Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
August 15, 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

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

A G E N D A

1. Consent Agenda (10 minutes):
   A. Approval of May 16, 2018 Minutes *(action)*
   B. Patient Care Policies *(action)* – Included in your board packet. Sue Morgan available to answer questions.
   C. 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. Year to Date July 2018 Financial Statements *(action)*

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

5. Board Education *(information)* – (15 Minutes) – "*Center for Education and Advance Care Planning Update*" – Cyndy Searfoss, Director of Education and Collaborative Partnerships, Hospice Foundation

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

Next meeting November 28, 2018 at 7:15 a.m.

# # #

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Center for Hospice Care

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CHAPTER TWO

CONSENT AGENDA

Center for Hospice Care
Board of Directors Meeting Minutes
May 16, 2018

Members Present:	Anna Milligan, Carol Walker, Corey Cressy, Jennifer Ewing, Jennifer Houin, Jesse Hsieh, Mary Newbold, Suzie Weirick, Tim Portolese, Tricia Luck, Wendell Walsh
Absent:	Amy Kuhar Mauro, Ann Firth
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. Minutes	• A motion was made to accept the minutes of the 02/21/18 meeting as presented. The motion was accepted unanimously.	S. Weirick motioned T. Portolese seconded
3. Patient Care Policies	• A motion was made to accept the new and revised Patient Care Policies as published. The motion was accepted unanimously.	C. Walker motioned M. Newbold seconded
4. Human Resources Policies	• A motion was made to accept the new and revised Human Resources Policies Manual for July 2018-June 2020 as published. The motion was accepted unanimously.	T. Portolese motioned M. Newbold seconded
5. QI Committee Meeting Minutes	• A motion was made to accept the 02/27/18 QI Committee minutes as published. The motion was accepted unanimously.	J. Houin motioned A. Milligan seconded
6. President's Report	• Today Mark M., Mike W., Chris Taelman and Tim Portolese are making a presentation to the Community Foundation of Elkhart County asking for $500,000 for the new Mishawaka inpatient unit. We first applied for the grant in December. About 10-11% of the patients served in the South Bend Inpatient Unit over the past couple years have been from Elkhart County. Several are coming out of SJRMC-Mishawaka and Memorial. With the proximity of the Mishawaka Inpatient Unit being closer, that number will probably go up. The total cost for the Inpatient Unit is $5M and $500,000 is 11% of that amount. The Community Foundation has also funded a number of projects in St. Joseph County and has demonstrated their willingness to make investments here because they benefit the citizens of Elkhart County as well. • Census continues to recover from the low of 364 in September 2017. January	

Topic	Discussion	Action
	ADC was 380, February 387, March 392, April 387, and through 05/15 it was 398. We have not been below 400 patients on census since 05/09. In April 47% of admissions died in seven days or less. The Inpatient Units lengths of stay are improving slightly. • The percentage of referrals refused for hospice as non-eligible is improving. Medical staff may be too compliant who we let into the program because of some CMS audits. We need to remind them that the LCDs are guidelines, not criteria on when a patient is likely to expire. Admission to hospice is based on the medical opinion of a doctor who is the attending physician and hospice medical director that the patient is eligible for hospice. This was also talked about at the NHPCO Management & Leadership Conference. This is a quality issue, because people are not getting into the program they are entitled to. We looked at the 2017 patients we said were not eligible to see if they then died within six months or less. We have enough of a cushion and could admit these patients. If we don't, our competitors will. This is happening to a lot of hospices across the country, because of the scrutiny CMS is putting on hospice admissions. • The percentage of referrals dying before admission through April is 9% compared to 6% a year ago. • Under our Community-Based Palliative Care program, we are looking at our HeartWize and BreatheEazy programs and getting people in sooner. This could include Telemedicine. The nurse practitioner could create a care plan, visit the patient once a month, and we could bill for it under Medicare B. We think this is a product others might be interested in paying for. We are working with a local insurance carrier on whether this would be something large self-employers would be interested in. We are keeping 97% of our HeartWize and BreatheEazy patients out of the ER and hospitals. The NHERT members care for about 3% of the hospice patients in the country and we could see if insurance companies would be interested in contracting with us. • La Porte census is at 17. We have a meeting scheduled with the CEO of La Porte Hospital to discuss a GIP contract, the capital campaign, and our La Porte office. The ground has not been broken yet for our new location down the street. • Physician recruitment – We have had more interest in positions than we have ever had. We did extend an offer to a doctor that works for Seasons Hospice in the	

Topic	Discussion	Action
	Chicago area. • The 2018 audit is on the agenda. Congratulations to Karl Holderman and his team for a clean audit. No changes were made to the financial statements presented at the February Board meeting. • MADS is doing great and their census hit 31—the highest ever. • Edo Banach, the President/CEO of NHPCO and the Hospice Action Network will be here July 17-18. We will have a reception for him on July 17 and he will give a presentation at an all staff meeting on July 18. We will be inviting area health care leaders to the reception. • A list of upcoming events Board members will be invited to is in the packet. • Another for-profit competitor has opened an office in Roseland. They have a provisionary Indiana hospice license. • Mark M. attended the NHERT meeting in Arkansas last week. One of the items discussed was strategic plans and we shared each other's plans. Some do a one year plan and others do three or five years. Ours ends this year and we will be discussing what we will be doing in the future. We do come up with goals every year and share those with the board. Perhaps those should be our annual strategic plans. • Lou Behre passed away a few weeks ago. For over 20 years he was the orchestrator of the Helping Hands Award Dinner. We often hear people say it is one of the best events in the community. He had 17 not-for-profits he was helping in the community in a variety of ways.	
7. Finance Committee	• The Finance Committee met 05/11 and reviewed the 2017 audit. We received an unmodified opinion, which is the highest possible. There were no material weaknesses, deficiencies or adjustments. It was a clean audit. The auditors gave a couple of best practices recommendations. One was in regard to wire transfers involving GPIC that a second person should review the transfers. Mark will start doing that. The other recommendation was how we account for the relationship between CHC and the Hospice Foundation (HF). From an accounting standpoint over the years there has been an increase in the amount due from CHC to the HF. This is purely an accounting item. The auditors said as that number grows it might become a source of concern for future entities, so we should consider on paper having the HF charge rent to CHC as a means of countering that. We will look at	

Topic	Discussion	Action
	rent as part of the 2019 budget process and may do some other things prior to that to eliminate that in the financial presentation going forward this year. As we look at individual silos it shows up, but as we look at consolidated financials those transactions are all eliminated. • A motion was made to accept the 2017 audit as presented. The motion was accepted unanimously. • The Finance Committee also reviewed the financial statements for 2018 YTD through April. Seeing three months at a time instead of month to month gives us a more seamless analysis of the financials. In response to a question from the board, we have added increased analysis on how we are doing compared to the budget. April YTD operating income $7.2M, total revenue $6.8M, total expenses $6.4M, net gain $368,000, net without beneficial interest in Affiliates $963,000. Compared to the prior year and budget, revenue is above budget and the prior year. Expenses are under budget and slightly over the prior year. The bottom line of the organization is influenced by our investments. Investments are something we factor out when we look at the financial performance of the organization every month. We just focus on income and expenses and make sure those numbers compare to the budget and the prior year, and that we are heading in the right direction. We are on track with where we were last year. We are about $10,000 ahead of where we were a year ago. Without the beneficial interest in affiliates we are about $24,000 ahead of a year ago. • A motion was made to accept the YTD April 2018 financial statements as presented. The motion was accepted unanimously.	S. Weirick motioned T. Portolese seconded C. Walker motioned M. Newbold seconded
8. Hospice Foundation Update	• The Capital Campaign has raised over $10.6M through May. 13½ months remain in the campaign. We do have a couple of under-funded priorities. We need an additional $1.5M for Raclin House. The other is we need $850,000 to meet the $1M match from the Vera Z. Dwyer Trust to establish a Fellow in Hospice and Palliative Medicine endowment. There is a five year time frame from the time the commitment was made, which was December 2016 or January 2017, to achieve the match. This is not an area we have focused on until now. The 2018 Friends of Hospice campaign will focus on raising money for that initiative. • Construction – Progress is being made on the Mishawaka campus and construction is going well. We are planning a ground breaking ceremony for Raclin House on	

Topic	Discussion	Action
	06/12. • A schedule of upcoming events the Board will be invited to is in the board packet. • Rose Kiwanuka and two PCAU staff will be here in July for a couple of weeks. The Board will be invited to opportunities to visit with them. Okuyamba Fest will be 07/31 and we're celebrating our ten years of partnership with PCAU.	
9. Board Education	• Joshua Gregory, IT Director, reviewed CHC's electronic data: connectivity, security, redundancy, and recovery. We have been doing point of care technology for several years. We have three IT staff providing 24/7 coverage. Josh reviewed the backup strategies and security measures we have in place. We have taken every reasonable precaution to prevent hacking.	
Adjournment	• The meeting adjourned at 8:15 a.m.	Next meeting 08/15

Prepared by Becky Kizer for approval by the Board of Directors on 08/15/2018.

_______________________________________ _______________________________________

Carol Walker, Secretary   Becky Kizer, Recording Secretary

PURPOSE: To insure the patient or legal representative will be informed of the type of care or services that will be provided.

POLICY: Informed consent for care is obtained from the patient or designated representative and documented in the medical record.

PROCEDURE:

1. Prior to admission, all patients are given a complete description of the palliative nature of care and the services provided by the Agency.
2. All patients and/or their legal representative(s) are required to acknowledge that they have been given a complete understanding of the services to be provided by the Agency.
3. Patients and/or their legal representative(s) are informed of the eligibility requirements for services, and that the goal of care is directed toward relief of symptoms rather than the cure of the underlying disease.
4. A signed "General Consent and Release of Information" form serves as confirmation of informed consent and is obtained from each patient and included in the patient's medical record.
5. Care is not provided unless and until a signed "General Consent and Release of Information" and applicable election forms are received.
6. If an individual adult incapable of consenting has not appointed a health care representative, or the health care representative is not *reasonably* available or declines to act, consent to health care may be given in the following order of priority:
   (a) A judicially appointed guardian of the person
   (b) Spouse
   (c) Adult Child
   (d) Parent
   (e) Adult Sibling
   (f) Grandparent
   (g) Adult Grandchild
   (h) Nearest relative in next degree of kinship
   (i) Friend who:
      (1) Is an adult
      (2) Has maintained regular contact with the individual, and
      (3) Is familiar with the individual's activities, health and religious or moral beliefs

(j) The individual's religious superior if the individual is a member of a religious order
When there is more than one member of a voting group, they must try and reach a consensus of what should be done. If they disagree; majority rules.

7. The following cannot make healthcare decisions:
   (a) A spouse when there is a legal separation or the spouse is the reason you are in the hospital.
   (b) A person who is subjected to a protective order involving the individual.
   (c) A person who is subjected to pending criminal charges involving the individual.
   (d) A person the individual intentionally excluded when the advance directive was signed.

8. If a patient has been adjudged incompetent, the person appointed pursuant to state law to act on the patient's behalf signs the form.

9. If questions, refer to the Decision Trees on the staff website under Files.

10. Regular medical record audits ensure that the "General Consent and Release of Information" and election form has been signed and received from every patient prior to the start of care.

REGULATION: 42 CFR 418.106 – Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment
Indiana State Department of Environmental Management
Drug Enforcement Agency (DEA)

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

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

Medications are the property of the patient and are not the property of the Agency. Agency nurses may only educate the POA/Responsible Party on proper handling and disposal of medications. Agency staff shall not perform medication destruction and disposal.

Education regarding proper medication disposal will be documented in the medical record by Agency staff in compliance with state and federal requirements.

On admission, the POA/Responsible Party will be given printed instructions on proper drug disposal methods, as well as locations of authorized collection receptacles.

PROCEDURE:

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

2. Medications, scheduled, unscheduled or over the counter **will not** be removed from the home under any circumstance by Agency staff. The patient's POA/Responsible Party takes control of the disposal of medication.

3. **Assist/**instruct the POA/Responsible Party on how to perform the following for proper medication disposal:
   a. Remove the medications from their original containers and mix them with water and an undesirable substance such as used coffee grounds or kitty litter. The medication will be less appealing to children and pets, and unrecognizable to people who intentionally may go through your trash.

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

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

d. Educate on community medication take-back programs that allow the public to bring unused medications to a central location for proper disposal. Call your city or county government or household trash and recycling service to determine when take-back programs are available. Many states including Indiana no longer recommend flushing medications.

4. INPATIENT UNIT: When any medications are disposed of in Inpatient Unit (IPU), they will be disposed of with the witness of two ~~staff members~~registered nurses or a registered nurse and LPN. If the IPU is closing, the medications will be locked in the EDK cupboard and an email will be sent to the nurse leadership on call so the medications can be counted and disposed of on the next business day if the IPU remains closed. The Medication/Disposal form will be completed and made available to QA to scan into the EMR.

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

6. INFUSION CASSETTES: Drain the cassette into an undesirable substance such as kitty litter or used coffee grounds. Remove the labels from the cassette or completely mark through patient identification information. Dispose of in a trash receptacle.

7. The Agency will comply with the DEA and adjust the policy as required to ensure total compliance with state and federal regulations. Failure to comply with this policy may result in disciplinary action.

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

ATTACHMENT: Inpatient Unit Medication Disposal Form

Effective Date: 01/97	Revised Date: 07/18~~01/17~~	Board Approved: 02/15/17
Reviewed Date: 05/16		Signature Date: 02/15/17

REGULATION: 42 CFR 418.112 – Hospices that provide hospice care to residents of a SNF/NF or ICF/MR.

PURPOSE: To identify essential Hospice records and communication elements in SNF/NF or ICF/MR—Extended Care Facilities (ECF) and outline Hospice staff responsibility for maintaining proper record keeping in ECF charts.

POLICY: The Hospice patient's ECF chart will contain the Interdisciplinary Plan of Care reflecting the current medical status and all required Medicare and Medicaid records.

PROCEDURE:

1 The admitting nurse will:
- Establish individual ECF preferences of notification of Hospice services
- Initiate the first plans of care
- Set up the Hospice Chart, either within the ECF chart with a divider section or a CHC binder (ECF preference), including any identifying dividers and chart insignias

2. Hospice documents placed in the ECF chart by the admitting nurse include:
- Copies of the Admission Consent, Notice of Election, DNR from ECF(if applicable), COTI indicating verbal certification and copy of IDT note indicating patient qualifies for Hospice services

3. Case Manager will:
- Initiate the Interdisciplinary Team sheet
- Update the plan of care and communicate with ECF staff care plan changes(if applicable) at every visit

4. The social worker will:
- Ensure that Advance Directives in the ECF chart
- Monitor the DNR status of the patient
- Keep the Social Work plan of care in the facility current and reflective of the status of the patient and family

5. The chaplain will keep the plan of care in the facility current and reflective of the status of the patient and family

6. For duel enrolled Medicare/Medicaid patients, CHC QA personnel will coordinate with Billing monthly to ensure copies of election forms are present in the ECF

7. CHC QA personnel will conduct ECF chart review monthly and coordinate with ECF medical records staff as needed to ensure that all necessary Hospice documents are present in the ECF chart

REGULATION: 42 CFR 418.54 – Initial and comprehensive assessment of the patient
42 CFR 418.106 – Drugs and biologicals, medical supplies, and durable medical equipment

PURPOSE: To ensure the safe management of all medications and biologicals related to the care of the hospice patient.

POLICY: All medications and biologicals will be ordered by a physician or nurse practitioner in accordance with the patient's plan of care. These medications and biologicals will be reviewed by a licensed pharmacist through contracted pharmacy for drug to drug interactions, drug-disease state contraindications, drug-allergy interactions, therapeutic duplication, drug therapy associated with laboratory testing, clinical abuse/misuse and appropriateness of drug, dose and duration of treatment.

PROCEDURE:

1. The registered nurse will obtain a verbal or written order for all medications, oxygen, and biologicals, both related and unrelated to the terminal diagnosis. A verbal order will be entered into Cerner by the registered nurse receiving the verbal order, and sent to the physician for his/her signature.
2. All medications and biological orders will be profiled with the contracted pharmacist.
3. The contracted pharmacist will review both dispensed and profiled medications upon admission of the patient and each time a medication is added to the profile.
4. This medication review occurs for all dispensing models, both mail order from the contracted pharmacy, and those dispensed from a local pharmacy.
5. Each time a medication is changed or added, the entire profile is reviewed for drug to drug interactions, drug-disease state contraindications, drug-allergy interactions, therapeutic duplication, drug therapy associated with laboratory testing, clinical abuse/misuse and appropriateness of drug, dose and duration of treatment.
6. The most recent medication profile review for each patient will be documented on the Active Medication Record in the contracted pharmacy database and corresponds to the start date of the most recent medication change.

Effective Date: 03/13	Revised Date: 07/18	Board Approved: 04/17/13
Reviewed Date: 05/16		Signature Date: 04/17/13

Signature: President/CEO

Center for Hospice Care

INPATIENT UNIT – MANAGING DRUGS AND BIOLOGICALS

Section: Patient Care Policies   Category: Hospice

REGULATION: 42 CFR 418.54 – Initial and comprehensive assessment of the patient
42 CFR 418.106 – Drugs and biologicals, medical supplies, and durable medical equipment

PURPOSE: To ensure the safe management of all medications and biologicals related to the care of the hospice patient residing in Inpatient Unit.

POLICY: All medications and biologicals will be ordered by a physician or nurse practitioner in accordance with the patient's plan of care. These medications and biologicals will be reviewed by a licensed pharmacist through contracted Pharmacy for drug to drug interactions, drug-disease state contraindications, drug-allergy interactions, therapeutic duplication, drug therapy associated with laboratory testing, clinical abuse/misuse and appropriateness of drug, dose and duration of treatment.

PROCEDURE:

1. The registered nurse will obtain a verbal or written order for all medications, oxygen, and Biologicals, both related and unrelated to the terminal diagnosis. A verbal order will be entered into Cerner by the registered nurse receiving the verbal order and print to the Medication Administration Record (MAR) checked.

2. All medications and biological orders are to be faxed to contracted pharmacy. Orders (either covered or non-covered) will be identified. The contracted pharmacy will profile all orders, but only send the medications requested.

4. The contracted pharmacist will review both dispensed and profiled medications upon admission of the patient and each time a medication is added to the profile.

5. This medication review occurs for all dispensing models, both mail order from contracted pharmacy and those dispensed from a local pharmacy.

6. Each time a medication is changed or added, the entire profile is reviewed for drug to drug interactions, drug-disease state contraindications, drug-allergy interactions, therapeutic duplication, drug therapy associated with laboratory testing, clinical abuse/misuse and appropriateness of drug, dose and duration of treatment.

7. The most recent medication profile review for each patient will be documented on the Active Medication Record in the contracted pharmacy database and corresponds to the start date of the most recent medication change.

Effective Date: 12/08	Revised Date: 07/18 ~~05/16~~	Board Approved: 10/19/16
Reviewed Date: 09/14		Signature Date: 10/19/16

Signature: President/CEO

PURPOSE: To establish an agency protocol when notified of a patient's death that supports the family/caregiver's psychosocial and spiritual needs.

POLICY: Agency staff will go to the patient's location to offer support and assist the caregiver in taking care of the final details following the death. In the state of Indiana, in the case of expected and attended death, it is not necessary for the physician to pronounce death. The death certificate is signed by the attending physician (the person responsible for the patient's care); the mortuary arranges for this signature.

