Center for Hospice Care
choices to make the most of life

# Board of Directors Meeting

**501 Comfort Place, Conference Room A, Mishawaka**
**November 28, 2018**
**7:15 a.m.**

# BOARD BRIEFING BOOK

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Center for Hospice Care
choices to make the most of life

# CHAPTER ONE

# AGENDA

Center for Hospice Care

**BOARD OF DIRECTORS MEETING**
Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
November 28, 2018
7:15 a.m.

A G E N D A

1. **Consent Agenda** (10 minutes):
   A. Approval of August 15, 2018 Board Meeting Minutes *(action)*
   B. Patient Care Policies *(action)* – Included in your board packet. Dave Haley available to answer questions.
   C. QI Committee *(action)* – Meeting Minutes included in your board packet. Carol Walker is available to answer questions.
   D. Bylaws – Included in your board packet.

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

3. **Finance Committee** *(action)* – Jesse Hsieh (15 minutes)
   A. 2019 Flex Spending Account Limit
   B. 2018 Retirement Plan Audit
   C. YTD October 2018 Financial Statements
   D. 2019 Budget

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

5. **Nominating Committee** *(action)* – Wendell Walsh (5 minutes)

6. **Board Education *(information)* –** "The Admissions Department, Responsiveness, and Opportunities" – Crag Harrell, Director of Marketing and Access (10 Minutes)

7. **Chairman's Report** – Wendell Walsh (3 minutes)
   A. 2018 Board Self-Evaluation Survey

8. Board Member Recognition – Mark Murray (5 Minutes)

Next meeting February 20, 2019

# # #

Center for Hospice Care
choices to make the most of life

# CHAPTER TWO

# CONSENT AGENDA

**Center for Hospice Care**
**Board of Directors Meeting Minutes**
**August 15, 2018**

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

| Topic | Discussion | Action |
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| **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 05/16/18 meeting as presented. The motion was accepted unanimously. | T. Portolese motioned<br>J. Ewing seconded |
| **3. Policies** | • Six revised policies were reviewed. Medication Disposal was changed to reflect current regulations. Our staff has the expertise to destroy medications, but the drugs are the property of the patient/family, not CHC. At the time of discharge we give the family a card with information on how to properly dispose of the drugs. We offer to destroy them and we document the family's response. In the past the government allowed our nurses to destroy medications. Congress is coming around and there are bills to allow hospice RNs to destroy medications in light of the opioid crisis, so in the future nurses may be able to destroy medications again.<br>• Informed Consent – Indiana law changed July 1st to clarify who can make health care decisions for patients if family members cannot agree on a course of action or the patient has no one to speak on their behalf.<br>• A motion was made to accept the revised policies as presented. The motion was accepted unanimously. | S. Weirick motioned<br>J. Hsieh seconded |
| **4. QI Committee** | • The QI Committee met May 22nd. A representative from each discipline serves on the committee, including chaplains. Families give feedback on chaplains in the CAHPS survey.<br>• A motion was made to accept the QI Committee minutes as presented. The motion was accepted unanimously. | J. Hsieh motioned<br>A. Milligan seconded |
| **5. President's Report** | • Census has recovered nicely from about this time last year. It has been over 400 | |

| Topic | Discussion | Action |
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| | for nearly every day since May. Through yesterday, August census was 405. Census reached a high of 419 on July 2nd. The ADC at the end of July was up 1.5% from a year ago. Referrals and original admissions are up and ahead of 2017. YTD conversion rate of referral to admission is down slightly at 72% compared to 73% a year ago. Anything above 70% is considered national to be optimal. Unfortunately, the percentage of patients dying before admission is up to 7% compared to 6.62% a year ago. This is due to ongoing very late referrals or families not capable of making a decision until after it is too late. The number of patients served is down seven patients, which has nothing to do with staffing or the temporary closing of the Elkhart Inpatient Unit. YTD deaths/discharges within seven days of admission are 41.3% compared to 43.7% a year ago. The national average is 28%. Part of that is because we have an inpatient unit and half of our referrals come from hospitals and most of those patients have a much shorter length of stay.<br>• The Elkhart Inpatient Unit is temporarily closed due to not having enough staff for two positions 24/7. In this job market we have had difficulty hiring staff, especially in Elkhart County. The number of people leaving employment is for a wide variety of reasons including retirement and changing to PRN. We have had great success in recruiting new staff, but they have to give notice to their current employers and then go through orientation. We had two interviews yesterday and both have accepted the positions. Our HR Director said in her 31 years working in Human Resources, she has never seen anything like this current work ethic or lack of ethics. People don't show up for work and don't show up for scheduled interviews. We will start hiring two RNs for at least the day shift in the IPUs, so at least it will be covered if one calls off. We were covering empty shifts with a couple of the nurse coordinators, but they were working 60 hour weeks and it also took them away from their regular job. Our plan is to reopen the Elkhart IPU on September 4th.<br>• Since the U.S. Labor Department starting tracking statistics, there are now more jobs available than people out of work. Everyone in the Executive Roundtable (NHERT) has IPUs and two or three are having the same problem we are. They are going to staffing agencies and using contracted staff, which is against Medicare regulations. Using staffing agencies in hospice IPUS is also not good care. There is a lot of specialty care work required in a hospice IPU. Core services | |

