements. It was a pleasure to work with her!

We are very grateful for the services provided by The Center for Hospice Care to our students in need. Thank you for your ongoing support to children in grief and to meeting those needs in the school setting.

Pam Schena

Pam Schena, LMHC, LSC
School Counselor

Monday, March 5, 2018

Center for Hospice Care to Honor Sister Carmel Marie Sallows with Helping Hands Award

An annual tradition of recognizing outstanding community service continues at Center for Hospice Care's 34th Helping Hands Award Dinner, where they will honor Sr. Carmel Marie Sallows, C.S.C.

MISHAWAKA, IND. (PRWEB) MARCH 01, 2018

Sr. Carmel Marie Sallows, C.S.C.

Center for Hospice Care's 34th Annual Helping Hands Award Dinner will take place on the evening of May 2, 2018 at the Hilton Garden Inn in South Bend. Each year, Center for Hospice Care (CHC) honors a deserving recipient with its Helping Hands Award. CHC is thrilled to be honoring someone who has faithfully served the community for more than 60 years – an individual known and loved by many – Sr. Carmel Marie Sallows, C.S.C.

Sr. Carmel was born in South Bend, and spent much of her life in the area. She attended St. Mary's Prep School, St. Joseph's Academy, St. Mary's College, and earned a master of science in education from St. Francis College in Fort Wayne. Sr. Carmel's teaching career began in 1954 and continued through 1985. She began serving as librarian at St. Joseph High School in 1985, and continues – at the age of 85 – to serve as an assistant librarian to this day. With a remarkable history of service and sacrifice, Sr. Carmel continues to volunteer at four non-profit organizations, including for CHC at its South Bend inpatient care facility.

Given the unique impact she has made on the lives of so many in the community, CHC has created a special fund called the Sister Carmel Helping Hands Fund. Money collected will support CHC's 38-year promise that no one eligible for hospice care will be turned away due to

an inability to pay. The establishment of this special fund will give those unable to attend the event an opportunity to participate in honoring Sr. Carmel.

In 2017, Center for Hospice Care provided nearly $2 million in unreimbursed and discounted patient care, as well as bereavement services to patients and families. CHC is proud to give back to the community, and the Sister Carmel Helping Hands Fund will help support those efforts. For more information, please visit foundationforhospice.org.

About Center for Hospice Care and the Hospice Foundation

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

The Hospice Foundation is committed to supporting the work of CHC through community outreach and education, fundraising activities and other special events. The Foundation helps CHC keep its 38-year promise that no one eligible for hospice services will be turned away, regardless of their ability to pay.

Contact Author

PETER ASHLEY

Hospice Foundation
+1 (574) 367-2457
Email >

Center for Hospice Care
Compliance Committee Meeting Minutes
February 20, 2018

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 2:00 p.m.	
2. Minutes	• The minutes of the 09//14/17 meeting were approved by consensus.	
3. GIP Utilization	• At the September meeting we talked about GIP Utilization. Rebecca Fear will report on GIP documentation and statistics at the QI Committee next week. We have increased visits for GIP in the hospital to two a day—one in the morning and one in the evening. The evening visit has enabled us to address issues that may have come up during the day at the hospital. Sue keeps Mark and Dave updated on the status of these patients. We watch the patients very closely to see when they would be appropriate to transfer to the IPU. The biggest problem is when families don't want the patient to be moved or the hospitalist says the patient can stay as long as they want. It's our patient, our care plan, we're paying the hospital for the stay, but it's difficult to get the hospital staff to understand and recognize this. Hospital staff turnover also makes it hard to keep them informed on the nuances of this type of event. • We had fewer GIP patients in hospitals in 2017 than 2016 which is good. Dr. Gifford did review GIP with the medical staff, but not the hospitalists yet. We will be doing that sometime this year. It is tough to get in to see people in the hospitals, especially during flu season. The hospitals are putting meetings on hold.	
4. OIG Work Plan	• The OIG has made some changes in the work plans. They are no longer publishing an annual work plan. It is now updated monthly and is easier to navigate. Two 2018 OIG hospice focused initiatives are (1) Duplicative and Overlapping Claims, and (2) Survey and Complaint Investigation. The OIG seems to be more focus now on survey data. The Citation Frequency Report is also shared by NHPCO as the top 25 survey deficiencies. Plan of care is always number one. The compliance committee doesn't need to review the Citation Frequency Report, but it is being looked at in other committees.	