PROCEDURE:

1. Upon notification of the death, advise the caller that a staff person will be in route to the residence of the patient.

2. If the patient was at a facility, CHC staff will go to that facility and work with the Extended Care Facility (ECF) staff to coordinate efforts to follow the routine for a death of a patient in their facility.

3. Contact the patient's attending physician and inform him/her of the patient's death and determine who is to sign the death certificate.

4. Ask the primary caregiver if there are any other physicians they would like notified.

5. Prepare the patient's body for transfer by removing catheters, bathing, redressing, etc. If patient resides in an ECF, only the nurse may do the above.

6. Check patient for personal affects (rings, watches, etc.) and document items and recipients of said items.

7. If patient has implanted pump, call their physician so it can be shut off.

8. If patient has defibrillator, take magnet to deactivate. We must have a physician's order prior to this procedure. Return the magnet to the office and clean per protocol. Location of magnet: South Bend—triage desk, Plymouth—nurses' room, Elkhart—chart/documentation room and the nurse's station in Inpatient Unit.

9. Assess whether the family or other appropriate caregivers wish to be a part in any way in the post mortem care.

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 Inpatient Unit (IPU) patients: Place wristband on the patient with patient's name and date of birth written on it. When the funeral home arrives, the funeral home director should verify they are the correct funeral home and verify the correct patient name 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.

Center for Hospice Care
QI Committee Meeting Minutes
May 22, 2018

Members Present:	Alice Wolff, Amber Jay, Anna Milligan, Carol Walker, Carrie Healy, Chrissy Madlem, Craig Harrell, Dave Haley, Deb Daus, Greg Gifford, Holly Farmer, Karen Hudson, Larry Rice, Mark Murray, Rebecca Fear, Sue Morgan, Tammy Huyvaert, Terri Lawton, Terri Smith, Tonia Batiste, Becky Kizer
Absent:	Jennifer Ewing, Lisa Bryan

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m. • Welcome to new members Tonia Batiste, Elkhart Inpatient Unit Coordinator, and Chrissy Madlem, South Bend Patient Care Coordinator.	
2. Minutes	• The minutes of the 02/27/18 meeting were approved by consensus.	
3. Hospice HQRP Reports	• HIS Comprehensive Pain Assessment at Admission – The Hospice Compare Website – This is publically reported information that is comprised of data from the CAHPS Hospice Survey and the Hospice Item Set (HIS). The HIS data is collected at the time of admission. Our lowest score was patients who got a timely and thorough pain assessment when pain was identified as a problem. In July 2016 our score was 54.2%. We found out we were collecting and recording the data incorrectly, so we implemented changes. Nurses were educated that they needed to capture at least five of the seven pain assessment elements. In June 2017 our score improved to 62.5% and in April 2018 we were at 100%. We don't know how frequently CMS updates the data, so it will take a while for the numbers to reflect what is going on currently. We now do a triple check of the data before it is submitted, and we monitor it monthly. Rebecca meets with the QA RN weekly to make sure the information is being submitted timely and accurately. • CAHPS Questions – The agency coordinators review the quarterly top box scores and look at any areas that fall below the 80th percentile. Overall our top box scores have been consistent. We did identify three areas we want to focus on: (1) getting help with symptoms, (2) understanding side effects, and (3) getting hospice care training. We put a QAPI team together to work on improving education for patients and families on medication side effects, and also the role of the IDT in helping patients identify and get	

Topic	Discussion	Action
	help for anxiety and sadness. Its first planning meeting is 06/07. • HIS Visits at the End of Life – The newest HIS measures are for the number of hospice visits when death is imminent. The first measure is there should be at least one visit from an RN, physician, nurse practitioner, or physician assistant should be made in the last three days of life. The second measure is there should be at least two visits should be made by a social worker, chaplain, LPN, or Hospice Aide in the last seven days of life. The QAPI reviewed how staff communicates with each other that a patient has had a significant decline. We established best practices and created a Final Bridge email alert that the nurse will send to care staff to notify them that a patient is approaching the end of life. All the coordinators will receive the email so they can track whether staff has contacted the patient or not. We also document if the family declines a visit. We started the Final Bridge email on 05/01, but we still need to educate the care teams. Final Bridge is internal term only. We anticipate these conversations with the family occurring before the patient is imminently dying including in the IDT. 49% of patients died within seven days or less in April, so we will change the PPS score to 30 instead of 20 to make sure we are getting those patients.	
4. Hospice Quality Monitoring	• Education and Training – We want staff to feel competent in what they do, so we did a lot of education and training in the first quarter of 2018. This included self-learning packets for nurses on falls and incident reports, patient rights, Pediatric ELNEC training, dementia and patient centered care, and creative approaches to bereavement. In 2018 we began to provide CE credits through the Ohio Nursing Association. Rebecca F. can present course work for CEs. The first was presented in February on "Quality Analysis: Organizing teams and projects." The next one will be 05/30. Rebecca is writing a cardiopulmonary boot camp for six CEs. We continue to provide Pediatric ELNEC and will write for CEs for that as well. • HIM Committee Updates – Some of the responsibilities of the committee includes overseeing the audit of medical records, approval of clinical forms, updating profiles in Cerner, etc. We are in the process of updating supervisory visits/electronic profiles in Cerner. We are in the final stages of creating an admission/comprehensive assessment profile in Cerner. We will pilot it in La Porte. We will be looking at revocations and live discharges in June. We continue to work on the Partners in Care project for documentation and communication in ECFs. Carol W. recommended the CAPC website as another resource. It has 14 different topics under their pain module.	

Topic	Discussion	Action
	• Infection Control – At the last meeting we approved the activities for 2018. We did annual TB skin testing for staff with 100% compliance. We had a bad flu season and tracked staff, but there were no outbreak patterns. We continue to monitor and track patients with MDROs, especially where they come from. • Mock Surveys – We are still waiting for our hospice survey, and we are due for a home health survey later this year. We have a lot of new staff and coordinators, so we will be doing some more mock surveys as a refresher especially in the Inpatient Units. Infection control is an important part of the survey. We will also remind staff to inspect their car trunk supplies.	
5. Hospice Patient Safety Monitors	• Incident Trends – We did education in January on falls and filling out the incident reports correctly and timely. This year we will be concentrating on documentation in the IDT when a patient falls, updating the care plan, and implementing appropriate interventions to prevent future falls. We will be separating the reports for falls, medication errors, and adverse events by hospice and home health. We will have six months of data to report at the August meeting. • We are also working on revamping all of our care plans to make them more user friendly and easier to individualize for the patient. This will include the use of DME or safety measures to prevent falls. We will also include Emergency Preparedness and safety measures for patients in the home. The care plans will also include measurable outcomes.	
6. Hospice Quality Indicators	• Chaplains – We continue to monito the quality indicators we developed last year. We also continue to measure the effectiveness of the Spiritual Comfort Measure and the Spiritual Health Assessment for patients and their caregivers. We will develop an education plan for staff regarding the role of the chaplain. There are other things the chaplain can do, especially for non-faith affiliated patients. • Social Work – We are exploring ways to identify when caregivers are in distress so we can anticipate their need for respite and problems related to caregiving. The social workers have a folder of materials and resources we share with families. The social workers will complete three Veteran trainings to meet the standards of the We Honor Veterans Level 4 guidelines, and incorporate the completion of military checklist forms. Social workers will receive pediatric training. We are also exploring providing monthly bereavement support time for staff in collaboration with the chaplains and	

Topic	Discussion	Action
	nurses. • GIP Documentation – Documentation should clearly justify the patient's need for GIP level of care. We need to document what we are doing, how often, whether it is working, and the patient's response to the interventions. Amber J. has trained her Inpatient Unit nurses on GIP documentation including what they should not document. For example, they should document the patient is comfortable and resting because of the interventions we have done. Education will include GIP in the hospital. We have designated staffs that visit these patients in the hospitals.	
7. Home Health QAPI Programs	• We are still waiting for the new Home Health CoPs interpretive guidelines. We did create a Home Health Family Handbook. We have new regulations of how to do the annual Aide site competency evaluation. New documentation templates will be coming soon. We continue to educate staff to help them understand the different regulation requirements between home health and hospice so they document the correct language that meets those regulations. • Over a year ago CMS did a probe and educate audit. Out of that came changes for home health agencies nationwide. One includes the Face to Face visit requirement by a physician with the reason for ordering home health services. A copy of this visit must be in the agency records. The reason for skilled services must be clearly outlined. The patient's homebound status is also required for Medicare home health. We did an internal audit and found we needed to improve our communication with the referring and attending physicians. • A lot of the home health requirements are time sensitive. When we receive an order for home health, we have 30 days to get the Face to Face visit in place, document it, document the homebound status, and upload it to the chart. The OASIS is sent for signature. Deb D. did an audit from February 2017 to February 2018. We admitted 109 home health patients. All criteria was met and uploaded into the charts and nothing was missing. We have implemented simple documentation tools that spell out what staff needs to do and when. We updated the internal home health guidelines with the new CoPs so all of the referral specialists know what needs to be done. Deb D. is the point person for this. A lot of phone calls and things need to be done for home health, so it is easier for one person to do that. • We are also monitoring how many home health patients switch to hospice. We get a lot of referrals from Michiana Hematology Oncology (MHO) and that is their express	

Topic	Discussion	Action
	wish—to ease the patient into hospice. Some of the reasons a patient was not admitted into hospice are they went back to baseline and no longer needed home health and were continuing treatments. We also researching live discharges. We will follow up on all live discharge a couple of weeks after discharge and then monthly as a wellness check. Some of the MHO patients are nearing the end of treatment and the patient and family just refuse hospice—they don't want to let go. So we need to provide further education with our case managers on having that discussion with families. It has to do with the family's grieving cycle. As long as a doctor offers new treatments, they will try it. The doctors are being honest, but the patients and families are in denial. • The social workers need to get in there and have those conversations with the patient and family too. They can do early bereavement discussion. The IDT can evaluate if the patient is ready to switch to hospice. We should tell the patient/family that their needs would be better met if they were in hospice. Having the case manager instead of the admission nurse do the change in program from home health to hospice has helped, because it gives consistency for the patient and family and eases the transition.	
Adjournment	• The meeting adjourned at 9:00 a.m.	Next meeting 08/28

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
August 15, 2018

(*Report posted to Secure Board Website on August 9, 2018)*

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:15 AM. This report includes event information from May 17 – August 15, 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

CHC's census continues to get stronger. Overall, July year-to-date (YTD) referrals are up 1.3% from the same time a year ago. Original admissions, new patients to us in this calendar year, are up 1.08% from a year ago. The YTD July conversion rate, turning a referral into an admission, is down slightly at 71.84% from 72.89% on 2017. However, anything above 70% is considered optimum. This is good news even with the unfortunate data that the YTD July percentage of patients dying before admission is up to 7.02% from 6.62% last year. This is due to ongoing very late referrals and families refusing to accept hospice care until after it's too late. Compared to a year ago, the total number of patients served is down 0.50% (just seven patients). YTD deaths / discharges of new admissions in seven days or less following admission is 41.3% down from 43.7% a year ago, however still above the national average which runs about 28%. Our one-day census high for the first seven months of this year was 419 on 7/2. Additional good news in that YTD July 2018 revocations = 44, down from 53 a year ago. Revocations are when a patient revokes the Medicare hospice benefit and goes back to regular Medicare frequently to seek curative treatment outside of the hospice care plan or when a family caregiver panics and calls 9-1-1, goes to the ER, and gets admitted to the hospital for curative treatment. At the end of July, we are currently above budget on the number of patients served and our insurance patient case mix is much better than a year ago with per diem hospice patients up 16% and home health patients down 14%. Our overall year-to-date average daily census is 396, well above our budgeted breakeven of 383.

July 2018	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Patients Served	517	1,396	1,403	-0.50%
Original Admissions	133	1,028	1,017	1.08%
ADC Hospice	394.87	378.76	363.04	4.33%
ADC Home Health	15.23	16.88	31.09	-45.71%
ADC CHC Total	410.10	395.64	394.13	0.38%

CHC HOSPICE INPATIENT UNITS

July 2018	Current Month	Year to Date	Prior Year to Date	Percent Change
SB House Pts Served	38	216	224	-3.57%
SB House ALOS	5.29	5.13	4.99	2.81%
SB House Occupancy	92.63%	74.60%	75.27%	-0.89%
Elk House Pts Served	26	181	186	-2.69%
Elk House ALOS	4.42	4.49	4.51	-0.44%
Elk House Occupancy	53.00%	54.72%	56.54%	-3.22%

MONTHLY AVERAGE DAILY CENSUS BY OFFICE AND INPATIENT UNITS

	2018 Jan	2018 Feb	2018 Mar	2018 Apr	2018 May	2018 June	2018 July	2018 Aug	2018 Sept	2017 Oct	2017 Nov	2017 Dec
S.B.:	223	217	202	191	195	204	215			215	216	221
Ply:	71	76	77	82	89	92	89			69	73	72
Elk:	77	85	96	91	93	90	81			78	77	79
Lap:			12	15	16	16	15					
SBH:	5	54	6	4	4	5	6			5	4	4
EKH:	4	4	4	4	4	4	4			4	4	4
Total:	380	387	392	387	402	411	410			371	373	380

PATIENTS IN FACILITIES

Of the 517 patients served in July 2018, 148 resided in facilities. The average daily census of patients served in nursing homes, assisted living facilities and group homes in July 2018 was 130 and year-to-date was 127.

FINANCES

Karl Holderman, CFO, reports the year-to-date July 2018 Financials will be posted to the Board website on Friday morning, August 10th following Finance Committee approval. For information purposes, the unapproved, year-to-date June 2018 financials, including a year-to-date summary are presented on the next page. On 6/30/18, at the HF, intermediate investments totaled $4,494.801.

Long term investments totaled $19,756,180. The combined total assets of all organizations on June 30, 2018 totaled nearly $51MM on 6/30/18 an increase of just over $3MM from June 2017. Year-to-date investments showed a loss of -$51,421. From a budget standpoint, we are over budget on operating revenue and under budget on expenses.

It should also be noted at the board meeting we will be concentrating only on year-to-date July 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 June 2018

June 2018 Year to Date Summary	**Center for Hospice Care**	**Hospice Foundation**	**GPIC**	**Combined**
CHC Operating Income	11,038,631			**11,038,631**
MADS Revenue	243,509			**243,509**
Development Income		587,460		**587,460**
Partnership Grants			205,265	**205,265**
Investment Income (Net)		116,325		**116,325**
Interest & Other	18,035	41,097	7,141	**66,273**
Beneficial Interest in Affiliate	(495,895)	(18,028)		
Total Revenue	**10,804,280**	**726,854**	**212,406**	**12,257,463**
Total Expenses	**9,839,296**	**1,222,749**	**230,434**	**11,292,479**
Net Gain	**964,984**	**(495,895)**	**(18,028)**	**964,984**
Net w/o Beneficial Interest	*1,460,879*	*(477,867)*		
Net w/o Investments				***848,659***

CHC NEEDS TO SUBMIT RFP'S FOR A NEW AUDIT FIRM

We were notified a couple weeks ago that our lead auditor, Craig Yahne, is no longer with David Culp and Co., LLP, our auditor firm for CHC, HF, and GPIC. They also prepare and file our IRS non-profit tax returns and perform our 403(b) audits of our tax-sheltered annuity retirement plan. Following the next IRS Form 990 preparation and 403(b) audit, the managing partner has said they will need to resign from the account due to no longer having the expertise or staff to handle CHC/HF/GPIC. This issue will be an agenda item for the Finance Committee at their meeting on

August 10. The Finance Committee selects the audit firm, meets with them in-person annually at an extended meeting, accepts the audit, and recommends it for acceptance by the full board. Culp has been our audit firm since 2011.

CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

The total Optum drug cost per patient day for the first five months of 2017 was $5.91 per patient day. This has been reduced to $4.63 per patient day for the first five months of 2018. This represents a 22% reduction in the Optum drug cost per patient day in one year. This reduction in cost is largely due to Dr. Gregory Gifford's efforts to be a responsible steward of drug expenses and his leadership in this area with the rest of the medical staff. The account executives at Optum are amazed at our progress and have indicated we are probably in their top four national client performers on this metric. And obviously this occurred as drug prices increased over the year. As a further comparison, during the first six months of 2015, our Enclara (former pharmacy vendor) total drug cost was $8.44 per patient day.

A physician applicant, Karissa Misner, D.O., M.P.T. visited us on June 13th. She is scheduled to start a Fellowship in Hospice and Palliative Medicine in Macon, Georgia this month and has accepted our employment offer and agreed to join us fulltime in September of 2019. Her father grew up in Bremen and she has relatives in Plymouth. Her husband is a pediatrician interested in obtaining a PhD in Theology at the University of Notre Dame. He is a big ND fan. He has just secured a part-time position at a clinic in Granger. Both doctors have spent two years in Peru doing missionary work, are very interested in Global Partners in Care, and speak fluent Spanish. They have three children.

Riddhi Shirlka, M.D., a Hospice and Palliative Medicine Fellow from Indiana University School of Medicine in Indianapolis, will be rotating through our agency from August 20 to 24.

We continue interviewing other possible physician candidates to fill the second physician position we have open.

The South Bend campus was surveyed by the Fire Marshall in July and we have no outstanding recommendations.

We participated in a community-wide disaster drill on July 26. The disaster scenario was a biological attack.

Carrie Healy, MSW, our Social Work Coordinator, resigned with an effective date of August 10. She is moving to Chicago to be closer to her daughter. Her replacement is being recruited. She also has the flexibility to stay at CHC longer than 8/10.

DIRECTOR OF NURSING UPDATE

Sue Morgan, DON, reports…

The Nursing Goals for 2018 are reviewed and progress is updated monthly at the Nursing Leadership Meeting.

Students from Saint Mary's College, Indiana University of South Bend and Bethel College will begin their clinical rotations for their Junior Nursing Clinical Rotation in August.

The Clinical Staff Educator has developed a program to assist the RN's in preparation for their nursing certification examination in hospice and palliative medicine. Study groups will meet monthly.