| Topic | Discussion | Action |
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| | have to be W2 employee including the nutritionist. We have two openings at the South Bend IPU that we are filling with Elkhart staff. We have also approached Kindred Hospital staff because that facility has closed.<br>• The OIG came out with a 41 page report on hospice fraud that got some mainstream media pick-up. Most of the data was five years old and heavy on for-profit abuses, a lot of which were small mom and pop programs. They highlighted some real outliers and made 16 recommendations to CMS. CMS rejected all of them except about five or six. CMS didn't think much of the report.<br>• Craig Yahne, our auditor at David Culp and Company, has left that agency. Karl H. talked to the managing partners and they said they no longer have the expertise and staff to do our audit, so they are resigning from our account. The Finance Committee discussed this at their meeting last week.<br>• Medication costs through Optum continue to go down. The cost is now $4.63 per patient day compared to $8.54 in 2015 with the former vendor. This has been a savings of $533,400.<br>• We had our ISDH Hospice survey eight to nine months after the federal mandate three-year deadline. The surveyor also investigated two complaints and found both unsubstantiated. Anyone can call the ISDH 800 hotline number and the ISDH has to investigate every complaint no matter what it is. There were only two issues found in the survey. One was we didn't list oxygen on the medication profile, which we have never done. We are doing that now. The FDA actually approved oxygen as a medication and a physician order is needed for an E tank to be placed in the home. The second issue was with one single visit the nurse didn't measure a wound. Our policy is to measure wounds at every visit and if our policy is stricter than the state and federal regs, the surveyor goes by whatever is stricter. We submitted a plan of correction and it was accepted. There will be no resurveys or further visits from the state.<br>• A new CMS policy goes into effect October 1st regarding early transfers to hospice from a hospital. If the hospital discharges a patient to a hospice during the course of the DRG, its payment will be reduced to a per diem for the days the patient is in the hospital. The hospice industry is concerned that this may be a disincentive for hospitals to refer to hospice. Congress sent this to MedPAC and wants to know by March 2020 if they see referral patterns change because of this. CMS said | |

| Topic | Discussion | Action |
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| | hospices are the only post-acute care provider not affected by this and for consistency they plan to add hospice and treat hospice like any other post-acute care provider.<br>• We've hired a new doctor that will start in July 2019. She is starting her board Fellowship in hospice and palliative medicine this year. Her husband is a pediatrician and has a new job locally. He wants to get a PhD in Theology at Notre Dame. They also have family in the area and like the private schools here for their children.<br>• We have been starting some diversity training for staff as part of our strategic plan. 86% of hospice patients in the U.S. are Caucasian. Training will be made part of the regular staff meetings or special meetings. We had a representative from the LGBTQ Center in South Bend do a presentation directors and coordinators. We will continue offering further training on a wide variety of minority issues.<br>• Edo Banach, NHPCO President/CEO, was here a few weeks ago. It was a good visit. He asked about having an ambassador for the State of Indiana for the NHPCO My Hospice Campaign to highlight the value of hospice care. He was impressed with Elleah Tooker, our Community Education Coordinator, and she has agreed to be Indiana's Hospice Action Network ambassador. Elleah was hired with funding we received from the Vera Z. Dwyer Trust for community education initiatives.<br>• Three staff members from PCAU visited us and helped celebrate our 10th anniversary with them. Thank you to Jen Ewing and Carol Walker for assisting Rose in getting a medical test she needed while she was here. Rose said now she has a better perspective from the patient side receiving treatment.<br>• Humana bought two national hospice chains and will become the largest hospice provider at that point. It is very frightening that insurance companies are becoming providers. If hospice is carve out goes away from Medicare, Humana could change and say patients have to use the hospices in their network. The article on this is in the board packet. | |
| **6. Finance Committee** | • The Finance Committee met last week and reviewed the YTD July Financial Statements. The case mix of hospice/home health patients is tracking very well with the budget. The committee is in the process of sending RFPs to Crowe | |

| Topic | Discussion | Action |
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| | Horwath, RSM, and Kruggel Lawton to be our new audit firm. A special Finance Committee meeting will be scheduled for their presentations. We feel these three can handle our audits.<br>• July YTD is tracking fairly close to the prior year and budget. Operating revenue is $13M, total revenue $13.1M, total expenses $11.5M, net gain $1.6M, net without beneficial interest in Foundation $1.8M.<br>• A motion was made to accept the YTD July 2018 Financial Statements as presented. The motion was accepted unanimously. | S. Weirick motioned<br>T. Portolese seconded |
| **7. Hospice Foundation Update** | • We are in the final year of our five-year, $10M comprehensive capital campaign. So far, we have raised $11M with 11 months to go. We are focusing on two underfunded areas. One is $5M for Raclin House. We need $1.5M to achieve that goal. Construction costs have been rising, employment costs, the cost of cost of steel and lumber, etc. Thank you to those that attended the groundbreaking ceremony. The other area is we received a $1M matching grant from the Vera Z. Dwyer Trust to endow a seat at the IU School of Medicine in hospice and palliative care Fellowship program. $610,000 is remaining to take advantage of that match. We have three years left in that five year challenge. We would love to have it done by June 2019.<br>• Okuyamba Fest was 07/31. About 175 people attended. It went really well. A number of people bid on the silent auction items. All of the proceeds go to the Road to Hope fund. There are 57 children in Road to Hope and of them, 51 are fully sponsored. By the end of the evening two more were sponsored. Rose was very complimentary of the contributions of staff. Many staff members are Road to Hope sponsors.<br>• A physician-focused version of IU Talk will take place on September 12-13the Mishawaka office. The workshop is designed to teach clinicians effective communication skills for difficult patient conversations. The workshop will be taught by Dr. Lyle Fettig and Dr. Erin Newton of the IU School of Medicine in Indianapolis.<br>• We will be hosting our fifth “Introduction to Hospice and Palliative Care” class at Notre Dame on 09/22. This is an all-day one credit hour course with required classes on either of two evenings that week as well. Our staff will be the faculty for the class. | |

| Topic | Discussion | Action |
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| | • Construction Update – We are on track with where we anticipated. There were some delays with the delivery of steel. We are in the process of finishing the foundation work on Raclin House. It is expected to be done next fall 2019. The residential house is expected to be done in November. If we can get $300,000-$350,000, that will do a lot for the Cedar Street Corridor and property values in the area. This was done as part of our agreement with city to build at least one residential home and sell it. We also want to make sure the neighborhood surrounding our campus is as good as it can possibly be. We are marketing the home as being built by Helman-Sechrist and Devine Homes by Miller. We are staying out of it as a silent partner. Thank you to Corey Cressy for helping us during all of this early on and navigate the waters, knocking on doors of neighbors, etc. The city has been great to work with. | |
| **8. Board Education** | • Cyndy Searfoss, Director of Education and Collaborative Partnerships, gave a presentation on the Center for Education and Advance Care Planning. We are not using the word hospice in the name, but we are using the logo burst. We want people to see that connection with CHC, but we are not trying to be specific that hospice is what we are talking about. Hospice will be a part of the conversation we are having, but we are moving way upstream and including 18-20 year olds. The mission is to be your complete resource for end-of-life planning. We want to help make talking about end-of-life concerns easier. We have three target audiences—professionals, people, and their loved ones. We have developed a website and are finishing its content. There are three areas—community education, professional education, and student learning. The website uses artwork from the After Images art counseling program.<br>• Honoring Choices Indiana-North Central (HCINC) is now a d/b/a of Hospice Foundation. CHC is one of about 22 members helping to put the organization together. HCINC will promote advance care planning in the community. HCINC will be hiring a part-time advance care planning coordinator that will oversee the day-to-day operations of HCINC.<br>• The Vera Z. Dwyer Trust is also funding IU Talk. We will be offering two-day intensive training to doctors on Sept 12-13 at the MC. We are offering 12 seats to various community medical providers and partners. We anticipate offering the workshop to mid-level clinicians in the future. We will also offer CEs for | |