Topic	Discussion	Action
5. Areas to Focus On	• One area we could look at is whether we are too strict in measuring eligibility for patients to get admitted into CHC. We have had and passed audits, but that may have frightened the medical staff so they are more cautious at approving admissions. We will be meeting with them tomorrow. The rules have not changed, it is the interpretations.	
6. Hospice Compare	• We are doing very well on the Hospice Compare website in every category except pain management, because we were doing it wrong. A year ago we identified the problem after a webinar that we were not collecting the pain management piece correctly. We were doing the screening but not the assessment. So we educated admission and IPU staff. The data on the website is incredibly delayed. The information posted can be 9-10 months old. Hospices that fail to comply with the quality data submission requirements face a 2% reduction to the market basket percentage increase for that fiscal year. Edo Banach, NHPCO CEO, sent CMS a letter saying they should take the website down, because it has a lot of inaccurate information. A lot of hospices were having the same problems as us, some due to EMR issues.	
7. Home Health Compliance	• Recent OIG reports have disclosed improper payments primarily of beneficiaries who were not homebound or did not require skilled services. The new home health CoPs are officially out, but the Interpretive Guidelines are still in draft form. We have been proactive in preparing for those changes. We are now working on the home health patient bill of rights. The contact information for the Administrator has to be listed on it. We are also creating a separate home health family handbook.	
8. Survey Readiness	• We feel we are prepared for a hospice or home health survey. We were due for a hospice survey last October and we're due for a home health survey in 2018. The last one was in November 2015.	
9. Meeting Frequency	• The committee agreed to meet twice a year. We can always call a committee as issues arise. The next meeting will be in August or September.	
Adjournment	• The meeting adjourned at 2:30 p.m.	Next meeting TBA

Center for Hospice Care
QI Committee Meeting Minutes
February 27, 2018

Members Present:	Alice Wolff, Amber Jay, Carol Walker, Carrie Healy, Craig Harrell, Dave Haley, Dr. Greg Gifford, Holly Farmer, Karen Hudson, Larry Rice, Lisa Bryan, Rebecca Fear, Sarah Ryder, Sue Morgan, Tammy Huyvaert, Becky Kizer
Absent:	Anna Milligan, Brett Maccani, Jennifer Ewing, Mark Murray, Terri Lawton, Terri Smith

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m. • New committee members Amber Jay, Elkhart IPU Coordinator, and Lisa Bryan, La Porte Patient Care Coordinator, were introduced.	
2. Minutes	• The minutes of the 11/28/17 meeting were approved by consensus.	
3. 2018 QAPI Reporting Plan	• The reports for the fourth quarter of 2017 were reviewed. For 2018 we created a Quality Report Calendar so the committee will know when each area will be reported. A motion was made to approve the 2018 Quality Reporting Calendar as presented. The motion was accepted unanimously.	T. Huyvaert motioned A. Wolff seconded
4. HQRP	• The CMS Hospice Quality Reporting Program (HQRP) and Hospice Compare Website was updated 02/20/18. The data is from 04/01/16 through 03/31/17 and now includes data from the CAHPS survey. We are still auditing the Hospice Item Set (HIS) data to insure staff is completing the questionnaire accurately. We had discovered that nurses were not assessing for pain on at least five of seven required elements. So starting a performance improvement project in March 20017 by educating the admissions and IPU nurses on how to correctly complete the HIS correctly. Prior to this we were at 58% compliance and are now averaging 87%. The threshold is 90%. • We have also pulled out nurse by nurse compliance percentages for the year. Yesterday we discovered we can hold that data until it can be validated. So effective 03/01/18 the nurses will no longer validate their own HIS information. The PCC will do that within 2-3 days after the admission and then talk to the nurse if anything needs to be corrected. We have 14 days after the admission to submit the HIS. We are also going to recommend increasing compliance to 100%. We will also talk to the nurses that almost always 100% complaint to see what processes they use, so they	