Quality Improvement Summary so far for 2018 includes:

- Medication orders—new tracking and notifications to the nurses and PCC's
- Care Planning Monitors
- Supervisory Visits—monitoring by Patient Care Coordinators with individual Plans of Care
- Live Discharge data review
- Specialty Programs (HeartWize, BreatheEazy, etc.) data review
- Extended care facility documentation and patient chart set up
- Hospice Information Set measures: Interdisciplinary visits the last two weeks of life

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

Year to Date Cumulative Monthly Revenue

	2013	2014	2015	2016	2017	2018
January	83,619.96	51,685.37	82,400.05	65,460.71	46,552.99	37,015.96
February	166,563.17	109,724.36	150,006.82	101,643.17	199,939.17	93,912.90
March	264,625.29	176,641,04	257,463.89	178,212.01	282,326.61	220,485.17
April	395,299.97	356,772.11	419,610.76	341,637.10	431,871.55	310,093.61
May	446,125.49	427,057.81	635,004.26	579,888.08	574,854.27	505,075.65
June	534,757.61	592,962.68	794,780.62	710,175.32	1,066,118.11	633,102.69
July	604,696.88	679,253.96	956,351.88	1,072,579.84	1,277,609.56	767,397.15
August	783,993.15	757,627.43	1,042,958.42	1,205,050.76	1,346,219.26	
September	864,352.82	935,826.45	1,267,659.12	1,297.009.78	1,466,460.27	
October	922,261.84	1,332,007.18	1,321,352.39	1,421,110.26	1,593,668.39	

November	969,395.17	1,376,246.01	1,469,386.01	1,494,702.09	2,443,869.12
December	1,185,322.83	1,665,645.96	1,757,042.51	2,018,630.54	2,730,551.86

Year to Date Monthly Revenue
(less major campaigns, bequests and significant one-time major gifts)

	2013	2014	2015	2016	2017	2018
January	83,380.18	51,685.37	57,971.60	52,156.98	31,552.99	37,015.96
February	82,943.21	43,038.99	67,572.77	36,182.46	35,125.58	56,896.94
March	98,212.12	66,916.68	107,457.07	73,667.84	79,387.44	113,969.42
April	130,674.68	180,156.07	162,146.87	163,425.09	149,569.94	87,978.18
May	40,825.52	100,285.70	160,178.34	93,318.98	142,982.72	182,601.92
June	65,815.51	97,258.66	159,776.36	127,315.24	146,200.17	46,947.92
July	69,939.27	38,243.88	93,586.27	52,394.52	61,505.45	64,243.53
August	92,732.69	79,015.87	86,606.54	97,470.92	63,593.03	
September	80,335.67	84,011.71	99,931.45	92,459.02	120,261.01	
October	56,439.02	55,208.68	53,693.27	71,323.54	127,208.12	
November	47,133.33	44,238.83	46,870.62	66,490.16	75,809.56	
December	130,277.99	193,065.45	161,519.80	138,328.11	286,687.74	
Total	**978,709.19**	**1,033,125.99**	**1,257,310.96**	**1,064,532.86**	**1,319,883.75**	**589,653.87**

Cornerstones for Living: The Crossroads Campaign

Campaign-related work in May, June and July 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 enter the final year of our comprehensive five-year $10 million campaign (7/1/14 thru 7/31/18) cash, pledges and documented bequests now total $11,001,493. We continue to remain intently focused on securing additional funding for two underfunded priorities, which include an additional approximately $1.5 million for the Ernestine M. Raclin House and $610,000 to match the $1 million challenge grant to fully endow the Vera Z. Dwyer Fellowship in Hospice & Palliative Medicine.

On May 16, Mike Wargo, Chris Taelman, board member Tim Portolese, and I made a presentation to the Key Initiatives Committee of the Community Foundation of Elkhart County. Our request for a $500,000 grant for the new inpatient unit was not among the projects selected for funding. It has been reported to us that the committee provided a total of approximately $600,000 in funding spread across three non-profits for projects that are based specifically within the boundaries of Elkhart County. We have, however, been encouraged to apply once again. The application process has changed, and we are moving forward based upon these new parameters.

Other activity included a campaign presentation to Bipin and Linda Doshi. Because of our meeting and a CHC Mishawaka Campus tour, the Doshi's made a pledge of $100,000 directed toward the Dwyer match. We continue to cultivate the Healthcare Foundation of La Porte and the Unity Foundation of La Porte as donors and we've attended meetings and events to elevate our presence and profile in LaPorte County.

Planned Giving

Estate gifts received since the previous board meeting totaled $11,000. We continue to receive requests from financial advisors and attorneys requesting information about planned giving and bequests.

Annual Giving

Our Friends of Hospice Appeal, which began late May and will continue through November, is focused on funding for the Vera Z. Dwyer Fellowship match.

Special Events & Projects

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

On June 5, we held our annual Gardens of Remembrance and Renewal event in Elkhart with approximately 70 people in attendance, the most in recent memory.

On June 12, we held our official groundbreaking ceremony for the Ernestine M. Raclin House, the new inpatient care facility on our Mishawaka Campus. The event was attended by approximately 100 donors, friends and dignitaries.

This year's Okuyamba Fest, celebrating the 10th anniversary of the CHC/PCAU partnership, was held on July 31 with 175 attendees, and included a special performance by the South Bend-based African-style dance team "Uzima." Nearly all silent auction items sold, and we secured two new Road to Hope child sponsors.

We have several other events planned for this year because of several anniversaries to celebrate. Events include celebrations around the 25th anniversary of Camp Evergreen (8/9) and the 10th anniversary of the Elkhart Campus (8/16). We also will be holding a combined Bike and Walk event on our Mishawaka Campus on 9/23. Finally, for 2018, we will have the Veterans Tribute Ceremony on 10/16, where we will rededicate the memorial as the Robert J. Hiler, Jr. Veterans Memorial.

Palliative Care Association of Uganda Partnership

Rose Kiwanuka (Country Director), Mark Mwesiga (Programs Manager) and Cynthia Kabagambe (IT Specialist) visited CHC in late-July/early-August. In addition to celebrating the 10th anniversary of our partnership, the team has also been engaged in a number of partnership activities, including: staff meeting presentation and update on PCAU's activities at a CHC staff meeting on August 8; mHealth training for Mark and Cynthia with multiple collaborators at the University of Notre Dame; an mHealth presentation on August 6th at ND to update departments and centers who

have worked with PCAU/CHC/HF on mHealth initiatives and/or internships over the past several years; meeting with representatives from the Vera Z. Dwyer College of Health Sciences at IU South Bend; meetings with CHC staff at the Roseland, Elkhart, LaPorte, Mishawaka and Plymouth offices to provide updates on PCAU's work and partnership projects. Other activities include lunch with the Friends of Uganda Network (FUN), strategic planning sessions, Global Partners in Care discussions, as well as a presentation by Rose to the Downtown South Bend Rotary Club.

The 10th anniversary partnership report will include activities through the partnership exchange visit this summer, an update on the Road to Hope program and other partnership projects. It will be mailed to partnership supporters and stakeholders this fall.

Kaitlyn Siler, an MPH student at the Eck Institute for Global Health (ND) has completed her capstone project which will help PCAU report palliative care access and morphine supply by mapping the location of nurses and clinical officers trained through the DCPC (Diploma in Clinical Palliative Care) program.

Road to Hope

There are currently 57 children enrolled on the Road to Hope Program. Through the end of July, 51 of these students had sponsors. Thanks to promotion of the program at Okuyamba Fest, two more children will be sponsored by local business owners.

We are working with South Bend-based Regional Innovation and Startup Education (RISE) to design a program focused on developing entrepreneurial skills programs for our older Road to Hope students. This program will work in tandem with empowerment retreat programming that was put into place earlier this year. Iris Hammel, executive director of RISE and Bethany Hartley, deputy director met with Rose, Mark Mwesiga and Foundation staff members to discuss possibilities for the curriculum, as well as a potential intern from Bethel College who would work on the project.

Education

We have given a few presentations to groups throughout the community on end-of-life topics. Those requesting presentations include the Mishawaka Lions Club, REAL Services, Mishawaka Councilman Woody Emmons, and Waterford Estates.

Collaboration with other community health providers/stakeholders on Honoring Choices® Indiana – North Central continues to be fruitful. Three of the major health systems (BEACON, Saint Joseph, and Goshen) have committed to funding Honoring Choices for the first year and we have received other donations as well. As part of their donation, the systems asked that the coalition find ways to track the impact of Honoring Choices. To jump-start this process a group of interns from EnFocus researched what other Honoring Choices (and similar community-based groups across the country) are using for metrics. The resulting report was very informative and will provide direction as we ramp up our activities. Since funding is now in place, we are actively recruiting a part-time Advance Care Planning Coordinator (ACP) who will oversee the day-to-day operations of the organization.

A physician-focused version of IU Talk, a workshop designed to teach clinicians effective communication skills for difficult patient conversations, will take place on September 12 and 13 at

the Mishawaka Campus. The workshop will be taught by Lyle Fettig, MD and Erin Newton, MD of the IU School of Medicine. Based on responses from health care providers, we see there is also a need for a mid-level practitioner workshop which we will discuss with our IUSM colleagues.

We continue to revise our one credit hour Introduction to Hospice and Palliative Care course which will next be offered on September 22nd at the University of Notre Dame. One of the objectives is to make some of the day-long Saturday session more interactive, so we are planning to offer a shortened version of "Death by Chocolate" during the afternoon. We will also incorporate a session on advance care planning in this next offering.

Mishawaka Campus

Construction is well under way on the new Clinical Staff Building, which began in mid-March. Progress made since the last report include: installation of the water main, first floor concrete and elevator shaft; setting structural steel, second floor bar joist and decking. Exterior wall framing is currently underway, and preparations are being made to pour the second-floor concrete as well as installation of the roof decking. We continue to anticipate construction will be completed in Summer 2019.

Since the last board meeting, we have finalized our agreement with DJ Construction for construction of our new 12-bed inpatient facility, the Ernestine M. Raclin House. A formal ground-breaking ceremony took place on Tuesday, June 12th, with construction commencing in the days immediately following the event. Excavation and backfilling are now complete, and work is presently underway to pour footings, form foundation walls and set anchor bolts. We continue to anticipate construction will be completed in Fall 2019.

DJ Construction is now fully utilizing the home we purchased earlier this year in place of a traditional job site trailer. Doing so will result in a projected cost savings of approximately $20,000. The home will be demolished after construction is completed.

Mike continues to hold semi-monthly construction meetings on the 2nd and 4th Thursday of each month with Helman Sechrist Architecture (architect), Jones Petrie Rafinski (engineer), DJ Construction (builder), Office Interiors (interior designer) and various subcontractors to ensure that both projects are staying on track and on budget.

Residential Housing

Since the last meeting, the Board of Zoning Appeals and Mishawaka Plan Commission approved our rezoning, sub-division and variances requests for the parcel located at the corner of Comfort Place and Cedar Street. Construction on the first of two Helman Sechrist-designed homes began in early July. Our construction partner, Devine Homes by Miller, has been making great progress during the past few weeks. Framing is complete, and the roof is being installed as of this writing.

Mike holds meetings Friday mornings with Jeff Helman and Brian Miller to ensure the project is on track and on budget. We anticipate construction will be complete by November 2018. A "For Sale" sign will be installed within the next week.

COMMUNICATIONS, MARKETING, AND ACCESS

Craig Harrell, Director of Marketing and Access, reports on marketing and access activities for April, June and July 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. During April through July our four Liaisons completed 1,813 visits to current and potential referral sources within our service area. They accomplished 402, 490, 485, 436, April – July respectively.

Melanie Marshall, our new Professional Liaison in La Porte, has completed her 90-day probation period and is doing an excellent job of connecting with referral sources and building relationships in La Porte and Porter Counties. We've also hired Kim Ransbottom as our new Admissions Representative to replace the previous person who is now the CHC Quality Review & Training Assistant in South Bend. Kim comes to us from a competitor where she worked in Business Development (like our Professional Liaison positions) and is excited about working closer with patients and families who need our services.

Access

For the months of April - July, the Referral Specialists received 872, 771, 722, and 810 incoming phone calls respectively to the Admissions Department. Last board report stated that our 'Deaths Before Admission' (DBAs) were running 57% above the same time in 2017. Thankfully, those have evened out and we're currently at 7.02% of our referrals as DBAs compared to 6.62% at the end of July 2017. We're responding quickly to referrals with 53.34% of our admissions being within 24 hours from receiving the referral. Most of the referrals that go beyond the one day or less timeframe is because of family requests to accommodate their schedules, have more time to consider, or examine other treatment options.

Website

During the months of April - July, CHC's website hosted 9,264 new users. In April - July 34.6% of visitors found us by entering our website address or through a search engine such as Google which is a 53.8% increase over the same period in 2017. Our page on 'career opportunities' is our number one viewed page followed by 'for patients and families'.

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 221,140 people for the April – June, had 591 shares, and 152 comments. Overall, our paid ads reached 67,806 Facebook users. We recently began adding more video with the intention of educating and focusing on what makes us different than competitors. From April through July, the most watched video was the interview of the CHC CEO by Peter Ashley entitled "The future of Center for Hospice Care" which had a

total viewing time of over 2,800 minutes followed by the "Groundbreaking Ceremony for Ernestine M. Raclin House" video. It was viewed for more than 1,400 minutes. 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 April - July it generated 266 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 9.56%.

INDIANA STATE DEPARMENT OF HEALTH HOSPICE LICENSURE AND MEDICARE RECERTIFITCATION SURVEY

Nine months past the federal deadline for a three-year maximum time frame for a hospice survey, we were visited by an Indiana State Department of Health (ISDH) Public Health Nurse Surveyor for seven consecutive business days in July. She was here for our Medicare hospice recertification survey as well as our survey for state licensure as a hospice program in Indiana. She was also investigating two complaints made against us presumably through the ISDH complaint hotline. Complainants remain anonymous and we really don't know what the complaints were to protect anonymity, but she did ask to see two specific patient charts. Following her investigation, she said the outcome was that both complaints were unsubstantiated. Nothing was cited from these complaints. Anyone can call the 800# complaint hotline for whatever reason. The ISDH must investigate all complaints.

At the end of the seven-day survey an "Exit Interview" was held which lasted last less then two minutes. Surveyors are no longer allowed to share with staff their findings and we only hear what happened via the state electronic portal many days later. When we received our findings, there were two minor deficiencies cited. One was that during her patient chart review she noted we did not list oxygen on the medication list. In 38 years, we never have. One local hospital reported they don't list oxygen on the medication list either. We have changed a policy and will begin listing O2 on the medication list of all patients in all settings. The other issue was that during her review of 20 patient charts, she discovered that five patients had wounds, and during one, single nursing visit the RN did not measure the wound which is counter to our own internal policy. To address these two issues, we had ten days to file a "Plan of Correction" which basically showed we would begin to list oxygen as a medication effectively immediately and would provide education to all RNs regarding our own policy about the frequency of measuring wounds. If a hospice program's policy is stricter than what is required by state and federal regulations, it's the strictest policy that is examined and held for accountability. We received an ISDH letter within days of submitting our plan that our Plan of Correction had been accepted. There will be no follow-up, further visits, or any other action on these two issues. Years ago, when surveyors performed chart review, deficiency citations would not be made unless a trend could be identified. For example, if ten charts were reviewed and the same issue was discovered in one-third of more of the charts, then it was cited. Today, surveyors are in a "see it, cite it" mode of operation. My colleagues in Michigan have reported the same process. Overall, this was a very good survey, particularly considering the size of our census, the interdisciplinary nature of hospice care charting (RNs, social workers, aides, chaplains, etc.) and the sheer number of patient visits we make every day.

QUALITY IMPROVEMENT AND POLICIES ON THE AGENDA FOR APPROVAL

There are five policies on the Agenda for approval. They are:
- Informed Consent
- Medication Disposal
- Agency Records in an ECF Chart
- Managing Drugs and Biologicals (home care and IPU versions)
- Death Procedure

All of these are revised policies based on regulatory or procedure changes, or due to our recent hospice survey.

Also included in your board packet is the May 22, 2018 Quality Improvement Committee minutes.

ELKHART INPATIENT UNIT TEMPORARILY CLOSED DUE TO STAFFING ISSUES NEEDED FOR A 24/7 OPERATION

On 7/23/18 the Elkhart Inpatient Unit (IPU) closed after the last patient was discharged and there were no new admissions at that time. The unit does close from time to time because of having no patients. However, this time is different.

During the last several weeks we have had RN's and Certified Nursing Assistants (CNA's) leave for various reasons, some with no notice, some because of transportation issues, some we're not sure why because they just don't report to work. Recruiting in Elkhart has been very difficult. Some candidates simply don't show for scheduled interviews. As you know, it has been reported there are some 21,000 open positions in Elkhart County and the unemployment rate is at 2%. We heard this week that one Elkhart home healthcare agency closed because they couldn't keep staff and couldn't find a manager for the office.

At the Elkhart IPU – at the time of this writing -- there are three vacant 12-hour RN shifts uncovered and two vacant CNA positions uncovered. The IPU coordinator and the ADON have functioned as staff RN's at the patient care level on the floor to help cover these shifts over the past few weeks when we have had patients. This became problematic as they were working up to 60 hours a week covering the open positions as well as being taken away from their regular jobs. The 30-year old archaic Medicare hospice regulations do not allow for using contracted staff from staffing agencies because all core services must be provided by "W-2" direct employees. An RN must be on duty 24/7 for a general inpatient (GIP) level of care (not an LPN).

The good news a couple weeks ago was that we had nurses in line to fill all the open Elkhart IPU RN vacancies with start dates in August. They needed to give notice at their current jobs and then will need to be oriented to CHC and the hospice inpatient unit. It was being estimated several weeks ago that between general orientation and inpatient unit orientation each nurse will take an average of four weeks to be ready to work the floor, although I hope this can somehow be accelerated. I have polled the National Hospice Executive Roundtable CEOs (NHERT) for best practices on new employee orientation to a hospice inpatient unit and while they have a variety of lengths, they are tailored as to what venue the staffer is coming from, i.e. hospital vs. no previous hospice experience. None of them have a one size fits all orientation program. We are going to

closely examine our current practices. Since January in the IPUs, we have had four RNs, four CNAs and one Coordinator quit or change to PRN status (PRN, meaning they can work when they want to, say no to shifts, and do not have to take call). These terminations have been for a variety of reasons and there is no theme. I am also told we were pleased that some of them chose to discover a new destiny. We recently had a new RN complete one week of orientation for the IPU and then quit because taking call was too inconvenient because she liked to go to Ohio on weekends. She was well-aware of the on-call requirements when she accepted the position.

Since January, reasons have included:
-- Changed to PRN status
-- Relocated out of the area
-- Quit during probationary period due to performance issues
-- Went to work for the US Postal Service
-- Retirement
-- Changed to PRN status then refused to work any hours and was terminated
-- FMLA for three months
-- Position was filled, staff due to start, but then quit due to an unexpected surgery

Please know that patients are receiving the care they need. General inpatient level of care is being provided via our contract with Elkhart General Hospital and by our Elkhart office residential home care staff. The Elkhart IPU staff can work in the South Bend unit if they choose to do so. I believe there may be one overnight opening that is being covered on a rotating basis. We are offering patients to go to the SB IPU, but if they refuse, they will receive GIP care at EGH until we have our staffing back up and running. To further complicate matters, our DON was on a three-week FMLA, the ADON was on vacation during the same time along with the HR Director. We are in the height of vacation season. We are using this down time at the Elkhart IPU for general maintenance of the area, stripping the floors and painting. You may remember a few years ago the entire facility was shut down for more than a month while 100% of the flooring was replaced.

HR says that after recruiting for 31 years, they have never seen a work ethic – or lack of one -- like they have seen recently. Getting people to show up for an interview, pass a drug test, and then show up for work is currently somewhat rare. Hospice CEOs, for both for-profit and non-profit programs, reported the same phenomena at the IHPCO Board meeting on August 2nd in Indianapolis. Some members of the National Hospice Executive Roundtable are taking their chances and remediating IPU staffing issues by using contracted agency staffing, which is again, against the Medicare hospice Conditions of Participation.

We are holding our own, but with vacations, medical leaves, no shows/no calls, and staff quitting because their car won't start, it has been a struggle. On Monday August 6th, I authorized HR to consider creating a target of hiring two RNs per shift along with one aide for the IPUs. We will be having further discussions. We will need to increase staffing for the new 12-bed unit in about a year anyway and having two RNs scheduled will leave us coverage and a backup for emergencies, vacations, illnesses, car trouble, and when the CNA simply doesn't show up. We have also reached out to Kindred Hospital which announced recently they will be closing next month with 117 employees losing their jobs, many of which are RNs and CNAs. Kindred is an LTAC hospital specializing in long term acute care. I would think these RNs could easily adapt to a seven bed IPU, especially considering the average daily census in Elkhart has been running less than four patients a day.