| Topic | Discussion | Action |
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| | accountants, financial planners, and attorneys. Some workshops will be held at IUSB and some at our Mishawaka Campus. We also have a number of student learning opportunities. One is the September 22 one-hour course at Notre Dame for pre-professionals, which is typically pre-med students, but some go into nursing or other clinical work. We are looking at making this more interactive for the students than just lectures.<br>• A number of students from the U.S. and Canada might be interested in being involved in GPIC projects. | |
| **Adjournment** | • The meeting adjourned at 8:30 a.m. | Next meeting 11/28 |

Prepared by Becky Kizer for approval by the Board of Directors on 11/28/18.

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Carol Walker, Secretary Becky Kizer, Recording Secretary

Center for Hospice Care

# DISCHARGE CRITERIA

Section: Patient Care Policies Category: Hospice Page: 1 of 2

REGULATION: 42 CFR 418.104 – Clinical Record

PURPOSE: To ensure appropriate discharge from Agency services.

POLICY: Patients may be discharged from the Agency for any of the following reasons:

- Death occurs
- Patient/family/primary caregiver (PCG) requests an end to the services of the Agency team (HMB/MHB would result in Revocation. See "HMB/MHB: Revocation" policy).
- Transfer to another hospice.
- Patient moves or transfers out of our service area
- IDT determines the patient no longer meets the definition of terminally ill as outlined in the appropriate LCD.
- Cause – The patient can be discharged for cause if the patient's behavior or other person in the patient's home is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the agency to operate effectively is seriously impaired.

Documentation within the medical record must be clear and ongoing, outlining the circumstances leading up to the decision to discharge ~~a patient based on the patient's improving condition~~. This documentation must include the patient/family education and understanding of the anticipated end to hospice services, and the attending physician's agreement with the IDT's findings.

Efforts will be made and documented to admit the patient into the Palliative program of the Agency.

~~**For Hospice Medicare Benefit Patients Only**~~

~~The patient can be discharged for cause if the patient's behavior or other person in the patient's home is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the agency to operate effectively is seriously impaired.~~

PROCEDURE: After the Interdisciplinary Team (IDT) meets and the decision is made for discharge, the patient/PCG will be notified. At the time of discharge, an IDT note and Discharge Summary is completed.

Complete a Discharge Summary under Patient Note in the computer. Begin note by stating it is a discharge summary. If deceased, information in the note will include:

- Date and time of death
- Who was present at death and reaction
- What doctor was notified, who will sign death certificate
- What funeral home was contacted
- Pharmacy notified
- DME/IV provider notified
- ~~Efforts to dispose of narcotics~~ Education on disposal of narcotics

- Family understanding of bereavement services

**~~For Hospice Medicare Benefit Patients Only~~ Discharging for Cause**
When a patient is discharged for cause, the following procedure must be followed before discharge:

- Advise the patient that a discharge for cause is being considered;
- Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;
- Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and
- Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into his/her medical records.
- Include DON, ADON, or VP/COO in the IDT.

The Agency must notify the Medicare contractor and the Indiana State Department of Health of the circumstances surrounding the impending discharge. The Agency may also need to make referrals to other relevant state/community agencies (i.e., Adult Protective Services) as appropriate.

**Discharge Order** – Prior to discharging a patient for any reason listed ~~above~~other than revocation, transfer, or death, the Agency ~~hospice~~ must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his/her care, this physician should be consulted before discharge and his/her review and decision included in the discharge note.

**Hospitalized Patients**
Hospitalized patients being discharged to an ECF Medicare A skilled bed must be given ~~the option to revoke~~education on revocation in order for regular Medicare to cover their skilled ECF days. They should not be discharged.

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.

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. If there is no funeral home identified and family can not be reached, will not make a decision, or there is no family to make a decision:
    - Call Social Work to work with the family or identified person
    - ~~13.~~ Notify your coordinator or nurse leadership on call, if Social Work is unable to resolve in a timely manner.

~~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.

PURPOSE: To ensure the availability of initial medications and treatments after the admission of a patient.

POLICY: Standing orders will be requested of the attending physician upon admission of the patient onto CHC services.

PROCEDURE:

1. Standing orders will be sent out at the time of admission to the attending physician for his/her signature.

2. Standing orders are **NOT** valid until they are signed, dated, and returned by the attending physician/nurse practitioner (NP). Verbal orders will not be allowed for standing orders.

3. Once the signed standing orders have been returned, if there are exclusions, additions, or changes, the QA department or the secretary at the branch offices will put "Standing Orders" into Alert/patient notification. ~~If the physician has made no changes to the standing orders, then the directions will state, "Standing orders." However, if there are~~These exclusions, additions, or changes~~, these~~ will be detailed in the Alert, e.g., "Standing orders with additions of Protonix."

4. QA Department will notify nursing staff when standing orders have been signed and returned via email.

~~4.~~5. When initiating a medication from the standing order, it is necessary for the RN/LPN initiating the order to notify the attending physician that a medication has been initiated per the signed standing orders. If it is after business hours, you **MUST** notify the physician on the next business day.

~~5.~~6. The medication that was initiated must be entered into the patient's medication profile marked as covered and a physician order created.

~~6.~~7. If a schedule II narcotic has been ordered from a local pharmacy or facility pharmacy, it will be necessary for the ordering RN to contact the attending physician for a hard copy of the prescription to be sent to the local pharmacy.

~~7.~~8. The nursing staff may call in refills on any of the medications on the standing order list as needed, unless otherwise indicated on the standing order.