Topic	Discussion	Action
	can share that with their peers. The data on the Hospice Compare website is not updated very often, so it could take a year to see improvements in our scores.	
5. New QAPI Teams	• Percentage of patients receiving at least one visit from an RN, Physician, Nurse Practitioner, or Physician Assistant in the last three days of life. From July 2017-February 2018 we averaged 88%. • Percentage of patients receiving at least two visits from a Social Worker, Chaplain/Spiritual counselors, LPNs, or Hospice Aides in the last seven days of life. From July 2017-February 2018 we averaged 59%. • This performance improvement plan is based on the review of HIS data on visits in the last 3-7 days of life, the visit needs for patients with a Palliative Performance Score of 30% or less, and CAHPS questions related to (1) help with symptoms, (2) getting training on care topics, (3) information on what to expect when the patient was dying. The QAPI has met twice and reviewed the data. Peer reviews were done and it was found that nurses usually increase visits at the end of life. So after every weekly IDT, Brett M. will email information to Carrie H. and Larry R. that a patient is declining and staff needs to make visits. We want to establish a standard way to communicate this information to the IDT. Each discipline is also working on best practices for patients/families at the end of life. Holly F. suggested at the death review if someone on the IDT could identify who should receive the CAHPS. • The Agency Coordinators meet quarterly and are reviewing the CAHPS top box scores. The scores have remained fairly consistent. The coordinators identify any areas for improvement off of these scores and are currently focusing on getting help with symptoms, understanding side effects, and getting hospice care training.	
6. Quality Monitoring	• Reviewed the education and training done in fourth quarter 2017. We also use the NHPCO presented twice a month on clinical and regulatory topics. Our planned education for 2018 includes an agency-wide general orientation, Pediatric ELNEC for all disciplines, interdisciplinary Continuing Education (CE) courses, CHPN certification courses, preceptor courses for aides and nurses, and We Honor Veterans training for all disciplines. The Indiana Nurses Association uses the Ohio Nurses Association as their official CE provider. This will be helpful for those disciplines requiring CEs for licensure or certification. • The first approved course was "Quality Improvement: Organizing Teams and	

Topic	Discussion	Action
	Projects." Rebecca F. will be starting this in March. Indiana doesn't require CEs for nurses, but is required for nurses to maintain their CHPN certification. Social work/counselors are required to have 20 CEs. The Hospice Foundation has purchased a package from the Hospice Foundation of America (HFA) to present education that offers CEUs. • Live Discharges – Patient initiated discharges are revocations and transfers. Agency initiated is no longer terminally ill/not meeting criteria, cause, leaves service area. In 2017 we had a total of 1,735 discharges. Of those 171 were live discharges or 10%. Of those, 53% were revocations (10 patients). Per the Health Pivots reports, since 2011 we have averaged around 10% live discharges a year. In 2018 we want to explore how we can manage revocations, are we following our policies, are we documenting like we should, are we offering GIP appropriately, educating correctly, following up with those no longer terminal, etc. Out of 90 revocations, 33 were for curative care, 22% rehab/Med A skilled bed in a facility, 20% treatment outside hospice plan of care, 15% symptoms related to hospice diagnosis, 10% other. 30% of patients who revoke returned to us within one week.	
7. QAPI Programs	• Infection Control – We would like to implement a new QAPI for Planned Infection Control Activities for 2018. This would include, but not be limited to, education and implementation of infection control policies, prevention and surveillance, infection control training for social work, spiritual care, and aides, review of infection control procedures in the IPUs, update the annual staff training on bloodborne pathogens, monitor medical supplies stored in staffs' cars and nursing bags, and identify patients with MDROs. A motion was made to accept the new Infection Control QAPI. The motion was accepted unanimously. • Blood Transfusions – We have resource packets located in Elkhart and South Bend. Blood transfusions can be done in the IPU, home or facility. A group of nurses are educated and skills validated on a routine basis. The nurse stays with the patient during the transfusion and follows up with them the next day. • HeartWize/BreatheEasy – The data for 2016 and 2017 was reviewed. During this period there were 445 BreatheEasy patients. Of those, 95.8% didn't go to the hospital, 1.1T went to the ER, and 3.1% were admitted to the hospital. We had 582 HeartWize patients during this period. Of those, 96.8% didn't go to the hospital, 1.2% went to the ER, and 2% were admitted to the hospital. We are getting the	Tammy H. motioned Rebecca F. seconded