MEETINGS HELD REGARDING REPURPOSING THE SUNNYBROOK PROPERTY FOR MILTON ADULT DAY SERVICES

We have been meeting with the new Executive Director for the Alzheimer's and Dementia Services of Northern Indiana (ADSNI), Angel Baginske and recently met with her and Becky Zaseck, CEO of REAL Services which owns ADSNI, about repurposing the Sunnybrook property for Milton Adult Day Services (MADS) and ADSNI's Institute for Excellence in Memory Care (IEMC). We believe this timetable and remodeling of the 12,000 square foot facility would begin in the fall of 2019 after all CHC staff has left and the SB IPU has relocated to the new Raclin House in Mishawaka. REAL Services would like a scenario when they would not just be a renter, but where they could count on being in that facility with IEMC in perpetuity. We have had one meeting looking specifically at the available space and what changes would be necessary. With IEMC taking up the southern part of the building, MADS would be in the northern half. With Indiana Medicaid Waiver rules such as they are, rest room and kitchen requirements, and the available space, we believe we could see clients up to a maximum number of 50. Currently we're seeing about 20 at the 922 E. Colfax Ave. location, so moving could more than double our adult day census. Again, conversations are preliminary, but I wanted you to know we're working on this now.

DIVERSITY TRAINING HELD FOR ALL COORDINATORS AND ABOVE MANAGEMENT

Jason Wilkinson, Executive Director of South Bend's relatively new LGBTQ Center provided three training sessions to CHC Coordinator and above positions during the month of July. Each presentation was the same, but three were scheduled to accommodate staff so they could attend one. The vision of the LGBTQ Center is "A community where everyone is valued, respected, and empowered." Diversity is a component of our current strategic plan and a paid endowed position is available in our Crossroads Campaign. We plan on continuing to provide training for staff on a wide variety of topics that deal with our diverse community and assist staff with a better understanding of our many constituencies and provide needed healthcare to everyone. We are tentatively planning on having representatives from the Jewish Federation of St. Joseph Valley make our next presentation.

OIG RELEASES NEW REPORT ON VULNERABILITIES IN THE MEDICARE HOSPICE PROGRAM THAT AFFECT QUALITY CARE AND PROGRAM INTEGRITY

Excerpt from Kaiser Health News…

Elderly patients spent over two weeks in uncontrolled pain or respiratory distress. Acute care was rare on weekends. And recruiters went door to door pitching fraudulent schemes, luring healthy patients to sign up for hospice in exchange for free housecleaning and medicine. These details appear in a report on hospice released Monday by a government watchdog agency calling on federal regulators to ramp up oversight of a booming industry that served 1.4 million Americans in 2016.

The report from the Office of Inspector General (OIG) at the Department of Health and Human Services sums up over 10 years of research into inadequate care, inappropriate billing and outright

fraud by hospices, which took in $16.7 billion in Medicare payments in 2016. A Kaiser Health News investigation last year revealed that while many of the nation's 4,000-plus hospices earn high satisfaction rates on family surveys, hundreds fell short of their obligations, abandoning families at the brink of death or skipping other services they had pledged to provide. The OIG report points to similar gaps in care and raises concerns that some hospices are milking the system by skimping on services while taking in daily Medicare payments. Regardless of how often their staff members visit, hospices collect the same daily flat rate from Medicare for each patient receiving routine care: $193 for the first 60 days, then $151 thereafter, with geographic adjustments as well as extra payments in a patient's last week of life. The report calls on the Centers for Medicare & Medicaid Services (CMS) to take 15 actions to improve oversight, including tying payment to quality of care and publishing public inspection reports on its consumer-focused website, Hospice Compare, as it does for nursing homes. In a letter to OIG in response to an earlier draft of its report, CMS Administrator Seema Verma objected to those two recommendations as well as six others. She concurred with six other recommendations and wrote that CMS is "committed to ensuring that the Medicare hospice program provides quality care safe from fraud, waste, and abuse."

While many of OIG's findings date back over five years, report lead author Nancy Harrison, deputy regional inspector general of the OIG's New York office, said that the vulnerabilities in the system persist and that CMS has failed to implement many of the recommendations OIG has been making for years. These vulnerabilities have emerged at a time when the industry has changed rapidly, she said. "Hospice is quite different than it used to be," Harrison said. "When it started out, there were faith-based and nonprofits," and most patients had cancer. As of 2016, there were 4,374 hospices receiving Medicare money, about two-thirds of which were for-profit. Fraud has pervaded the industry, with some hospices ripping off taxpayers by enrolling patients who are not dying, paying kickbacks for patient referrals or carrying out various inappropriate billing schemes. From fiscal years 2013 to 2017, OIG investigators won back $143.9 million from 25 criminal actions and 66 civil actions against hospices.

Fraud has run wild in Mississippi, where hospices were paying recruiters to solicit business door to door from people who were not dying. The recruiters offered free housecleaning, medicine and doctors' visits to patients who signed up — not knowing they were enrolling in hospice and forgoing Medicare payment for curative care, according to OIG field agents. One recruiter, a convicted sex offender, was sent to prison for 40 months in 2016 for taking payments from five hospices, earning $200 to $600 for each hospice-inappropriate Medicare beneficiary he sent their way. Also, in Mississippi, hospice owner Regina Swims-King was sentenced in 2014 to nearly six years in prison for an $8 million Medicare fraud scheme involving patients who did not need hospice, services that patients never received, and claims based on forged doctors' signatures. She forfeited 12 real estate properties and 17 vehicles. Charles Hackney, an assistant special agent in charge who oversees OIG investigators in Mississippi, said fraud there, which was perpetrated by small mom-and-pop operators, has subsided after many criminal convictions.

But nationally, fraud cases continue: Just last October, the federal government reached a $75 million settlement with Vitas Hospice Services — a large for-profit chain owned by Chemed Corp., which also owns the Roto-Rooter plumbing company — to address allegations of fraudulent billing.

The complete OIG report on hospice may be downloaded here: https://oig.hhs.gov/oei/reports/oei-02-16-00570.asp

NHPCO REPONDS TO OIG REPORT

To: NHPCO Membership
From: Edo Banach, President and CEO
Date: July 31, 2018

As many of you may be aware, the Office of the Inspector General has released a portfolio report, "Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity," focusing on concerns with the Medicare hospice benefit. NPR's Morning Edition and Kaiser Health News (which concludes with some important quotes I offered before the report was released) both did pieces on the report that I'm sure some of you have read or heard this morning. Let me stress that many of the issues brought up in the new report have been discussed in previous OIG documents. NHPCO has addressed these issues in regulatory alerts and resources, on our Webinars, at our conferences, in staff presentations to the field, in our Regulatory Podcasts, and explored by our board committees. So, I hope the contents of the report do not come as a complete surprise and cause you to be too discouraged.

Let me offer some additional comments and context in response to this OIG report. NHPCO recognizes the value of some of the OIG recommendations and we welcome measures that will help hospices focus on value over volume and patients over paperwork. However, NHPCO continues to stress that outliers cited in the report do not adequately reflect the context of hospice care provision in the U.S. Importantly, CMS rejects over half of the OIG's hospice recommendations, and we generally agree.

We believe that incidents of deliberate fraud and abuse in the hospice field, though rare and isolated, are indefensible. For this reason, NHPCO has been and continues to be a champion for accountability and transparency within the hospice community. And we look to our members to be our partners in this important work. Furthermore, it is necessary to understand that rare incidents of deliberate fraud and abuse should be viewed separately from unintentional documentation or mathematical errors in an extraordinarily burdensome and complicated regulatory environment.

We look forward to working with the Administration to simplify and streamline the hospice benefit and compliance process and to ease the governmental red tape to encourage honest and law-abiding hospice providers while protecting the public from unacceptable intentional abuse. This includes better use of hospice data that CMS already obtains and to focus government efforts on truly abhorrent providers and spare compliant programs from needless and duplicative investigation.

NHPCO encourages the OIG and CMS to examine ways in which the current structure of the benefit can prevent patients and families from accessing medically necessary care and subject them instead to more costly and less beneficiary-friendly environments. Also important to examine is underutilization of hospice care. As reported in our annual Facts and Figures Report, 28 percent of beneficiaries received care for only seven days or less in 2016. Like intentional fraud, this is unacceptable.

Hospices have a sacred obligation to serve patients and family caregivers throughout the end of life journey. As the hospice care community – like the rest of America's health care system – continues to evolve to meet patient and family needs, it is critical that government regulations also adapt and modernize to meet the needs of those served by this unique care model. Let us work with the OIG,

CMS, and Congress to build on our 35 years of experience with the Medicare hospice benefit to seek solutions in caring for people facing serious and life-limiting illness.

For the work you do every single day, thank you.

CMS FINALIZES APPLICATION OF POST-ACUTE TRANSFER POLICY TO EARLY HOSPITAL DISCHARGES TO HOSPICE.

The Bipartisan Budget Act of 2018 included a provision under which certain "early" hospital discharges to hospice care will be paid at a per diem daily rate in lieu of the full diagnosis-related group (DRG) rate beginning October 1, 2018. The Centers for Medicare & Medicaid Services (CMS) provided insights into its plans for implementing this requirement as part of the proposed FY2019 Hospital Payment Rule issued in late April 2018 and in Change Request 10602/Transmittal 2094. Last week, CMS issued a final version of the FY2019 Hospital Payment Rule that finalized those plans and included a brief discussion of comments received on the topic. While this change does not directly impact payments made from Medicare to hospice providers, the hospice community is concerned that it may delay (and potentially eliminate some) admissions to hospice care, since hospitals will now have the financial incentive to retain some patients on service for longer lengths of time prior to discharge. Hospital referrals are already the latest referrals CHC receives with the shortest length of stay from any referral source. They are also the majority of all "d/b/a" referrals – death before admission – comprising 75% of all d/b/a referrals so far in 2018. We see this new policy as an opportunity to exacerbate an already bad situation. While CMS plans to apply the transfer to hospice policy in all of the DRGs subject to the post-acute care policy (which number approximately 280 DRGs), a positive aspect of the plan is that CMS is defining a hospital to hospice transfer as a direct to hospice transfer, which will limit the applicability to only those hospital discharges that occur on the same date as the patient begins hospice care (the effective date of hospice election).

As part of the final FY2019 Hospital Payment Rule, CMS acknowledges the many comments submitted expressing concerns about this provision but indicates that the agency believes a reduced hospital payment is justified because in early transfer cases the hospital is providing only a limited amount of treatment. CMS further indicates that application of the discharge policy "addresses the appropriate level of payment once clinical decisions about the most appropriate care in the most appropriate setting have been made" and references a belief that the statute is "unambiguous" as to the steps that the agency must take on this policy. CMS notes that the Medicare Payment Advisory Commission (MedPAC) has been mandated by Congress to conduct a detailed evaluation of the implementation and impacts of the policy change, including analysis of whether timely access to hospice care has been affected through changes to hospital policies or behaviors. Preliminary results of the study are due to Congress by March 21, 2020.

OUT AND ABOUT

Several staff, including Karl Holderman, Dave Haley, and Sue Morgan attended the Indiana Hospice and Palliative Care Organization's annual Regulatory and Reimbursement Day on June 5 and 6.

I attended the Hospice Action Network board meeting and NHPCO Board Issues Sessions at NHPCO headquarters in Alexandria, VA June 19 – 21.

I chaired the Indiana Hospice and Palliative Care Organization's Board of Directors meeting on August 2nd in Indianapolis.

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

Dave Haley's Census Charts.

Karl Holderman's Monthly dashboard summaries.

The press release for the 33rd annual Walk for Hospice.

The press release for the 10th annual Bike Michiana for Hospice.

June and July CHC Volunteer Newsletters.

Copy of a letter from a ten-year old donor

Story from the Baltimore Sun regarding Global Partners in Care partnership between a Maryland hospice and a Tanzania hospice. GPIC's own staffer, Lacey Ahern, is quoted.

Story about Okuyamba Fest celebrating CHC's ten-year partnership with PCAU published by valpolife.com

Flyer for LGBTQ Diversity Training

Story from the New York Times about Humana purchases to make them the largest hospice provider in the U.S.

Flyer for CHC sponsoring the Juneteenth Celebration sponsored by CHC.

Press release for Mishawaka Groundbreaking of the Ernestine M. Raclin House

Press release for the Dwyer Charitable Trust gift to fund hospice medical education

South Bend Tribune front page story about the Mishawaka Campus construction and the Dwyer gift

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

Year to Date July 2018 Financials

2017: The Year in Review

Promotional postcard for Walk for Hospice and Bike Michiana for Hospice

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, November 28th 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

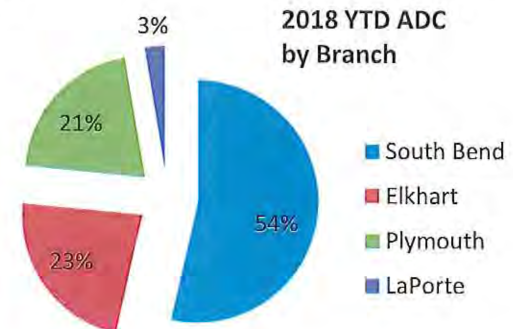
2018 YTD Average Daily Census (ADC)

(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	402	199	97	90	16
J	411	209	94	92	16
J	410	221	85	89	15
A					
S					
O					
N					
D					
2018 YTD Totals	2769	1483	637	577	74
2018 YTD ADC	**396**	**212**	**91**	**82**	**11**
2017 YTD ADC	394	229	95	69	0
YTD Change 2017 to 2018	2	-17	-4	13	11
YTD % Change 2017 to 2018	**0.4%**	**-7.5%**	**-4.2%**	**19.5%**	**NA**

2018 ADC by Branch

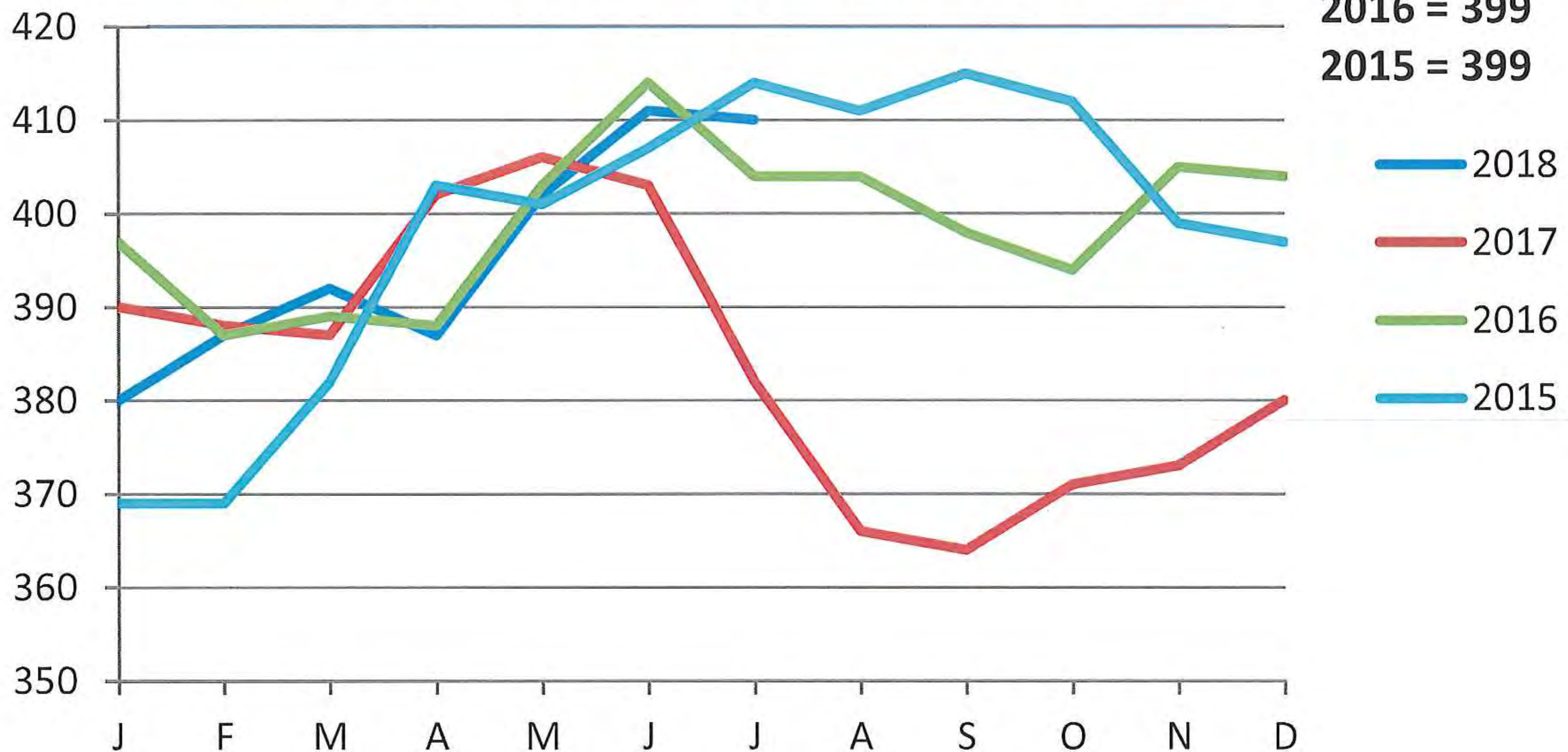
South Benc	54%
Elkhart	23%
Plymouth	21%
LaPorte	3%
All	100%