~~8.~~9. If the attending physician is unavailable, the Medical Director/Hospice Physician will write orders.

Signature: President/CEO

~~9.~~10. Standing orders are never to be placed in the long-term care (LTC) facility charts. When a medication from the standing orders is initiated on a LTC patient, an order for that medication must be given to the LTC facility.

~~10.~~11. Standing orders are **NOT** to be used on the pediatric patient or on any patient weighing less than 95 pounds.

Effective Date: 01/06 Revised Date: 11/18~~11/16~~ Board Approved: 10/19/16
Reviewed Date: 09/14 Signature Date: 10/19/16

Signature: President/CEO

Center for Hospice Care

# ALERTS IN THE ELECTRONIC MEDICAL RECORD – DRAFT



PURPOSE: To establish an Agency protocol on what constitutes a notification/alert of potential issues.

POLICY: Agency staff will plan an Alert in the electronic medical record (EMR) to notify all staff of potential issues in patient's place of residence, or notification of exceptions to orders/procedures.

PROCEDURE:

1. Upon assessment of a potential issue, the Agency staff member will notify the Quality Assurance (QA) department to place an Alert in the EMR under the patient alert tab.
   (a) Case managers can add Alerts if QA is unable.
   (b) Alerts should be added the same day they are identified.
   (c) Information regarding the Alert that staff needs to know should be placed in the Alert text box.

2. Potential issues that should be placed in Alerts:
   (a) Aggressive animals in the home
   (b) Infestations
   (c) Lockbox
   (d) Written agreements
   (e) Single prescriber for opioids
   (f) Multi-Drug Resistant Organisms (MDRO)
   (g) Exceptions to standing orders or algorithms
   (h) Other issues that all clinical staff need to be aware of

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|---|---|---|
| Effective Date: 11/18 | Revised Date: | Board Approved: |
| Reviewed Date: | | Signature Date: |

REGULATION: 42 CFR Part 484.65 – Quality assessment and performance improvement

PURPOSE: To develop, implement, and maintain an ongoing, Agency-wide data-driven quality assessment and performance improvement program that reflects documented evidence of results.

POLICY: The Agency's governing body will ensure that the program will:

- Reflect the complexity of the organization and services
- Involves improvement projects that are centered on Home Health services
- Focuses on indicators related to improve outcomes such as, but not limited to: hospital admissions, use of emergency care services, medication errors, falls, and other Agency identified patient care outcomes.
- Take action to demonstrate improvement in Home Health program care performance.
- Evaluate QAPI programming and projects annually.
- Focus on high risk, high/low volume or problem prone areas.
- Ensure designation of one or more individuals are responsible for QAPI programing.

The Quality Improvement Committee shall meet quarterly and report their activities to the governing body following every meeting. Additionally, governing body members are invited to attend all meetings of the Quality Improvement Committee.

The number and scope of improvement projects will reflect the complexity of Home Health services and Agency past performance with approval by the Quality Improvement Committee.

PROCEDURE: The Agency's Home Health quality programming will be data driven, show improved outcomes, and report to the Quality Improvement Committee quarterly. The roadmap for improving includes the use of:

- AIMs – Consider evidence, prevalence, and severity of high risk, high volume, problem prone areas that reflect Home Health outcomes, patient safety, and quality of care.

- Measures – QAPI projects will include collecting and analyzing data for quality measures from OASIS (when applicable) and other Agency identified relevant data.

A model for improvement projects can include use of the PDCA cycle for improvement:

- Plan – Decide on the change project and collect the data
- Do – Carry out the plan

- Check – Analyze the results and compare them to predictions
- Act – based on results, make a plan for the next actions

**Annual Program Evaluation**

An annual program evaluation will include a review of patient care services and business operations. Individuals, organizations, and care partners with CHC in patient care activities are invited to participate in the evaluation. The evaluation will include, but not be limited to:

- Effectiveness of the QAPI programming and projects
- Effectiveness, quality and appropriateness of Agency services provided to patients and the community, including services provided under contract.
- Effectiveness of administration and fiscal operations
- Utilization of staff
- Review and revision of policies and procedures

**Confidentiality**

All information related to QAPI program activities is confidential. Confidential information may include, but is not limited to: Quality Improvement Committee meetings, performance improvement project reports, electronic data gathering, medical record reviews, and adverse patient events.. Some information may be disseminated on a "need to know" basis as required by agencies such as federal review agencies, regulatory bodies, or any other organization with a proven "need to know."

**Center for Hospice Care**
**QI Committee Meeting Minutes**
**August 28, 2018**

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

| Topic | Discussion | Action |
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| **1. Call to Order** | • The meeting was called to order at 8:00 a.m.<br>• Welcome to new committee member Connie Haines, Admissions RN Coordinator. | |
| **2. Minutes** | • The minutes of the 05/22/18 meeting were approved by consensus. | |
| **3. Hospice Compare Reporting – Comprehensive Pain Assessment at Admission** | • Hospice Quality Reporting includes the scores from the Hospice Item Set (HIS) and CAHPS Hospice Surveys. The data on the website is old and is slowly updated with a year's worth of data every quarter. CHC's pain assessment at time of admission score for the period of 04/01/16 – 03/31/17 was 54%, for 07/01/16 – 06/30/17 it was 62%, and for 10/01/16 – 09/30/17 it was 69%. We put in place education to increase awareness and two people check the data and give feedback to individual nurses to make sure that seven of the pain assessment elements are captured. This data will be pulled monthly. This will be an ongoing project and education to ensure the information in the medical record matches what is in the HIS. Compliance has improved from 87% in 2017 to 97% in 2018. | |
| **4. Hospice CAHPS Questions** | • Identified improvement projects based on the CAHPS scores include (1) getting help with symptoms, (2) understanding side effects, and (3) getting hospice care training. These scores have been below the 80$^{th}$ percentile. It is important to remember that these scores are when the survey was returned, not when the patient was on service. We can go into the Press Ganey database and pull the data for when the patient was on service. Then we can compare our before and after scores to show our efforts to improve.<br>• The CAHPS Survey Improvement QAPI is working in improving education for patients/families on medication side effects, and the IDT's role in helping patients identify and get help for anxiety and sadness. We researched teaching methods and | |