Topic	Discussion	Action
	names of these programs trademarked. Sue M. and Rebecca F. will be presenting on them at the NHPCO Management & Leadership Conference in April in Washington, DC.	
8. Patient Safety Monitors	• Adverse Events – We are in the process of changing the way we do data collection for incident reports. We are looking at trends and will have separate reports for hospice and home health. In 2017 we had 144 adverse events. We had five medication errors, the highest in one year. None if these had a negative impact on the patient. Some of it was due to new staff in the IPUs. • Medication – Overall there were 12 medication errors. In December we had some issues with Omnicare. Some were delivery issues and some the doctor was having problems with e-prescribing. These issues have been resolved. We also had a few delivery problems with DeliverCareRx when they were using the USPS out of Elkhart. We followed up with them and 90% were coming from the courier service they were subcontracting. • Falls – We had a total of 626 falls in 2017. The majority of these take place when the patient is ambulating, usually on their own. When we see a number of repeat falls, the PCC talks to the case manager and asks what is being put in place to prevent more falls. In January the nurses were given a self-learning packet on incident reports and how to complete them and how to educate patients/families.	
9. Hospice Quality Indicators	• Spiritual Care – We will continue to monitor the ongoing effectiveness of the Spiritual Comfort Measure (SCM) and Spiritual Health Assessment (SHA) for patients and caregivers. This year we will look at the effectiveness of these scales to see if they are helpful in communicating to the rest of the IDT where the patient/ caregiver is in terms of spiritual comfort. We also want to develop an educational plan for other disciplines to increase awareness of the scope of spiritual care for patients and families, to insure they are getting the best spiritual care that could be given. • Social Work – We are working on an assessment tool for patient problems related to caregiving to indicate when the family will be in need of more caregiving. Then we can be more proactive instead of having emergency placements in an IPU or ECF. Social workers will also complete three veteran trainings to meet the standards of the We Honor Veterans program. This will include completion of Military Checklist forms. Social workers will also receiving Pediatric ELNEC training. Along with	

Topic	Discussion	Action
	other disciplines we will be exploring providing monthly bereavement support for CHC staff. • Medication Orders – In 2016 we identified a trend that many medications that were paid through Optum didn't have a corresponding order in the EMR. There were 389 in 2016. We identified the error and began education in 2017. Nurses must enter medication order immediately into the EMR prior to ordering/reordering. ECF nurse will check for orders since their last visit. The PCCs will be included in email from QA about missing orders. In 2017, 337 were missing orders. From 11/08/17-01/25/18 80 were missing, and 90% put in the EMR within one week. We improved accountability by nurses to ensure orders are present for all medications, improved the QA process, monitoring and reporting, and improved communication and accountability between the PCC and nurses.	
10. Home Health QAPI Program	• New Home Health CoPs went into effect January 2017 and we are still waiting for the interpretive guidelines. New policies or revisions were made to meet the new CoPs. We created a new home health admission monitoring tool to make sure all criteria are met. Improvement projects for 2018 include monitoring the length of need of the 485, face-to-face notification sheet being given to patients/families at admission, creating a documentation template for IDTs, educating staff on home health requirements, and creating a home health patient family handbook.	
11. Other Business	• We are due for a home health survey in 2018. We are still waiting for a hospice survey which we were expecting last October. • We finally received permission from CMS to open the La Porte office.	
Adjournment	• The meeting adjourned at 9:00 a.m.	Next meeting 05/22