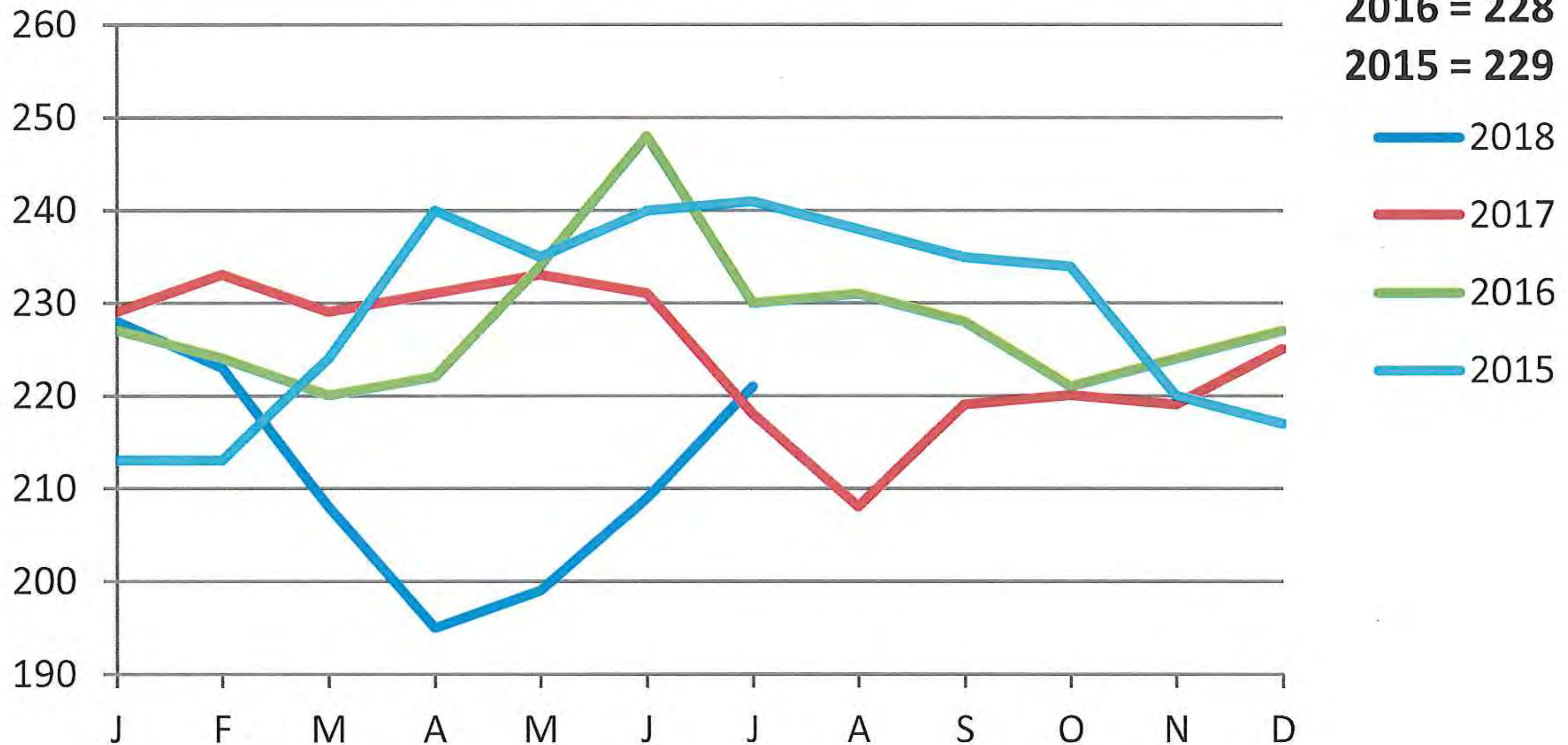


Center for Hospice Care
Total Average Daily Census (ADC)

ADC

YTD 2018 = 396
2017 = 384
2016 = 399
2015 = 399




South Bend
Average Daily Census
ADC
YTD 2018 = 212
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
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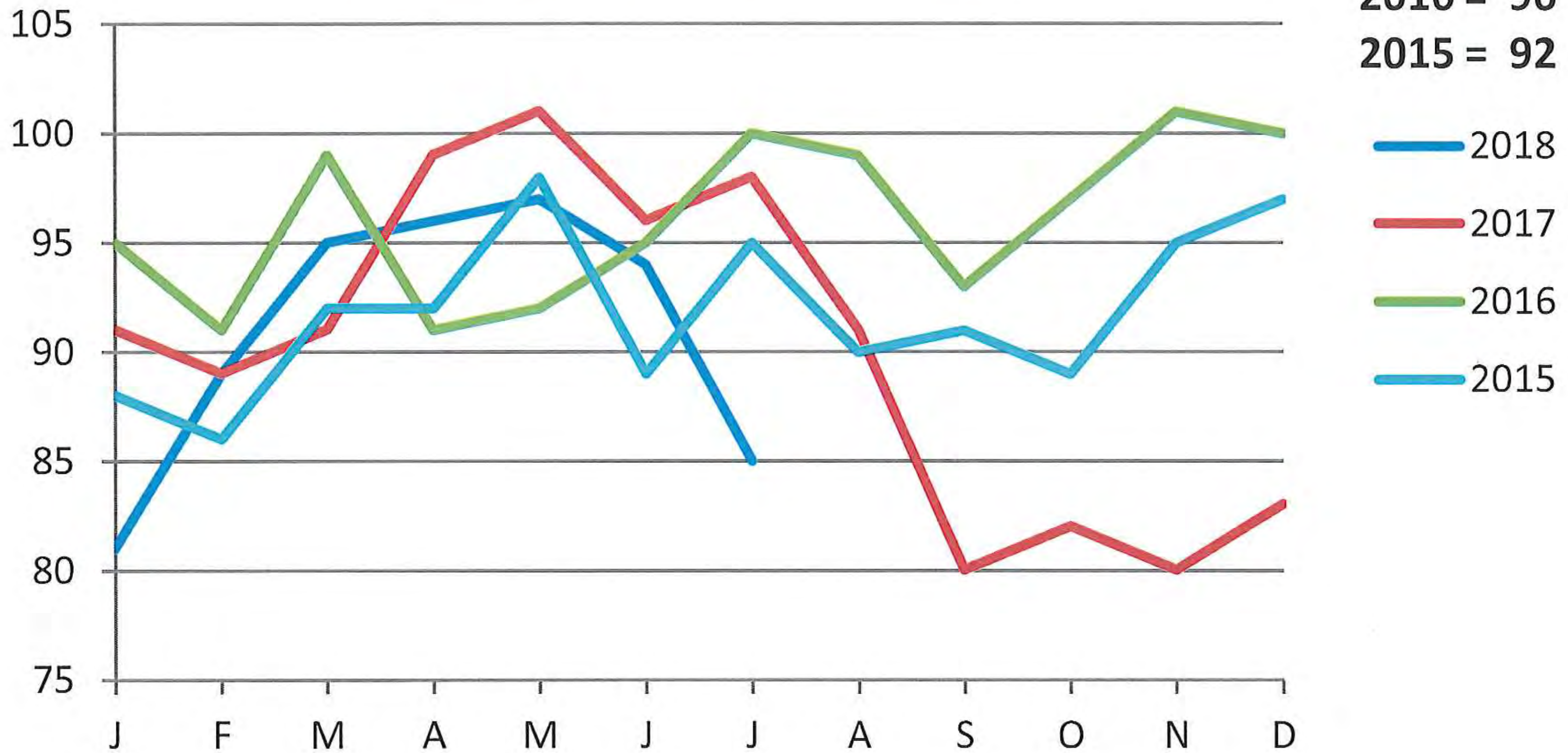
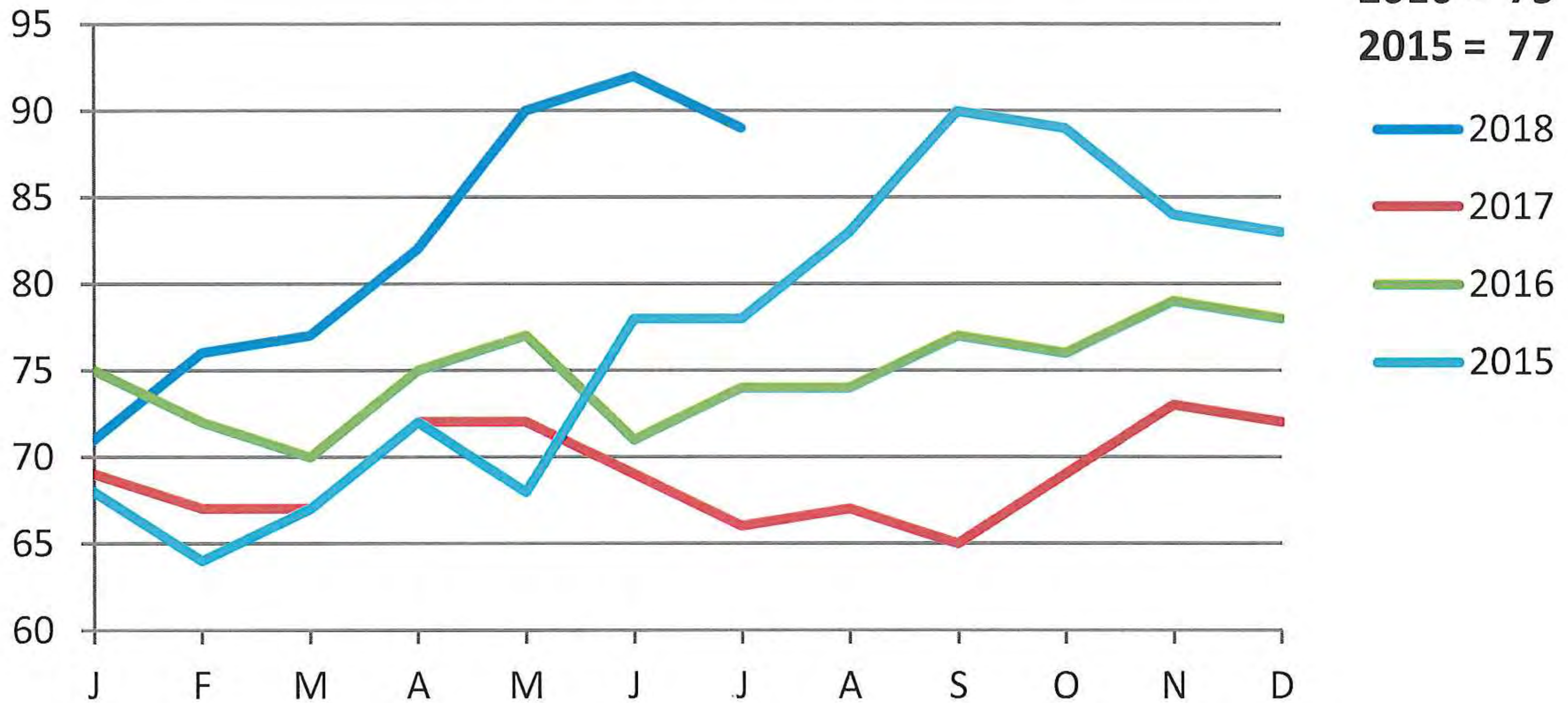
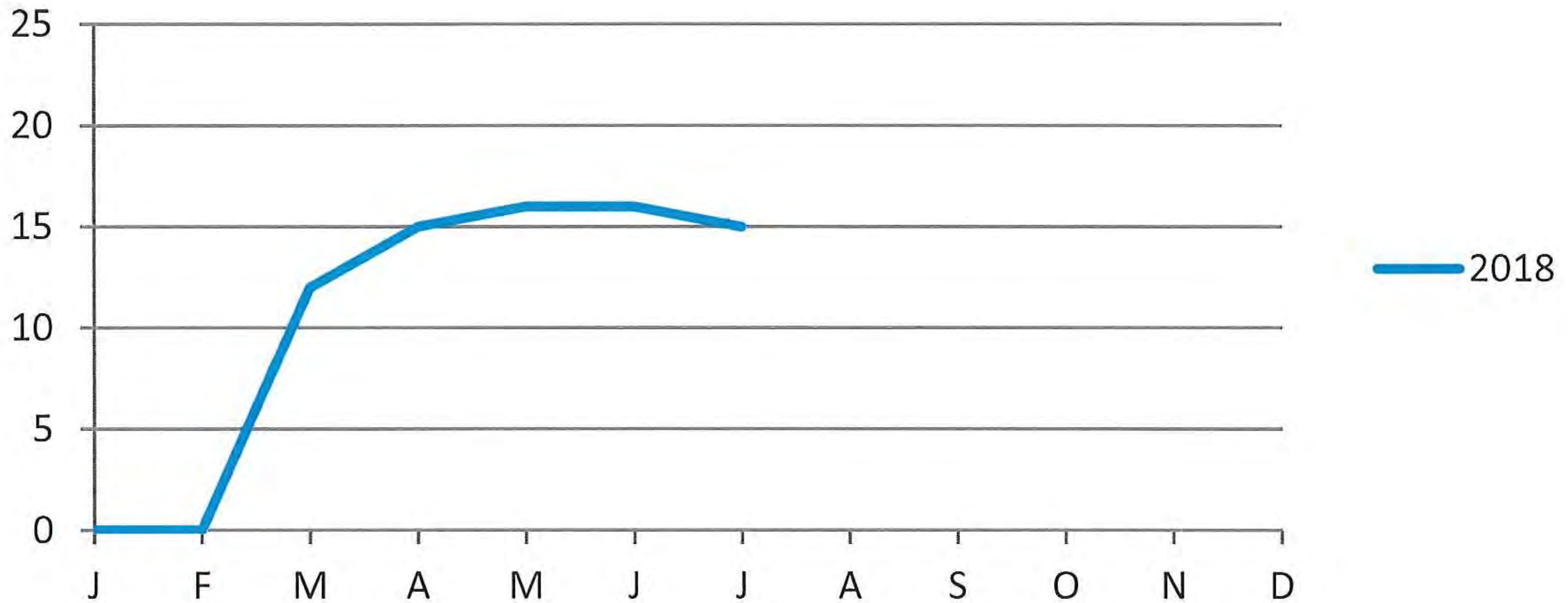

Elkhart
Average Daily Census
ADC
YTD 2018 = 91
2017 = 90
2016 = 96
2015 = 92
105
100
95
90
85
80
75
J
F
M
A
M
J
J
A
S
O
N
D
2018
2017
2016
2015


Plymouth
Average Daily Census
ADC
YTD 2018 = 82
2017 = 69
2016 = 75
2015 = 77
95
90
85
80
75
70
65
60
J
F
M
A
M
J
J
A
S
O
N
D
2018
2017
2016
2015

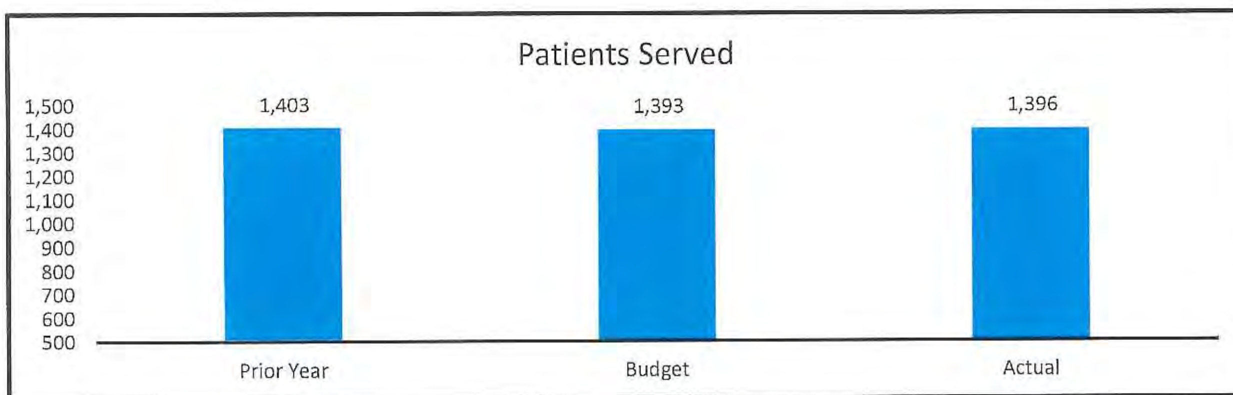
LaPorte
Average Daily Census

ADC
YTD 2018 = 11
2017 = 0

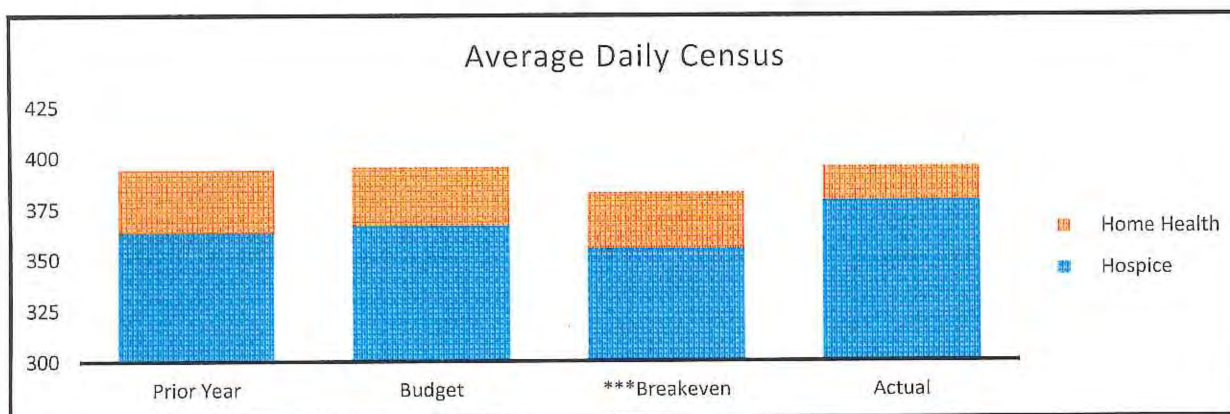


Center for Hospice Care
July 2018 Summary

	Prior Year	Budget	Actual
Patients Served	1,403	1,393	1,396

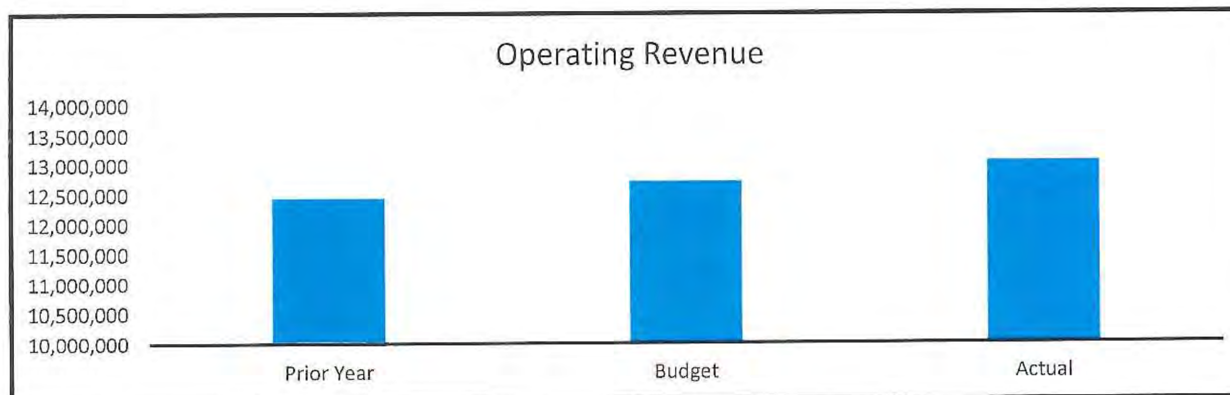


Average Daily Census	Prior Year	Budget	***Breakeven	Actual
Hospice	363.04	366.55	354.98	378.76
Home Health	31.09	28.81	27.90	16.88
Total Average Daily Census	**394.13**	**395.36**	**382.88**	**395.64**

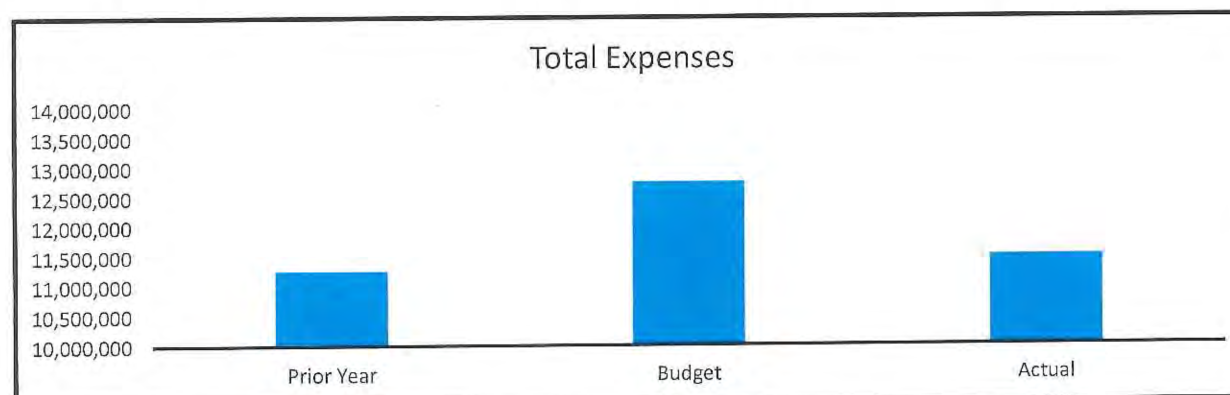


**** Budgeted Breakeven*

	Prior Year	Budget	Actual
Operating Revenue	12,440,988	12,716,843	13,062,612



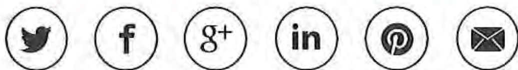
	Prior Year	Budget	Actual
Total Expenses	11,262,313	12,759,509	11,514,428



Friday, July 13, 2018

Center for Hospice Care to Hold 33rd Annual Walk for Hospice on September 23, 2018.