| Topic | Discussion | Action |
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| | want to focus on the "teach back" method to make sure the patient/family understands what they are being taught. One resource is the care kit in the home. We want to make sure the caregiver feels comfortable administering the meds in the kit. We are working with our nurses to take the care kit out on their first visit and review it with the patient and family. Carol W. asked if there was anything written like bullet points as a reference for the patient/family. DeliverCareRx does provide information. We find that families are not in a position to know to even go to those resources. We will create a simpler teaching sheet for them and attach it to the care kit. 40% of admissions die in seven days or less, so there is not a lot of time for teaching.<br>• The QAPI is also looking at the IDT's role in helping patients to identify and get help for anxiety and sadness. We are considering the use of tools and resources to adequately get this information and how to best help patients and families. One element is for all clinical staff to be educated on how to identify and know what to do when sadness/anxiety is identified as an issue for them. These will be ongoing projects until we have the education in place.<br>• We follow up on any negative comments on the CAHPS. The PCCs follow up and report the results and action plan at the monthly nursing leadership meetings, and then Sue M. reports the results to the administrative team. If the comments involve other disciplines, those coordinators follow up and report to Dave H. Last month we found we had already followed up with two of the four comments with families earlier. Some of the positive comments are listed in the weekly announcements that go out to all staff. | |
| **5. Hospice HIS Visits at End of Life** | • Measure One is at least one visit from an RN, physician, nurse practitioner, or physician assistant in the last three days of life. Measure Two is at least two visits from a medical social worker, chaplain, LPN, or Hospice Aide in last seven days of life. Exclusions are patients receiving Continuous Care, Respite or GIP in the last seven days of life or had a length of stay of one day. The IDT receives an Enhanced Care email alert to notify them that a patient is imminently dying. We use a PPS score of 30 or below. We have seen an increase in the number of RN visits since we began the email alert. The QAPI looks at the scores, creates new action plans, and looks at other mechanisms we can put in place in addition to the alert email to ensure the right team members visit the patient at least twice in the last seven days of life. Sometimes the family refuses the visit and we document that. The QAPI team will work with IT to see | |

| Topic | Discussion | Action |
|---|---|---|
| | if a Cerner report can be generated to help better track the visits in the last seven days of life. The team will also look for ways to track any visit refusals. | |
| **6. Hospice Education & Training** | • We provide education to staff to make sure they have the skills and competence to meet the needs of the patients/families. NHPCO webinars are offered twice a month. The CNAs have a monthly inservice. HeartWize and BreatheEazy education includes the social workers and chaplains. A cardio-pulmonary boot camp was held in June and another will be held this week. We did blood transfusion skills validation. We had an IHPCO webinar on best practices for caring for pediatric patients. We also had orientation with new employees. | |
| **7. Hospice – IPU Projects** | • Respite – We identified a need through some consumer concerns and CAHPS comments that we needed to improve the experience of patients/families for respite stays in the IPUs. Amber J. and at that time Sarah Ryder put together a Respite Questionnaire where the IPU nurse or PCC calls the family before the patient comes in for Respite and asks questions so we can make their stay as home-like as possible. The questions include what time the patient likes to get up/go to bed, favorite food, TV shows, do they like to get dressed and sit in chair for the day, etc. Staff has embraced this and the families have been very happy we are asking these questions. We also educate staff to make sure they understand the difference between Respite and GIP. Under Respite the patient is our guest and it is more of a customer service.<br>• GIP Documentation – We are looking closely and documentation and educating staff to document why Medicare should pay us for GIP. In February we starting pulling charts randomly to see if the documentation showed why the patient was in the IPU, what we were doing for them, is it working and if not what were we doing about it. In the beginning compliance was about 65%. We began education and individual face-to-face meetings. Since then we have seen compliance improve to 80%, and among the nurses that we did face-to-face meetings, compliance improved to 97%. The PCCs review charts to make sure we are documenting what we tried in the home before the patient came to the IPU for GIP. | |
| **8. Hospice Survey** | • We had our hospice survey in June. The surveyor investigated two complaints and found both unsubstantiated. We don't know what the complaints were. The surveyor identified two concerns during the survey. One was oxygen was not on the medication profile. Staff was educated and all oxygen orders are now listed on the medication profile. We monitor this in the weekly IDTs. The other concern was a wound was not | |

| Topic | Discussion | Action |
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| | measured on one visit per CHC policy. We reviewed wound and skin care practices with all nurses and review this in the weekly IDTs. The care plans were also updated in Cerner to reflect increased detail in care planning. The state accepted our plan of correction. | |
| **9. Hospice Safety Monitors** | • Over the past six months we separated hospice and home health adverse events. There were some skin tears which are usually related to someone bumping into something. We continue to look at medication errors and drug diversions. We average two a month. When we suspect any type of diversion, we try to get as much information as we can, have an IDT to look at next steps, and try to determine if the diversion is by a family member, patient, or someone else. We look to see if we have tried other options or brought in a lockbox. The next step is to see how many patients have been discharged for cause. It is very rare that this occurs. We refer the patient/family back to the Attending Physician (if there is one) or to other providers/resources, and we document the referral. We also keep the Attending Physician informed. We treat it like a regular discharge. We also give a report to the new provider.<br>• Fall trends – Since April we have seen an upswing in the number of falls. Some patients continue to fall several times even when we've done everything we could to make sure they are safe. One fell twice over the weekend. The major reasons for falls are getting out of bed and toileting. | |
| **10. Hospice Quality Indicators – IDT Experience Model** | • We began the Experience Model for IDT meetings a little over a year ago. It was going very well, but recently we find staff going back to old habits. Rebecca and Chrissy visited each office's IDT in June and July. Every doctor that goes to each office should find the same IDT process. The biggest disconnect we found was nurses going back to the medical side of things and what they can do as a nurse, not the patient/family goals which is the focus of the Experience Model. So we will re-educate staff on the model. We will formalize the findings and work with each office to make sure the model is hardwired into their practices. | |
| **11. Hospice OIG Portfolio Review** | • The OIG issued a report on "Vulnerabilities in the Medicare Hospice Program affect Quality and Program Integrity." Some of the report included old data and outliers from years ago. CMS rejected over half of the OIG's findings and found some of them to be either extraordinarily burdensome, not needed, out of the surveyor's scope, and in a few instances statutorily prohibited. NHPCO's response acknowledged there are areas for improvement. Its recommendations included working with Administration to | |