Share Article



Center for Hospice Care and the Hospice Foundation are thrilled to announce that the 33rd Annual Walk for Hospice will take place on Sunday, September 23.

MISHAWAKA, IND. (PRWEB) JULY 12, 2018

Center for Hospice Care (CHC) and the Hospice Foundation are thrilled to announce that the 33rd Annual Walk for Hospice is Sunday, September 23. As in year's past, the walk will start and finish at Center for Hospice Care's Mishawaka Campus, next to beautiful Central Park, along the scenic St. Joseph River. For the first time, this event will take place on the same day as CHC's Annual Bike Michiana for Hospice, which will also begin and end at Center for Hospice Care.

What's New?

T-Shirts – A Walk T-Shirt is now included in the registration fee. Simply select the appropriate size during online registration.

Fundraising – To support CHC's mission of providing compassionate care to all eligible, regardless of their ability to pay, this year's participants will be able to raise money for CHC in honor or in memory of a loved one.

Post-Event Party – This year's post-event party will have more food, music and fun, as CHC is holding a joint party for returning walkers and cyclists. Yesterday's will provide the delicious food.

Advance registration will be required this year.

What's Not Changing?

Location – The walk will begin and end at CHC's Mishawaka Campus, next to Central Park.

Fun – Central Park is a great place to spend time before and after the ride.

Fellowship – Have a great time for a great cause, enjoying family, friends and neighbors.

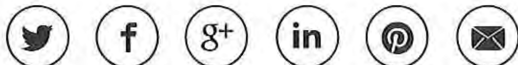
For more information about this event, please visit foundationforhospice.org/walk.

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 promise that no one eligible for hospice services will be turned away, regardless of their ability to pay.

Share article on social media or email:



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Contact Author

PETER ASHLEY

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

VISIT WEBSITE

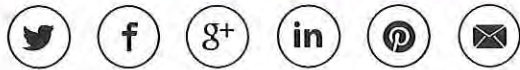
News Center

PRWeb

Thursday, August 9, 2018

Center for Hospice Care to Hold 10th Annual Bike Michiana for Hospice on September 23, 2018

Share Article



Featuring new routes, new restaurants and a new starting location, the 10th Annual Bike Michiana for Hospice benefiting Center for Hospice Care takes place on September 23, 2018.

MISHAWAKA, IND. (PRWEB) JUNE 28, 2018

Center for Hospice Care (CHC) and the Hospice Foundation are excited to announce that the 10th Annual Bike Michiana for Hospice will take place on Sunday, September 23, 2018. For the first time, the ride will start and finish at Center for Hospice Care's Mishawaka Campus, next to Central Park, along the scenic St. Joseph River. This year's ride is presented by Trek Bicycle Store Granger, and will have many exciting changes.

What's New?

Location – The ride will now begin and end at Center for Hospice Care's Mishawaka Campus, next to Central Park.

Routes – There will be a new route for casual cyclists and families, plus two longer routes for cycling enthusiasts.

Fundraising – To support CHC's mission of providing compassionate care to all eligible, regardless of their ability to pay, this year's cyclists will have the opportunity raise money for CHC in honor or in memory of a loved one.

Advance registration will be required this year.

What's Not Changing?

Great Food – Yesterday's Food & Spirits will provide food for the post-event party; and Olympia Candy Kitchen and 523 Tap & Grill are providing food at the SAG stops.

Fun – The new location and routes will make for a memorable event. Central Park is a great place to spend time before and after the ride.

Fellowship – Have a great time for a great cause, enjoying family friends and neighbors.

To learn more about this event, please visit foundationforhospice.org/bike.

About Center for Hospice Care and the Hospice Foundation

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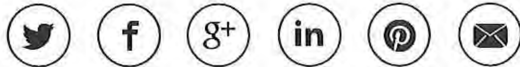

View article via:

PDF PRINT

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VISIT WEBSITE

News Center

June 2018

Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

Inside this issue:

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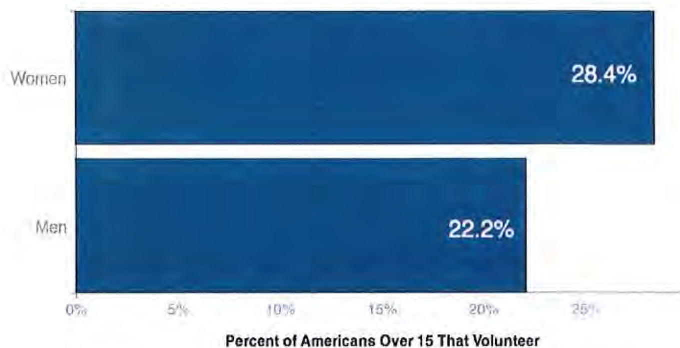
Needed: More Male Volunteers

Are Men Or Women More Likely to Volunteer?



Percent of Americans Over 15 That Volunteer

Center for Hospice Care is so fortunate to have wonderful male volunteers who do a variety of roles within our agency. The reality is, we need more.

The Bureau of Labor Statistics gives us a picture of the volunteer situation as a whole, not just hospice volunteers. "The volunteer rate for **men** was little changed at 21.8 percent for the year ending in September 2015. The rate for **women** was 27.8 percent, down from 28.3 percent in the previous year. Across all age groups, educational levels, and other major demographic characteristics, women continued to volunteer at a higher rate than men."

We share this information to bring to light this need.

According to an article in Pricenomics (https://priceonomics.com/the-altruism-gender-gap/), cultural expectations may be partly to blame.

"So what accounts for the volunteer gap between the sexes? One common explanation is cultural expectations. Men are often conditioned in America to think that they should devote all of their energies to generating income. The sociologist Hiromi Taniguchi found that when men and women are out of work, women increase their time spent volunteering, while men spend all of their time looking for work."

Regardless of the reason, we know that there are many men out there with talents to lend to CHC. We need our current volunteers to spread the word that we really need more male volunteers.

Some people, men and women alike, fear volunteering with CHC because they don't feel like they are equipped caregivers. Know that not all respite situations require hands on care. We need men who can share stories, listen, talk sports, and simply be a friend.

You may say, "I am already volunteering!" We know and we appreciate you. Help us gain more male volunteers by sharing your story. Let other men know that they are equipped to serve too. We simply need people who are committed, willing to learn and who like people.

And it's good for your health. According to Psychology Today, volunteers live longer and are healthier. "In fact, during later life, volunteering is even more beneficial for one's health than exercising and eating well."

Mark Your Calendars

Mandatory Annual Skills Validation

NEW Mandatory Skills Validation is for any Level III trained volunteer who plans to continue as a Level III volunteer.

This is an open house style. No appointment times. First come, first served. Successfully complete the skills and you're free to leave.

Drop in at any of the following:

Mishawaka Campus
Monday, July 23, 2018
9:00am-1:00pm and
3:00-6:00pm

Plymouth Public Library
201 N. Center Street
Tuesday, July 24, 2018
9:30am-3:00pm

Elkhart Campus
Friday, July 27, 2018
9:00am-3:00pm

Georgia's Weeping Willow

By: Kristiana Donahue

Georgia Dunbar, who sits quiet most days, her mind clouded with dementia, can still sing a few lines of her own song. There's just something about music that digs deep into our memories.

Georgia was the middle child of 16 children. Her large family was generously supplied with multiple talents: musicians, artists, and Georgia, the writer. She devoured over a thousand books which fed her hunger for language. She was married at 17 years old, even though all she wanted to do was write. Two years, two months and two days after their wedding, Janet, their daughter was born.

Janet now is a caregiver for her mother. As an only child, she doesn't share this journey with a sibling. She has learned a lot. First rule in dementia care, according to Janet, "Don't argue. Just agree." This was quite helpful recently, when Georgia shared some amazing stories with her daughter. "I came in here a month ago and she had hitchhiked back from New York. One time she had been out chasing dogs all night trying to get them back where they belonged. And another time she had been to Georgia and

Continued on page 6

Birthdays

7/2
Erik Chalman

7/2
Casey Kasper

7/4
Scott Boyle

7/5
Joni Kanzler

7/6
Daniel Shuppert

7/11
Gianna Haller

7/12
Jeanne Belote

7/12
Mary Cory

7/15
Carolyn Peterson

7/16
Herbert Kuzmich

7/18
Kathy Davis

7/23
Cornelia Langheinrich

7/24
Leslee Smith

7/26
Sandra Maichen

7/28
Paul Alwine

7/29
Caroline Sherry

7/30
Gene DeMorrow

7/30
Nettie Russell

Volunteer Spotlight
Anila Mondabaugh, South Bend

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

I have been a CHC Volunteer since July 2005—almost thirteen years. Although I've helped with a couple of office projects, my volunteering has focused on patient care—1-1 companionship and respite care, Eleventh Hour, CAM (Caring Touch and previously Progressive Muscle Relaxation & Imagery) and Life Bio (which I've especially enjoyed). I've also filled in on an interim basis with patients of other volunteers when those team members needed to be away.

Why do you volunteer with CHC?

I feel privileged to be a CHC Volunteer, caring for and supporting those making their sacred journey from this life to the next. In 2002 my mother and our family utilized hospice services for her in my hometown in Florida. The loving care we all received and participated in reinforced a long-time desire of mine to become a hospice volunteer myself. I love serving others, so as I was moving toward retirement from a decades long career as a clinical social worker in private practice and holistic health and yoga instructor, I finally was able to participate in hospice work by joining the fabulous volunteer team at the Center for Hospice Care. The only "down-side" for me is that I don't have MORE time and energy to give to this wonderful organization!

What is your favorite food?

My favorite food is popcorn (which I have fond memories of sharing with my mother over the years), but I actually really love all vegetables, the more variety the better and so healthy!

Where would you most like to go in the world and why?

I've already gone on spiritual pilgrimages to Mexico, Israel and India. If I had the opportunity, I'd love to visit England, Ireland and Scotland for the culture and antiquities and Africa to experience the people and wildlife.

Favorite movie and why?

I am a "cinemaphile", so I feel hard-pressed to name just one movie as my favorite. However, I'm quite fond of movies with "food/cooking/eating" as a theme (e.g., "Chocolat", "The Hundred Foot Journey", "Julie & Julia", "Ratatouille"), or most any version of "Alice In Wonderland".

Tell us a bit about your family.

My engineer husband, Jim and I have been together twenty-three years. We have shared our home with several Humane Society adoptees: currently our two grey and white cats, Sylvia and Sydney.

"When it comes to a kind heart and a comforting touch, Anila is one of the best. Companionship and Caring Touch visits are her specialty and patients appreciate her personalized attention."

Debra Mayfield, South Bend Volunteer Coordinator

Welcome to the Team

Sara Hodges

La Porte CNA

Angelette Johnson

South Bend CNA

Nicole Kuta

La Porte CNA

Sue Schurman

Commercial Billing Representative

Training Tips & Reminders

Helpful Hints for Dementia Patients

Attention grabbers

Try to get your patient's full attention when doing an activity. Rather than sit side by side, sit at a 45 degree to a 90 degree angle. Your patient will be better able to focus on you and see the nonverbal cues in your gestures and expressions.

If your patient's attention wanders, precede questions with your patient's name. For example, "John, did you know that Chicago is known as the Windy City?" If you are still having trouble, gently take your patient's hand in your own and say something like:

- "I'd like to hear more about you."
- "Tell me more about..."

Welcome New Volunteers

Please join us in welcoming these new CHC volunteers! They completed volunteer training on June 20, 2018.

Front row, left to right: Ruben Ottenwalder, Gianna Haller, Linda Strain. Back row, left to right: Josh Jantzi, Michael Seraphin and Janice Berger

Volunteer Needs

Inter-disciplinary Team Meeting (IDT) Volunteer

We are in need of volunteers to help out at IDT meetings weekly. Volunteers are vital to help the meetings run smoothly for the CHC staff. Training is provided, but being comfortable with computers is necessary.

Elkhart Office

Thursdays, 8:00am-approximately 10:00am or until meeting ends

Plymouth Office

Tuesdays, 8:00am-approximately 10:00am or until meeting ends

If you are interested in helping with this opportunity, please contact your Volunteer Coordinator.

Patient Home Visitors

We are in need of volunteers to go into homes to provide respite for caregivers and companionship and care to patients. This is always a need. If you are Level III trained and not yet involved, but would like to be, contact your Volunteer Coordinator.

Elkhart Office

Elkhart needs anyone interested! Male volunteers are greatly needed!

South Bend and Plymouth Offices

All offices are always in need of more Patient Home Visitors.

Spanish Speaking Volunteers

We are in need of volunteers who speak Spanish to help our families and patients communicate effectively and express their needs to our staff and volunteers.

Event Volunteers

We are looking for volunteers for our 10th Annual Bike Michiana for Hospice as well as our 33rd Walk for Hospice. Both events will take place on Sunday, September 23, 2018 and will launch and finish at our Mishawaka Campus next to the beautiful St. Joseph River. Volunteers are needed in many capacities including: Registrant check-in, SAG (support and guidance stops) throughout Elkhart County, After-party support, etc. If you can't make the day-of event, we also need support in the days leading up to the event. For more information, please contact Hannah Nichols via email at NicholsH@FoundationforHospice.org or phone at 574-243-3119.

Male Volunteers

We really need more male volunteers to be a companion, provide respite and help in various volunteer roles within CHC.

Comments from Our Families

- My mother was so fortunate to have spent her last days with you wonderful people. We were treated so well. I miss her so much, but also so grateful for everyone's kindness to us during her transition. I can't praise you enough. The warm blankets for me were so extra special nice. I needed that! Thank you all again so much.
- CHC has set a very high bar for our family. I hope all hospices are this wonderful.
- They provided a lot of education for me and my family about their role and my role. They made it possible for us to keep my brother at home and comfortable as possible, so he could be with us. I am very grateful for everything hospice did to support us. I'm blessed to have been able to provide a peaceful passage to my brother surrounded by his family.
- The care given to my mother during her transition at the Roseland Hospice facility was simply outstanding. We were blessed by your organization's services.

Continued from page 2

back in the pickup truck detasseling corn." Janet listens attentively and responds in a supportive and reassuring manner, letting her know she's glad she had a good time. "You might as well go with the flow, because it won't change anything. Two seconds after it is said, it is gone."

It's amazing that amongst the confusion in Georgia's mind, there are accurate bits of information to be found. Her long lived desire to write and create songs is still available to her. When asked about *Weeping Willow*, Georgia paused a moment, and then she started singing. We had to lean in to hear her soft voice, but it was there, "*Crying weeping willow, makes me feel so blue...*"

Her brother was responsible for getting her poem into song. In such a large family, older siblings were responsible for certain little ones. Georgia was responsible for her younger brother. He eventually moved to California. "She had sent him a copy of the poem," Janet shared. "He knew a recording artist out there. The brother wrote the music and this other guy recorded it. Then he sent it back to mom as a surprise." The song was played on the radio locally.

Weeping Willow, like her other writings, is personal. "She wrote about the things that meant something to her," Janet said. "She wrote about the river, which she lived across the street from." And she wrote about other important aspects of her life, like her friend Carol. Carol planted many weeping willow trees throughout her life. Georgia and Carol were close friends and after she passed away, Georgia wrote *Weeping Willow*.

Though the visits with Georgia can be on the quiet side, Janet visits her faithfully. She appreciates the care that Center for Hospice Care provides. "It has been really nice to know that she is being checked on," she shared. While Janet tried to care for her in her own home, the risk for both became too much. Georgia fell frequently and was capable of wandering off, which was her daughter's fear. It took a toll on Janet's health. But with Georgia now settled into an extended care facility, Janet can focus on her visits with her mom. "CHC staff sometimes notice things that aren't apparent when I'm here. They will catch it and take care of it...I appreciate that."

Dementia has infiltrated the minds of so many people. And while it may feel impossible to connect, because all that seems to surround the person is silence, we may have to dig just a bit further. Somewhere in the depths of even the most confused minds are genuine bits and pieces of who they are: memories, music, laughter and love. If we take our time and listen closely, we might just hear the poem on their lips.

Weeping Willow

By Georgia Dunbar

Crying weeping willow, makes me feel so blue,
Crying weeping willow, makes me weep for you.

You were always planning willows wherever you go.
Planting weeping willows, watching as they growed.

Now you lay beneath one, on the green, grassy hill.
The crying weeping willow stands so very still.

The crying weeping willow, its branches hanging low,
Its tear drops falling softly on your mound below.

Crying weeping willow, makes me feel so blue,
Crying weeping willow, makes me weep for you.

Crying weeping willow, raise your branches high,
Soon there will be no reason to bow them down and cry.

The graves will all be opened, the dead will come forth free,
Crying weeping willow, don't you cry for me.

Georgia and her daughter Janet holding a framed picture of some of Georgia's poems, including *Weeping Willow*.

July 2018
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

Wayne's Tractors

By Kristiana Donahue

There was a time when Indiana fields were plowed with horses, cows were milked by hand and sugar was carefully rationed. Times changed, and tractors started to populate the fields and cows were milked by machines. However, every farm kid still had a robust school lunch, with a meat sandwich, hard-boiled egg and a mama-made dessert. Wayne Harter lives in the Wakarusa farm that has been in the family since the 1840's, which is exactly where he wants to be.

Wayne didn't care for plowing fields by horsepower. He always loved tractors. So when he was about ten years old, he was quite excited to hear his dad put his name on a list for a tractor. "He told me early on that he would buy a tractor if I would maintain and take care of it," Wayne recalled. "On January 1st of 1947 the dealer in Wakarusa got a Massey-Harris 20. It was a little smaller than what we wanted. It pulled a two bottom plow. Not as well as a bigger tractor would, but it was a big improvement over horsepower."

Tractors and farm equipment weren't always available during the War years. Demonstrations were still held even when

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Comments from Our Families	5
Wayne's Tractors Continued	6

Mark Your Calendars

Elkhart Ice Cream Social

Wednesday, August 15, 2018

2:30-4:00pm

22579 Old US 20 E.

Elkhart, IN 46516

In the large conference room

Please RSVP to Marlane Huber ((574) 970-0401) by Monday, August 13th.