| Topic | Discussion | Action |
|---|---|---|
| | simplify and streamline the hospice benefit, better oversight and accountability for fraud versus general documentation errors, and recommended agencies use NHPCO's Standards of Practice for Hospice Programs. All PCCs have a copy of it. | |
| **12. Home Health Quality Improvement** | • The new home health CoPs came out in 2018. We established a home health survey took and checklist, updated policies, and created an Aide Annual On-site Supervisory Visit form. Annually the PCCs observe the aide performing care as part of their annual competency evaluation. We have created home health version of the family handbook. Next phases include monitoring documentation to ensure the patient remains eligible for home health services, and that there is no co-mingling of home health and hospice eligibility requirements. | |
| **13. Home Health Mock Survey** | • We are due for a home health survey any time after 09/01. We will do some mock surveys and get staff prepared. We will be doing car checks of medical supplies in September. | |
| **Adjournment** | • The meeting adjourned at 8:50 a.m. | Next meeting 11/27 |

**BY-LAWS**
**OF**
**THE CENTER FOR HOSPICE AND PALLIATIVE CARE, INC.**

## ARTICLE I

## Identification and Purpose

**Section 1 Corporate Name.** The name of this Corporation shall be The Center for Hospice and Palliative Care, Inc. (d/b/a "Center for Hospice Care") (hereinafter referred to as the "Corporation").

**Section 2 Aims, Purposes, and Powers.** The Corporation is a nonprofit, public benefit corporation serving citizens of St. Joseph, Marshall, Starke, Fulton, Elkhart, LaPorte, Kosciusko, Porter, and LaGrange Counties in the State of Indiana. Its aims, purposes, and powers are:

(a) To improve the quality of living.

(b) To operate primarily as a state licensed and Medicare certified hospice, but also provide palliative care programs and services for persons with life threatening illnesses and their families as a state licensed and Medicare certified home health agency.

(c) To have and exercise all the general rights, privileges and powers permitted under the Indiana Nonprofit Corporation Act of 1991, as amended (the "Act"); provided, however, that it shall engage in no activity which is not permitted by an organization that has been determined by the Internal Revenue Service to be a tax-exempt organization as described under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). The Corporation shall not intervene in, or participate in, any political campaign on behalf of any candidate for public office. No part of the net earnings of this Corporation shall inure to the benefit of any private individual and no director or officer of the Corporation shall receive any pecuniary benefit from the Corporation, except such reasonable compensation as may be allowed for services actually rendered to the Corporation.

## ARTICLE II

## Fiscal Year

The fiscal year shall begin January 1st and end on December 31st of each calendar year.

## ARTICLE III

## Membership

The Corporation shall have no members.

## ARTICLE IV

## Board Of Directors

**Section 1 Government.** The management of the affairs of the Corporation and corporate power shall be vested in a Board of Directors. New members of the Board of Directors shall be elected by current member of the Board of Directors at the Annual Meeting of the Board of Directors and at other times throughout the year, as the Board of Directors may deem appropriate.

**Section 2 Disqualification of Board Members.** No individual, who is a member of the Board of Directors of the Corporation, can at the same time be an employee of the Corporation.

If any situation should arise in which a board member may have interests in conflict with the interests of the Corporation, such board member shall promptly report such conflicts of interests to the Board of Directors and shall be disqualified from voting or otherwise acting for and on behalf of the Corporation with respect to that matter. The Board of Directors shall approve a formal Conflict of Interest Policy that shall be reviewed every three years during the triennial review of these By-Laws.

**Section 3 Number.** The Board of Directors shall consist of not less than nine (9) nor more than fifteen (15) members. The terms of office for members of the Board of Directors shall be three (3) years. Members of the Board of Directors may serve no more than two (2) consecutive three (3) year terms. The term of a member of the Board of Directors shall commence at the first board meeting of the fiscal year. If a member of the Board of Directors is serving as an officer of the Board of Directors at the expiration of his second board term, then his term on the Board of Directors shall be extended to coincide with the expiration of his position as an officer of the Board of Directors. In addition, former members of the Board of Directors shall be eligible for re-election to the Board of Directors following a lapse of one year as a member of the board.

**Section 4 Duties.** The duties of the Corporation's Board of Directors include the following:

(a) To review and approve the annual operating budget of Corporation;

(b) To be charged with the responsibility of reviewing, approving, and developing a total program of quality services;

(c) To assess community needs for services to patients with a life threatening illness and their families;

(d) To review and approve program planning and development of long range objectives to meet those identified needs;

(e) To recommend implementation, modification, termination, or monitoring of programs and services of the Corporation;

(f) To hire and discharge the President/CEO based upon recommendations from the Executive Committee of the Board of Directors;

(g) To support The Foundation for the Center for Hospice and Palliative Care, Inc. (d/b/a "The Hospice Foundation") (hereinafter referred to as the "Foundation") in its efforts to raise and allocate funds in the best interest of the Corporation's mission;

(h) To perform any other duties the Board of Directors of a nonprofit Corporation can perform consistent and in accordance with the Act.

**Section 5 Resignation.** A director may resign at any time by filing his/her written resignation with the Secretary of the Board of Directors.

**Section 6 Removal.** Any director may be removed for cause by the affirmative vote of the majority of the Board of Directors of the Corporation. Any director who has been absent from three (3) consecutive regular meetings may be removed by the affirmative vote of the majority of the Board of Directors present at the meeting. In other respects, a member of the Board of Directors can be removed as allowed by the Act.

**Section 7 Vacancy.** Any vacancy in the Board of Directors caused by death, resignation, increase in number of directors or otherwise may be filled by appointment by the Board of Directors for the remainder of the vacated term.

**Section 8 Order of Business.** Robert's Rules of Order are to apply at all meetings of the Board of Directors unless waived by a majority of the members of the Board of Directors present.

**Section 9 Delegation of Authority Among the Board of Directors.** It is agreed that the Board of Directors shall elect~~,~~ at its annual meeting each year—applicable to the two (2) year term of the position, a Chair~~man~~, Vice Chair~~man~~, Immediate Past Chair~~man~~, Secretary, and Treasurer of the Board of Directors to assume and perform the responsibilities set forth below.

(a) **Chair~~man~~ of the Board of Directors**. The Chair~~man~~ shall preside at all meetings of the Board of Directors. S/he shall have chief official responsibility for directing and implementing each meeting of the Board of Directors, and shall be responsible to perform other duties as may be prescribed from time to time by

the Board of Directors, these By-Laws, the Articles of Incorporation of the Corporation, or as deemed appropriate within the discretion of said Chair~~man~~.

(b) **Vice Chair~~man~~ of the Board of Directors**. The Vice Chair~~man~~ shall assist in the discharge of the duties of the Chair~~man~~ of the Board of Directors, and shall serve as the Chair~~man~~ of the Board of Directors in the Chair~~man~~'s absence. Said Vice Chair~~man~~ shall perform such other duties and responsibilities as may be prescribed from time to time by the Board of Directors, these By-Laws, or the Articles of Incorporation.

(c) **Secretary of the Board of Directors**. The Secretary of the Board of Directors shall keep correct and complete record of all of the proceedings of the Corporation and shall, in general, perform all of the duties which are incident to the office of Secretary of the Board of Directors and prescribed from time to time by the Board of Directors, these By-Laws, or the Articles of Incorporation.

(d) **Treasurer of the Board of Directors.** The Treasurer shall have supervisory responsibility and control of all funds and assets belonging to the Corporation subject to the authority of the Board of Directors of the Corporation. An account of the financial condition of the Corporation shall be rendered to the Chair~~man~~ and other directors at the regular meeting of the Board of Directors and whenever requested by them.

(e) **Immediate Past Chair~~man~~ of the Board of Directors**. The Immediate Past Chair~~man~~ shall continue to serve as a member of the Executive Committee for the two (2) year period immediately following his/her service as Chair~~man~~ of the Board. The primary purpose of this position is to ensure continuity and to serve in an advisory capacity.

(f) **Immediate Past Chair of the Foundation Board of Directors.** The Immediate Past Chair of The Foundation for the Center for Hospice and Palliative Care, Inc. (Foundation) shall continue to serve as a member of the Executive Committee for the two (2) year period immediately following his/her service as Chair of the Foundation Board. The primary purpose of this position is to ensure continuity and to serve in an advisory capacity.

(f) **Right to Vote**. The Chair~~man~~, Vice Chair~~man~~, Immediate Past Chair~~man~~, Foundation Immediate Past Chair, Secretary, and Treasurer of the Board of Directors shall be members of the Board of Directors and shall be entitled to vote on all matters submitted for a vote of the Board of Directors.

(g) **Election of Officers on Board of Directors**. The Chair~~man~~, Vice Chair~~man~~, Secretary, and Treasurer of the Board of Directors shall be elected by the Board of Directors at the time of the Annual Meeting of the Board of Directors for two (2) year terms.

## ARTICLE IV

## Officers

**Section 1 Appointment.** The officers of the Corporation shall include a President/CEO, a Vice-President/COO, and a Chief Financial Officer. The President/CEO shall be appointed by the Board of Directors based upon a recommendation from the Executive Committee and according to Board of Directors approved policy in place at the time. The President/CEO shall appoint a Vice-President/COO, a Chief Financial Officer and shall be responsible for the hiring and discharging of all paid staff of the Corporation.

**Section 2 Duties.** The principle duties of the officers are as set forth below.

(a) **President/CEO**. The President/CEO shall attend all meetings of the Board of Directors. The President/CEO shall be the chief executive officer of the Corporation and shall have the general supervision, direction, and active management of the property, affairs and business of the Corporation subject to the discretion, control and approval of the Board of Directors. S/he shall perform such other duties as may be prescribed from time to time by the Board of Directors, these By-Laws, or the Articles of Incorporation of the Corporation. S/he shall be a non-voting member of the Board of Directors and all standing committees. The President/CEO shall also be the President/CEO of the Foundation and shall be responsible for the overall relationship between the two (2) entities.

(b) **Vice-President/COO**. The Vice-President/COO shall help with the discharge of duties of the President/CEO and shall serve in his/her absence and shall perform such additional duties as may be prescribed from time to time by the Board of Directors, by the By-Laws, or by the Articles of Incorporation. The Vice-President/COO shall be a non-voting member of the Board of Directors and standing committees as appointed by the President/CEO.

(c) **Chief Financial Officer**. The Chief Financial Officer shall help with the discharge of duties in the absence of both the President/CEO and the Vice-President/COO and shall perform such additional duties as may be prescribed from time to time by the Board of Directors, these By-Laws, or the Articles of Incorporation. The Chief Financial Officer shall be responsible and accountable for the receipt of the Corporation's funds and pay out of the same under policies approved by the Board of Directors and under the direction of the President/CEO. The Chief Financial Officer shall be accountable for the deposit of all moneys, checks and other credits to the account(s) of the Corporation in accordance with policies approved by the Board of Directors. The Chief Financial Officer shall enter regularly into the books of the Corporation to be provided for that purpose a full and accurate account of all moneys received and paid out on account of the Corporation. The Chief Financial Officer shall be a non-voting member of the Board of Directors and standing committees as appointed by the President/CEO.

The Chief Financial Officer shall also be the Chief Financial Officer of the Foundation and be responsible and accountable for the financial relationship between the two (2) entities.

**Section 3 Vacancies.** Whenever any vacancies occur in the office of the President/CEO of the Corporation, such vacancy shall be filled by the appointment of an Interim President/CEO as detailed within Board of Directors approved policy in place at the time.

**Section 4 Loans to Officers and Directors.** No loans of money or property shall be made to any officer or director by the Corporation.

## ARTICLE V

## Authority To Obligate Corporation

**Section 1 Checks, Drafts, and Similar Negotiable Instruments.** The President/CEO, the Vice-President/COO, and the Chief Financial Officer of the Corporation shall have authority to sign checks or similar negotiable instruments on behalf of the Corporation. Any of the three (3) can sign checks up to $25,000.00 for ordinary budgeted items. Any check over $25,000.00 would require two (2) of the three (3) signatures.