Welcome to the Team

Katie Dooley-Echevarria
South Bend IPU PRN RN

Colin Henderson
South Bend RN

Kelly Newman
Elkhart IPU RN

Renee Svorec
South Bend Quality Review & Training RN

Birthdays

8/1
John Guyse

8/7
Destiny Wilson

8/10
Kathy Schlegelmilch

8/11
Linda Meeks

8/11
Donald Neely

8/14
David Simons

8/17
Pamela Rigsby

8/18
Sue Collins

8/20
Diane Hogsett

8/20
Ruth Yoder

8/22
Doris Shea

8/23
Lisette Bolduc

8/23
Patricia Osborne

8/25
Sr. Carmel Marie Sallows

8/30
Paul Piller

8/31
Ginny Russell

Volunteer Spotlight
Norma Diedrich, South Bend

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

On October 19, 1993, I completed the Center for Hospice Care training program. For the past several years, my volunteer hours have been spent with inpatient care.

Why do you volunteer with CHC?

In 1984 , my husband was diagnosed with lymphoma. Five years later, he died. Center for Hospice Care (CHC) was not available to me and I was his only caregiver. In 1989, another family member developed cancer and I became caregiver. I applied for CHC and received it. My experience with CHC was beyond belief. I wanted to give back through CHC to others who needed help to manage these difficult times.

What is your favorite food?

I could live on stir fried vegetables and rice. It is healthy, has lots of variety and very easy to cook.

What do you do in your spare time?

My spare time is spent, as much as possible, with family members. I enjoy working in the yard, reading and arts and crafts.

Tell us a bit about yourself.

I spent most of my life in South Bend. After 30 years of employment with IBM Corp, I retired and became a "snowbird" living in Tampa, FL 6 months and South Bend 6 months. During this time, I was a hospice volunteer in both cities.

Anything else you'd like to share?

Being able to help patients and their families has been very rewarding and helped shape my life in many ways. Thank God for Center for Hospice Care.

"Norma has served CHC patients and families for nearly 25 years! Many of those years have been spent assisting in our South Bend IPU where she is valued for her calm demeanor and compassion."

Debra Mayfield,

South Bend Volunteer Coordinator

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Male Volunteers

Training Tips & Reminders

What is Grief?

Grief refers to the process of experiencing the psychological, social and physical reactions to your perception of the loss. You experience grief through your feelings, thoughts and attitudes, through your behavior with others and through your health and bodily symptoms. It is a natural and expected reaction to all kinds of losses, not just death. It will come and go and involve changes over time. It is based on your perception to the loss. Mourning refers to the process of gradually undoing the psychological ties that bound you to your loved one, to help you adapt to the loss and help you learn how to live healthily without your loved one. Bereavement is the state of having suffered a loss. (Rando 1988.)

The Phases of Grief

Avoidance

A time when the bereaved feels shock, denial and disbelief. "I can't believe it. You must have made a mistake." "I woke up this morning and went to wake up my daughter. I didn't want to believe she is gone."

Confrontation

A highly emotional time when the bereaved realizes over and over that their loved one is gone and the grief is most intense. "I feel like a part of me died with him." "I just want him back. All of my memories hurt."

Accommodation

When the bereaved feels a gradual decline of intense grief and begin to enter their everyday world emotionally and socially and during this time they learn to live with their loss. "I just realized that it has been a week since I cried." "I found myself laughing while out with my friend. I haven't been out with her in a long time and I haven't laughed in a longer time!" "The water heater stopped working. That is something he would have taken care of, but I took care of it and I am proud of myself."

Adapted from Therese Rando

Plymouth Recruiting Event
Please invite people

WHAT CAN YOU DO IN FOUR HOURS

It doesn't take a lot of time to make a big impact on someone's life. Learn more about becoming a hospice volunteer, where your time helping others will greatly impact their lives, as well as yours.

- **Talk to current volunteers! Hear what they have to say.**
- **Ask questions of our volunteer staff.**
- **Apply to become a volunteer.**
- **Bring a friend!**

MONDAY, AUGUST 20, 2018

First United Methodist Church
400 N. Michigan Street
Plymouth, IN

Located in the Education Building behind the church

1:00pm-2:00pm CT – "Volunteering with Center for Hospice Care: How You can Make an Impact"

2:00pm-3:30pm CT – Open House: browse information, talk to volunteers talk to volunteer staff, apply to become a volunteer

Comments from Our Families

- My brother was here a short time in hospice care. It happened to be during the biggest snow storm of the year. This did not prevent the CHC personnel to be here in a moment's notice whenever we needed them. They were awesome and we truly fell in love with all of them. They are such a blessing and gift from God!
- CHC made my last two years caring for my wife so much easier. Thank you CHC.
- My dad was a WWII vet and the team arranged a ceremony and gave his certificate and pin to honor his service. It was very nice.

Continued from Page 1

farmers couldn't purchase them. Later on dealers would put on field days for the farmers and their families. They'd provide sack lunches, tell them about the new equipment and show pictures. "That was always a treat," Wayne remembered. "We'd go to John Deere Day and International Day. That was part of my growing up years."

Wayne also enjoyed tracking the evolution of tractors from the War years on. "Growing up there were a lot of Model A Fords. Farmers would buy them in a junk yard, put bigger tires on the back and farm with them," he recalled. "The biggest problem with the homemade tractors was that since they weren't designed as tractors, pulling a plow slow and steadily would cause them to overheat." But the ingenuity and creativity involved in improving the process is to be commended.

Farm life included early evenings and even earlier mornings. There was community, family life and lots of activity and fresh air. Saturday nights their family would go into town to exchange eggs for groceries. "The men would usually find other men to visit with. The women would visit too. They would leave a list with the grocer, who would have everything ready to go, including the bill. They'd show a movie at the town park, or a concert at the square. Popcorn was available and everyone was welcome."

Wayne also remembers when his parents got electricity. "When my folks moved here in 1941, they had their name in for electricity," he shared. They had to wait for the wiring to become available to build the lines. So they didn't actually get electricity until 1943. His one-room country school didn't have electricity either. "When it was overcast or hard to see, the lamps didn't shine very far," Wayne said. "We'd break for recess and make it up later."

Sitting in the living room with Wayne almost takes you back to the days he remembers. It's exactly that comfort of being at home, surrounded by farm fields and his beloved tractors, that he appreciates. Especially when receiving care. Center for Hospice Care has been coming into his home to provide care. "I think in years past when you told somebody hospice is coming, they automatically thought they don't have long to live," Wayne's daughter commented. "It has changed. It is different now." Wayne has benefited from months of care and the continued comfort and quality of life that CHC offers. "They have been very helpful," he shared. "They have the resources that I wouldn't know of otherwise."

Part of palliative care, also known as comfort care, is keeping patients where they want to be. To be around loved ones and memory-filled homes provides levels of comfort that can't be substituted otherwise. Outside the white, quintessential Indiana-farmhouse, are outbuildings housing the tractors Wayne has collected over the years. He has collected six tractors. He has a Minneapolis Moline, which happens to be the oldest tractor in his collection. Wayne farmed with the Allis Chalmer D 17, which now belongs to his son in law, Doug. He also has a John Deere, Massey Ferguson 65, 1962 Ford 3000 and a 1958 Oliver 550. Wayne enjoys driving the tractor on his property. It brings him joy and fulfillment. "It has been a pleasure to take a tractor out for a drive, or go back to the woods or across the road to the ditch," he shared.

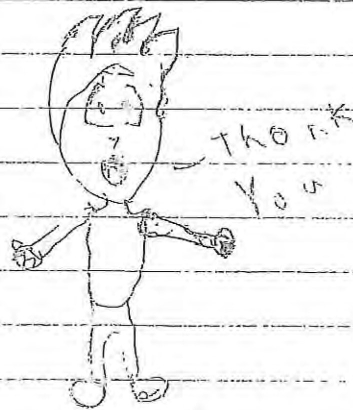
Wayne truly loves the farm life. Not everyone is equipped for it. He has known many people who have tried it and never really took to it. "You have to like what you do," he said, which is true for everyone. Besides his passion for tractors, his ever-grateful attitude for his life, his blessings and his family is evident. "He has been such a hard worker his entire life," his daughter shared. "He started at such a young age and worked as long as he could. He was so good at what he did." And Wayne would tell you that's because he liked what he did.

"I have so much to be thankful for," Wayne smiled. He has seen transformations in his life: from a dozen hand-milked cows to 100 head milked in the parlor, from horse-plowed fields to a collection of tractors and from rations of sugar to a plethora of sweets. However, all of those memories intertwine with his current life as he reclines in the chair so comfortably situated in the 1840's family home. Past and present coincide harmoniously.

Dear Hospice

My name is Braxton Bontrager I am almost 11 years old. I have worked hard to earn this money and it's important to me that it goes to your organization Hospice is important to me because it has helped take care of my family physically and mentally. I just want you to know you guys and girls are superheros to me. What you guys and girls do for your patients and their families is super important. I hope this money will be helpful and if there is anything else I can do for you please let me know.

From,
Braxton
Bontrager



Nonprofit with Towson ties helps breathe 'new life' into seriously ill Tanzanian patients

Two groups in partnership — Gilchrist and the Nkoaranga Lutheran Hospital — provide hospice and palliative care in the United States and Tanzania, respectively. Gilchrist first visited the country in sub-Saharan Africa in 2010.

By **Leah Brennan**
Towson Times

AUGUST 6, 2018, 5:00 AM

When Don Hohne visited the Arusha region of Tanzania in 2012, he saw a man with an enlarged abdomen, swollen with fluid to the point that it looked like he was nine months pregnant. Seeing the man's pain and discomfort, Hohne's group inquired with a local palliative care staff member if the fluid could be removed.

He recalled the staff member saying, "Yeah, it's possible that we could do that. It could be problematic getting him to the hospital, and then he doesn't have any money, so he has no way of covering any of the costs."

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Hohne's four-person group from Gilchrist, a Maryland nonprofit providing hospice and palliative care in partnership with Nkoaranga Lutheran Hospital where that staff member worked, decided to fund a hospital trip for the man, whose name was Thomas. So he was loaded onto a motorcycle and bumped down rugged roads to the Lutheran hospital, which is housed in a series of one-story buildings connected by covered walkways.

Gilchrist provides care for the seriously ill in Baltimore, Carroll, Frederick, Harford and Howard counties and Baltimore City — serving about 5,300 patients annually and about 940 daily — mostly in people's homes and residential care facilites, such as assisted living or nursing homes, as well as across its various facilities, said Lori Mulligan, the senior director of development and marketing. It orchestrates the partnership out of its Hunt Valley corporate office, which is its main administrative office, and has five buildings with 62 beds across the three in-patient centers in Towson, Columbia and Baltimore City.

Hohne, of Sykesville, one of Gilchrist's chaplains and an ordained minister through the United Methodist Church, said Thomas' care cost "a pittance" compared to what it would cost in the U.S.

"You either have what you need or the community provides it, or you go without," the nonprofit's clinical specialist for spiritual care said.

'So much with so little'

Gilchrist Hospice Care began traveling to Nkoaranga, where the hospital is located, in 2010 and aims to bring a new four-person team composed of Gilchrist staff and volunteers, some of whom are medical professionals, every other year. Tanzania, a country of about 53 million people, is located on the east coast of Africa along the Indian Ocean. Nkoaranga Lutheran Hospital members have traveled to the U.S. to visit Gilchrist once and are planning to bring a three-person group in April 2019. The trips are used to share palliative care techniques and observe each other's practices.

The groups' connection began in 2009, when Gilchrist President Catherine Hamel went to a National Hospice and Palliative Care Organization conference and attended a section focused on U.S. hospices in partnership with African groups. She thought it would be valuable to be a part of one, said Robin Stocksdale, Gilchrist's global partnership coordinator. The Gilchrist and Nkoaranga Lutheran Hospital bond is one of Global Partners in Care's 50 partnerships connecting hospices in 20 states with 12 countries, said Lacey Ahern, the program director for the organization. Global Partners in Care links U.S. hospice and palliative care groups with "sister organizations in low-resource settings," according to its website.

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Hohne, 61, said that during the trip they would head out over the hot, dusty terrain in a Land Rover with the hospital's palliative care team in Arusha to visit patients in their homes, coursing up and down difficult roads to ramshackle buildings where people slept and cooked in the same room.

"What we would arrive to find would be a person, a patient, an individual there in that community who was struggling through some sort of end-of-life terminal disease or condition; it could have been terminal cancer, it might have been something that wasn't entirely diagnosed," he said. "Or, oftentimes, we would be visiting with families who were struggling with the after-issues around some members of the family who had died of AIDS."

Palliative care is dealt with in a "very different way" in Tanzania, said Dr. Paul Mmbando, a native Tanzanian who directs the Evangelical Lutheran Church's palliative care program in the African country and who spoke from Tanzania to a reporter. Stocksdale, who works closely with Mmbando and the hospital's leadership, said that with a lack of medical resources, there's a greater focus on interpersonal services, such as prayer, singing and emotional support.

Sharmean Young, of Baltimore City, is a health information management specialist for Gilchrist's pediatric team who went on the trip in 2015. She said the use of basic supplies to help with wounds really stood out to her, recalling that local staff used a mango from a family's front-yard tree to help keep a woman's wound clean, placing the chopped, unripe fruit on her head. She was surprised by how much the people were able to do with a small staff.

"I was shocked," Young, 45, said. "It was life-changing. They were so overwhelmingly grateful for every little bit that we give them."

Karen Hohne, a nurse and Don Hohne's wife, agreed the experience was life-changing. She recalled climbing up a hill with local staff to visit a young boy with Type I diabetes in a home with dirt floors and no refrigeration for preserving insulin. He ended up in the hospital, which didn't have strips for its glucometers for testing blood sugar, so she and her husband purchased some and brought them back, she said.

"Just simple things like that we take for granted here is such a hardship for them there," she said. "I have a greater appreciation for our medical system here, and greater compassion for people who are living in developing countries who don't have the quality of medical care that we have here."

The sub-Saharan African palliative care team serves "well over" 1,000 patients with about five medically trained staff members and 30 volunteers, Stocksdale said. Mmbando said the doctor-patient ratio in Tanzania is one per 25,000 patients, and many of the patients struggle with cancer, HIV and AIDS.

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“The partnership kind of breathed a new life to people in that category, who can’t afford to care for themselves anymore,” he said. “[Gilchrist visitors] managed to see how people do so much with so little and still make a difference in human life, and they fall in love with that.”

About 1.4 million adults and children — about 2.5 percent of the country’s population — are living with HIV in Tanzania, according to a UNAIDS 2016 country fact sheet, and about 33,000 adults and children died that year from AIDS. The Evangelical Lutheran Church of Tanzania has a network of 24 hospitals throughout the country, each with a palliative care program, and Global Partners in Care has 12 partnerships within that network, Ahern said.

Gilchrist does year-round fundraising for Nkoaranga Lutheran Hospital’s $68,000 operating budget through a variety of events, such as concerts, Breakfast with Santa and the sale of African crafts in local churches, as well as payroll-deduction donations from Greater Baltimore Medical Center and Gilchrist employees and community organization donations. Volunteers who return from the trip are also charged to help fund-raise for a year following their trip. Since the trips began, 12 people have gone, all of whom are from Gilchrist’s service area, Stocksdale said.

Other area organizations also have contributed to the operation of Nkoaranga Lutheran Hospital’s hospice services.

In 2014, with the help of the Rotary Club of Hunt Valley and a private foundation, Gilchrist was able to buy a Toyota Land Cruiser for the hospital to use as an ambulance. Funds have also gone to the hiring of a doctor, patient hospital stays, home visits for hospice care, medication, school scholarships for children, HIV support groups for children and adults, and volunteer training, among other efforts.

There are also discussions about potentially building a free-standing palliative care facility to serve northern Tanzania, but they’re still in the preliminary planning stage and a site has yet to be determined, Stocksdale said.

Upcoming fundraising efforts hosted by Gilchrist include a “Paint and Sip” event on Aug. 14 at Greater Baltimore Medical Center, during which mocktails and snacks will be served while people paint. Admission is $45, and those interested can register through Eventbrite. Gilchrist is also raffling two tickets to the Ravens-Steelers game; winners will be drawn Aug. 15. Donations can also be made at gilchristcares.org.

“It’s made a huge difference in this part of the world, and many people’s lives have been changed,” Mmbando said.

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For more information on Gilchrist's partnership with Nkoaranga Lutheran Hospital or fundraising opportunities, contact Robin Stocksdale at rstocksdale@gilchristcares.org.

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Okuyamba Fest 2018: Celebrating a 10-Year Partnership Between Center for Hospice Care and PCAU

Written by Mandy Haack on August 1, 2018

On any given day, most would not think twice about the accessibility to over-the-counter medicine for a headache or a visit to the doctor for a fever. For many parts of the world, access to any healthcare is a challenge, especially end-of-life care. The Palliative Care Association of Uganda (PCAU) is focused on expanding access to palliative and hospice care to all in Uganda. PCAU also encourages us to think about our own privileges, be thankful for them, and consider those who are not so fortunate.

Palliative care focuses on the treatment of patients who are suffering from life-threatening illnesses and relief for their families. PCAU specifically focuses on patients in Uganda who have little to no access to health care. This limited accessibility puts emotional and physical stress on the suffering patients as well as their families.

[Click here for more photos!]

Center for Hospice Care, based in Mishawaka, reached out to PCAU 10 years ago, hoping to affiliate themselves in this global cause. Once ties were made, the connection bloomed into a fruitful partnership. The partnership is celebrated through a very special event—Okyuamba Fest. Okuyamba is the Luganda word for "Help."

This year marks 10 years of growth and support within this relationship. The Okuyamba Fest was held at Center for Hospice Care's Mishawaka Campus on July 31.

Mike Wargo, Chief Operating Officer of the Hospice Foundation (the supporting foundation for Center of Hospice Care) spoke to the positive contributions of the partnership.

"We started working with PCAU when palliative care was only available in 34 of the 112 districts of Uganda," Wargo said. "Now it is available in 97 of those districts. We've provided the funding and support for 60 nurses to go through the clinical palliative care diploma program so they can become prescribers, which has helped them get palliative care into so many districts over that period of time."

Rose Kiwanuka, the Country Director and the creator of PCAU, attended the celebration and gave a heart-warming speech about the partnership's growth.

"It all started in 2008—I remember them calling me; I was the only employee in the organization," Kiwanuka said. "They told me I have been partnered with Hospice in Indiana. Mark Murry [President/CEO of Center for Hospice Care,] thank you for buying into the vision and thank you for studying it."

Kiwanuka credited Center for Hospice Care in helping forge PCAU's path.

"The partnership has made PCAU visible," Kiwanuka said. "You improved our visibility. It is the most successful partnership I've seen globally. We have learned from each other and become brothers and sisters."

A special performance by Uzima, a dance troupe based in the area, guided the celebration inside. As they performed, the spirit of African culture spread throughout the room through the power of dance and drum beats. Men and women of all ages waved vibrantly colored flags while dancing to the beat and encouraged the crowd to do the same. Soon enough, the entire room was dancing, singing, and clapping along.

"This is a good way to represent the culture I come from," said Tawonga Katundu, a member of Uzima. "It gives an accurate representation, instead of what you see on TV. It's a rich culture that you can share with everyone."

During the festival, food and drink was shared alongside passionate conversation about the cause. A silent auction was held to support PCAU; its items included authentic Ugandan artifacts.

Michael Ssemwanga's passion for PCAU hits close to home, as his homeland is Uganda. Ssemwanga owns Entech Solutions, a successful IT business in South Bend.

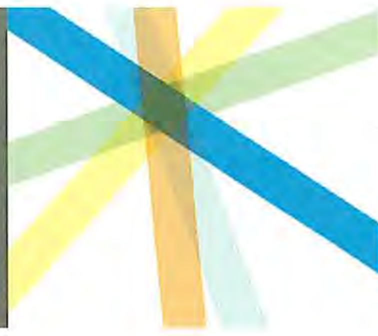
"When you look at hospice care, the people at the end of life, you see they need a comfortable life," Ssemwanga said. "We all have parents. We always grow, we keep growing. We know our parents are going to get there before us. But we need to support this cause because they [our parents] knit the actual fabric of our life!"

"I am a big believer that we have, in our country, everything we need to succeed; it's just a matter of taking opportunities that are presented and asking to help along the way," Wargo added."We are helping people whose circumstances are not anything like ours. People who live in extreme poverty, or people who have no access to health care or education. Though they are oftentimes very happy, the difficulty is when they get sick, there is nothing to help them get better. The only thing we can really do is help relieve the suffering they are experiencing."

The PCAU and Center for Hospice Care's partnership is only expanding. While always displaying the reality of circumstances regarding healthcare around the world, the organizations provide an opportunity for members in the community to reach out and make a difference.

If you are interested in this cause, visit https://pcauganda.org/news/. To learn more about Center for Hospice Care and the Hospice Foundation, please visit cfhcare.org or foundationforhospice.org.

LGBTQ Diversity Training



Speaker: Jason Wilkinson, Executive Director
The LGBTQ Center

All sessions at the Mishawaka Campus

Tuesday, July 10
3:00 - 4:30 PM, Room A

Thursday, July 19
3:00 - 4:30 PM, Room B

Wednesday, July 25
1:00 - 2:30 PM, Room A

RSVP the date you can attend to Barb King at kingb@cfhcare.org
or Kathy Kloss at klossk@cfhcare.org.
Minimum of 10 people required for each session.

Center for
Hospice Care

choices to make the most of life

The New York Times

When a Health Insurer Also Wants to Be a Hospice Company

Humana is teaming up with two investment firms to become the nation's largest provider of hospice care, dominating a rapidly growing — and controversial — business.

By Reed Abelson

June 22, 2018

Humana's decision to purchase two hospice outfits puts it squarely in the middle of the debate over whether for-profit companies can deliver quality hospice care. Luke Sharrett/Bloomberg

Death has always been lucrative enterprise, whether it involves mahogany caskets or teams of estate and tax lawyers. But hospice, the business of caring for those who are nearing death, has become a booming multibillion-dollar industry that is attracting more and more for-profit companies, including one of the nation's major insurers.

That insurer, Humana, is making an unusual bet beyond the current strategy of health insurers to merge with pharmacies or buy up doctors' practices. In teaming up with two investment firms, Humana plans to buy two hospice chains that together would create the industry's biggest operator with hundreds of locations in dozens of states.

Humana, which specializes in offering private Medicare Advantage plans, joined forces with TPG Capital and Welsh, Carson, Anderson & Stowe, two private-equity firms, last December to take over a division of Kindred Healthcare that offers both home health and hospice care. In April, the same group said it planned to buy another large hospice outfit, Curo Health Services, owned by another investment firm, Thomas H. Lee Partners.

In short, Humana, which provides Medicare Advantage plans to about 3 and a half million people for their medical needs, also wants to dominate care for those at the end stages of life, whether it provides aid in a home setting or in a facility.

But a spate of government lawsuits charging negligence and malfeasance against some hospice providers underscores the risks of profiting from the dying: Companies have been accused of signing up people who are not terminally ill, denying visits from a nurse or even refusing a needed trip to the hospital.

While people getting hospice care may be at less risk for getting medical tests and treatments they do not need or want, they could get too little care, said Dr. Joan Teno, a professor of medicine and a health services researcher at the Oregon Health & Science University. The danger when a profit-driven company is delivering care is "the focus is more on profits than on quality," she said.

"We need to make sure quality is front and center," she said.

Humana's decision to purchase the two hospice outfits puts it squarely in the middle of the debate. Both of the companies it plans to acquire have been embroiled in lawsuits brought by the federal government accusing them of, in one case, overbilling Medicare and, in another, paying doctors and nurses illegal kickbacks to refer patients to hospice.

Medicare has largely driven the recent interest in hospice, spending about $17 billion on such care in 2016, the most recent figure available. The program covering health care for people 65 and over began paying for hospice in 1983, a time when many people at the end of life were forced to spend their last days in a hospital bed, receiving expensive but futile treatments. To allow people to die more comfortably at home, the program started services like nursing care and a home health aide for people with a life expectancy of six months or less. People typically agree to stop treatments aimed at curing their disease in favor of care that makes them more comfortable.

'A Pretty Profitable Business'

Hospices are paid a fixed amount per day and are expected to oversee the care of someone with a terminal illness, including home visits, medicines to control pain and trips to a specialist or hospital if needed. While a hospice is paid about $150 to $200 a day for routine care, they can get paid nearly $1,000 a day if someone needs round-the-clock services. Patients can stay in hospice as long as doctors agree they remain terminally ill.

Providing hospice care can be a "pretty profitable business," said Emily Evans, a managing director for Hedgeye Risk Management, a research firm. She estimates some private companies make as much as 40 cents of profit for every dollar of revenue they take in, an extremely high profit margin of 40 percent. The Medicare Payment Advisory Commission, which does research for Congress, estimates that for-profit companies running hospices, which make up about two-thirds of the industry, had an overall profit margin of 16 percent, compared to about break-even for nonprofits.

Many hospice outfits have been sued by the government, accused of overbilling Medicare by enrolling patients who did not qualify, or for stinting on care. Last year, the Department of Justice settled a lawsuit against one company, Chemed, for $75 million. Chemed, a public company, also owns Roto-Rooter, the plumbing and drain cleaning business.

Government officials had accused Chemed and its hospice unit, Vitas, of aggressively billing Medicare for "crisis care," even when patients did not require intensive services. One nurse who worked for Vitas described being sent to patients' homes during a so-called crisis only to find the patients "were at church, the beauty parlor, or playing bingo." Vitas, which was the nation's largest hospice chain at the time, went ahead and billed for crisis care, according to the government's lawsuit.

In one particularly egregious case, a hospice outfit in Texas has been accused by the federal government of giving patients unnecessarily high doses of medication that may have led to some deaths. Earlier this month, a nurse case manager pleaded guilty in the case, acknowledging that she collected unused medications like morphine from patients who had died to administer to other patients, and admitted to helping overmedicate some patients to hasten their death.

Kindred, whose hospice business Humana hopes to buy, was penalized $3 million in 2016 by federal officials and closed some facilities after the government said it could not ensure that it was not overbilling Medicare. The hospice outfit now owned by Kindred had paid $25 million in penalties in 2012 to settle accusations of improper billing.

Curo, the other hospice business, has also had its share of run-ins with federal officials. Last year, it paid $12 million to settle accusations that it handed out kickbacks to reward doctors for sending patients to its hospices.

Even UnitedHealth Group, the nation's largest health insurer with fingers in a number of pies like doctors' practices, free-standing surgery clinics and urgent care centers, sold its hospice business in 2016, the same year it settled a case with the Justice Department.

United's hospice unit, known as Evercare, was accused of enrolling patients who did not qualify, setting "aggressive census targets" for enrollment and paying employees bonuses if they met those targets. The company employed a team to "troll nursing homes, hospitals and other care facilities to obtain new Evercare hospice patients," the Justice Department said.

The flood of lawsuits has discouraged some companies from getting into this field. "There's a lot of risk," said Paul Keckley, an independent health care analyst.

But Ms. Evans contends that "the margin may well be worth the headline risk." The federal government doesn't seem to have "a good plan or an aggressive plan" in prosecuting some of the bad behavior that takes place, she said.

Cutting Staffing and Services

The potential for great profit margins has certainly caught the eye of bigger businesses. While local nonprofit groups used to provide services, much of the hospice care now available is dominated by companies that may seek higher profits even if that involves enrolling patients who don't need such care, or cutting staff and services to bare levels.

For-profit companies tend to argue they are more efficient and can invest in the people and technology to provide better care for dying patients, especially at home. Humana and the two investment firms declined to comment because they have not yet completed the purchases.

Humana has a significant interest in being able to better manage people in their Medicare Advantage plans, which are private insurance plans for people enrolled in Medicare who do not want to be in the traditional program where the government pays doctors and hospitals directly for their care. Its proposed merger with Aetna, another giant insurer, was blocked last year after the Justice Department claimed it would harm consumers.

Analysts say any insurer offering a Medicare Advantage plan would benefit in seeing patients opt for hospice, rather than continue much more costly treatments at the end of life. Under the current system, the federal government pays for all of the costs for anyone who is in hospice. If a patient does not enroll in hospice and stays in a Medicare Advantage plan, the insurer remains responsible for all of the medical bills.

An insurer that can steer patients toward its hospice has "better control," said Rob Smith, an analyst with Capital Alpha Partners. After giving consent, dying patients can be shifted to the hospice program, and while an insurer would lose out on money it received from Medicare to cover that person, a company like Humana could count on the revenue generated by its hospice business. "Your other pocket is filled by Medicare," he said.

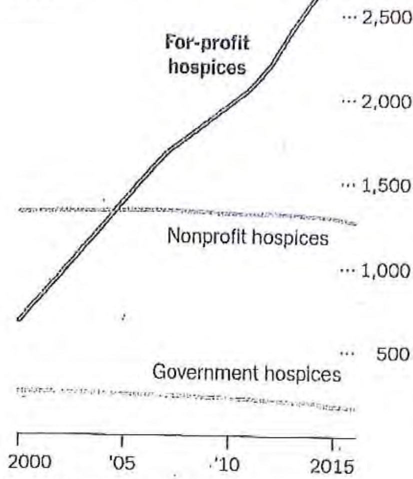
The hospice business has "a pipeline coming from Medicare Advantage," said Ana Gupte, a senior health care analyst at Leerink Partners. "There is a clear synergy from a top- and bottom-line perspective," she said.

Home health care, including hospice, is a critical component of Humana's strategy, analysts say, which is to offer an array of services for people as they age. The insurer may also be betting that hospice care in the home eventually becomes a part of what private Medicare plans must cover in the future.

"Humana wants to own the home," said Chas Roades, a founder of Gist Healthcare, a consultant, even at the end.

Reed Abelson covers the business of health care, focusing on health insurance and how financial incentives affect the delivery of medical care. She has been a reporter for The Times since 1995. @ReedAbelson

A version of this article appears in print on June 24, 2018, on Page BU1 of the New York edition with the headline: Humana Makes a Bet On Hospices


For-Profit Hospice Care
The number of for-profit hospices has more than quadrupled since 2000.
For-profit hospices
Nonprofit hospices
Government hospices
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2,000
1,500
1,000
500
2000
'05
'10
2015
Source: Medicare Payment Advisory Commission
THE NEW YORK TIMES

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Tuesday, June 5, 2018

Center for Hospice Care Plans Groundbreaking on New Northern Indiana Inpatient Care Facility

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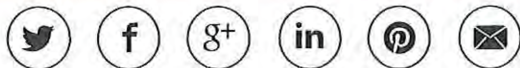

Center for Hospice Care will hold a groundbreaking ceremony on June 12 at 5:30 p.m. on its new 12-bed inpatient care facility to be called the Ernestine M. Raclin House.

MISHAWAKA, IND. (PRWEB) JUNE 05, 2018

Center for Hospice Care (CHC) is in the midst of a five-year comprehensive campaign called "Cornerstones for Living: The Crossroads Campaign." The centerpiece of the Crossroads Campaign is the construction of a new 12-bed inpatient care facility overlooking the St. Joseph River. Thanks to a generous lead gift from Ernestine Raclin, the noted community philanthropist and Chairman Emeritus of 1st Source Corporation, the inpatient care facility will be named the Ernestine M. Raclin House.

Center for Hospice Care Mishawaka Campus Master Plan

"Half of all deaths in America occur when people are receiving hospice care and that number is increasing each year. At CHC, 25% of the 35,000 patients we've cared for over 37 years were seen in just the last four years alone," said Mark Murray, President/CEO of Center for Hospice Care and the Hospice Foundation, the supporting foundation responsible for raising funds for the new facilities.

The Ernestine M. Raclin House, along with a new clinical staff building currently under construction, will be the focal point for providing hospice care throughout much of CHC's service area. "When you consider the first of the 76 million baby boomers began signing up for Medicare seven years ago, the need for hospice care will only escalate dramatically over the next 20 years. This 'Crossroads' campaign is all about CHC putting the infrastructure in place today to meet this need of our communities tomorrow," said Murray.

For more information or to RSVP for this special event, please visit foundationforhospice.org/groundbreaking.

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, Porter, St. Joseph and Starke counties in northern Indiana.

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

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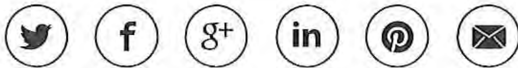

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Major Gift to Center for Hospice Care Will Advance Medical Education

Increasing demand for hospice care, combined with a need to train physicians specializing in hospice and palliative medicine, advanced Center for Hospice Care's (CHC) partnership with the Vera Z. Dwyer Charitable Trust. A transformational gift focused on hospice and palliative medicine education is the result of this collaboration.

A generous $1.75 million gift from the Vera Z. Dwyer Charitable Trust is increasing the number of hospice and palliative care physicians in northern Indiana and will help improve the quality of medical care provided in the region for generations to come.

The Dwyer Trust's gift to the Hospice Foundation, supporting foundation of Center for Hospice Care (CHC), is part of the foundation's five-year campaign to raise $10 million for new construction, endowment and programming needs.

"For adults age 65 and older, the current U.S. supply of hospice and palliative medicine specialists is just 13 doctors per 100,000 people, and the ratio varies widely across the country," said Mark Murray, president/CEO of CHC. "Current training capacity is insufficient to keep up with the demographic growth of those who benefit most from these services."

To become board certified, physicians must complete a one-year Fellowship program in Hospice and Palliative Medicine. U.S. fellowships will need to increase from the current 325 graduates a year to up to 600 per year by 2030, just to ensure enough physicians are available to provide hospice and palliative care services.

According to Murray, "There is a shortage today, and we need to address this shortage, especially as we consider an increasing demand for hospice services."

That demand is coming from the Baby Boom generation and the demand becomes more significant each day. Murray added, "Baby Boomers, those born between 1946 and 1964, now account for 23% of the U.S. population and the first Baby Boomer turned 65 in 2011. Right now, every day, 10,000 Baby Boomers nationwide turn 65."

Vera Z. Dwyer

Recognizing this burgeoning need, trustees of the Vera Z. Dwyer Charitable Trust generously provided a $1.5 million gift to Center for Hospice Care to establish the Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine. The two-part gift provides funding of $500,000 over five years to immediately increase physician training in hospice and palliative medicine, as well as a generous matching grant of $1 million to create an endowment to fund the Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine in perpetuity.

The new fellowship seat will be housed in the Indiana University (IU) School of Medicine's Hospice and Palliative Medicine program, with which CHC has a long-standing collaboration to train physicians participating in IU School of Medicine's fellowship program. The first Vera Z. Dwyer Fellow, Kayla Herget, MD, recently concluded her four-week clinical rotation at CHC and will complete the 12-month fellowship program next month.

To round out the $1.75 million gift, $250,000 is being provided over five years to develop community education programs, which include educational workshops, seminars and events focused on end-of-life care and the importance of sharing those wishes with loved ones, including the development of written advance directives.

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May 3, 2018

"This amazing gift puts CHC at the forefront of delivering specialized training in hospice and palliative medicine," said Murray. "By enabling us to support additional community educational activities and train more physicians, CHC will continue to lead the way in end-of-life care issues."

Vera Z. Dwyer was devoted and generous to her community. In life, she had a significant impact on the lives of many. Upon her death in April 2010, at the age of 89, The Vera Z. Dwyer Charitable Trust was established to advance community health education and community outreach, and to support other causes important her. As a result, her legacy of philanthropic assistance will continue to improve the quality of living in our community for generations to come.

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, Porter, St. Joseph and Starke counties in northern Indiana.

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

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umber of cats for the organization," according to the affidavit for inspection and seizure warrant.

"We've been here 40 years," Pam Comer, Pet Refuge executive director, said. This is the first time I've ever had this kind of situa-

naming because she hasn't been charged with a crime, is no longer active with Pet Refuge and only goes to the shelter to visit the cats taken from her home.

Comer also said the

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Pet Refuge volunteer's home May 3. The 1½-year-old domestic medium hair cat is now available for adoption.

Tribune Photo ALLIE KIRKMAN

HOSPICE CAMPUS ADDS BUILDINGS

Tribune Photo/MICHAEL CATERINA

The Center for Hospice Care has started to build a two-story clinical staff building next to its existing building near Central Park in Mishawaka.

$10M project and medical fellowship begin

By Joseph Dits | South Bend Tribune

MISHAWAKA

Two major buildings will begin to rise this year at the nonprofit Center for Hospice Care campus, next to the city's popular Central Park and along the banks of the St. Joseph River.

Work began in March on a new clinical staff building next to the Center for Hospice Care's current building that will look similar and also be two stories.

And, to the east of that, on Tuesday the charity will break ground on a 12-bed inpatient care facility where terminally ill patients will come to bring their symptoms under control. Some will return home or spend their final days there.

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Tribune Photo/MICHAEL CATERINA

The Center for Hospice Care has started to build a two-story clinical staff building next to its existing building near Central Park in Mishawaka.

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Hospice

The single-story structure will be called the Ernestine M. Raclin House, named after a local philanthropist who made the lead gift. Reservations for the 5:30 p.m. ceremony can be made at foundationforhospice.org/groundbreaking.

That comes as the Center for Hospice Care has also announced a $1.75 million gift that it received to help increase the number of palliative care physicians in northern Indiana. The matching grant comes from the Vera Z. Dwyer Charitable Trust, helping to finance a fellowship, training and community events.

It's all part of an ongoing fundraising campaign. The clinical staff building alone will cost in the range of $4 million, but combined with the Raclin House and landscaping and added parking, the total cost could be about $10 million, said Mike Wargo, chief operating officer for the Hospice Foundation, which supports the center.

The charity still needs to raise another $1.5 million for the Raclin House, he said.

Also, Wargo said, it needs $700,000 to draw all $1 million in a matching grant from the Dwyer Charitable Trust gift, which would create an endowment to support a 12-month fellowship in hospice and palliative medicine each year. Doctors in the program will spend most of the year at Indiana University's School of Medicine in Indianapolis but also spend a four-week clinical rotation at the Center for Hospice Care. This marks the fourth such fellow at the center, recently filled by Dr. Kayla Herget.

The Dwyer gift also provides $500,000 over five years to increase physician training in hospice and palliative medicine. and $250,000 from the gift will go toward community workshops, seminars and programs over the next five years that focus on end-of-life care.

The Center for Hospice Care has seen a spike in growth that keeps it the largest provider of hospice care in Indiana, where it serves about 2,000 patients per year across nine northern counties. It is among more than two dozen agencies, both nonprofit and for-profit, that provide hospice care in that area.

President and CEO Mark Murray cites that a quarter of the 35,000 patients it has seen across the agency's 37 years came in just the past four years.

The clinical staff building may be finished in summer of 2019. Once the Raclin House opens in fall 2019, Wargo said, the center's current Hospice House with seven beds in Roseland will be converted into the new home of the center's Milton Adult Day Services, serving people with dementia, where it will have room for more clients.

The center runs a similar seven-bed Hospice House at the eastern end of Elkhart County that will remain open.

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