**Section 2 Authority to Borrow Funds.** The President/CEO of the Corporation along with the Chair~~man~~ of the Board of Directors or the Treasurer of the Board of Directors shall have the authority to obligate the Corporation for lending transactions on behalf of the Corporation as approved by the Board of Directors from time to time.

**Section 3 Execution of Documents.** The President/CEO of the Corporation shall have the authority to bind the Corporation, to contracts or other similar business agreements entered during the ordinary course of the Corporation's business.

**Section 4 Membership in Regional and/or National Organizations.** The Corporation may maintain membership in other regional and/or national organizations whose purposes are consistent with those of the Corporation. The Corporation may support financially such an organization to the degree deemed appropriate and as allowed by the Act and the Code.

## ARTICLE VI

## Meetings

**Section 1 Annual Meeting.** The Annual Meeting of the Board of Directors shall be the final meeting of the fiscal year and shall be designated as the Annual Meeting for election of directors, officers of the Board of Directors and the Corporation, and for conducting any other business that may come before the Board of Directors.

**Section 2** **Regular Meetings.** Regular meetings of the Board of Directors shall be held at least four (4) times a year. Directors shall be notified, in writing, in advance of all meetings.

**Section 3** **Special Meeting of Board of Directors.** Special meetings of the Board of Directors may be called by the President/CEO or on written application of five (5) directors made to the Secretary who shall mail notices to all members of the Board of Directors not less than one (1) week prior to the meeting stating the purpose of the meeting, unless waived. No other business may be transacted at a special meeting.

**Section 4** **Quorum for Board Meetings.** A majority of the total number of directors shall constitute a quorum. Directors must be present, in person.

**Section 5** **Voting.** Each director shall have one (1) vote on all issues presented for the vote of the Board of Directors of the Corporation.

## ARTICLE VII

## Committees

**Section 1** **Standing Committees.** All Standing Committees, except for the Executive Committee, shall be appointed by the Chair~~man~~ of the Board of Directors for one (1) year terms, may be reappointed, and may have non-directors as members.

**Section 2** **Executive Committee.**

(a) **Membership**. The Executive Committee shall consist of the Chair~~man~~, Vice Chair~~man~~, Immediate Past Chair~~man~~, Secretary of the Board of Directors, the Treasurer of the Board of Directors, and the Foundation Immediate Past Chair~~man of the Foundation.~~ The Executive Committee shall perform the duties of the Board of Directors in the interim between board meetings and shall report all actions for ratification at the earliest meeting of the Board of Directors.

(b) **Duties.** The Executive Committee of the Board of Directors shall make recommendations with regard to hiring and termination of the President/CEO according to Board of Directors approved policy in place at the time. The full Board of Directors shall have final determination. The Executive Committee shall have the sole authority to conduct reviews of the President/CEO's performance and determine compensation and benefits according to the Board of Directors approved policies in place at the time.

**Section 3** **Finance Committee.**

(a) **Membership**. The Finance Committee shall consist of the Treasurer of the Board of Directors who will Chair the Committee and other appointees by the Chair~~man~~ of the Board of Directors. This committee is responsible for review and

recommendations to the Board of Directors regarding the financial matters of the Corporation.

(b) **Duties**. The Finance Committee shall review budgets for proposed lands and projects, review and approve annual recommended budget proposals to be submitted to the Board of Directors and review the annual audit after each fiscal year. The Finance Committee shall also review and plan long-range financial goals for the Corporation.

**Section 4 Personnel Committee.**

(a) Membership. The Personnel Committee shall consist of appointees by the Chair~~man~~ of the Board of Directors, and be chaired by the Chair~~man~~ of the Board of Directors.

(b) Duties. The Personnel Committee shall concern itself with the review and recommendations for approval of the Personnel Policies governing the staff of the Corporation.

~~**Section 5 Professional Advisory Group.**~~

~~(a) Membership. Membership is to include, but not be limited to:~~

- ~~At least one physician~~
- ~~One registered nurse~~
- ~~Appropriate representatives of disciplines involved in delivery of Home Health services under the Corporation's state home health license and federal certification to provide home healthcare services.~~

~~The chairman shall be the Corporation's current Chief Medical Officer. Other members are appointed for one (1) year terms by the Chairman of the Board of Directors and may be reappointed.~~

~~(b) Duties. The Professional Advisory Group shall advise the Corporation on professional clinical issues, participate in the review of the Corporation's clinical programming, patient care policies, procedures and clinical records as required by the federal and/or state Home Health regulations.~~

**Section 6 Nominating Committee.**

(a) **Membership.** The Nominating Committee shall consist of appointees by the Chair~~man~~ of the Board of Directors in such numbers as they deem necessary.

(b) **Duties**. The Nominating Committee shall have responsibility for nominating candidates for positions on the Board and officers of the Board of Directors.

**Section 7** **Special Committees.** Special committees may be appointed by the Chair~~man~~ of the Board of Directors as the need arises.

**Section 8** **Appointment of Permanent Committees.** New permanent committees, as needed, may be appointed by a majority vote of a quorum of the Board of Directors from time to time.

**Section 9** **Terms.** Terms of all committees shall expire at the annual meeting of the Board of Directors.

## ARTICLE VIII

## Indemnification and Conflict Of Interest

**Section 1** **Indemnification of Representatives.** The Corporation shall indemnify its employees, officers, directors and agents from any claim, lawsuit, administrative action or other proceeding, provided that

(a) Such indemnification shall be entirely covered by policies of insurance purchased by the Corporation; and

(b) The indemnified persons' conduct for which indemnity is provided meets the standards set forth in Indiana Code Section 23-17-16-8, as it may be amended form time to time.

The Corporation may purchase policies of insurance which shall include, but not be limited to, general liability, medical or health care malpractice, and directors' and officers' liability.

This section of the Corporation's by-laws shall not obligate the Corporation to purchase any of the foregoing insurance coverage but shall, provided any coverage is purchased, permit and require any insurance company or surety to fulfill its coverage obligations under the policies issued to the Corporation, as provided in Indiana Code Section 23-17-16-14. This section of the Corporation's by-laws shall not prevent the Corporation from providing indemnification which exceeds the scope of the foregoing insurance coverage, but any such excess indemnification must be provided only in accordance with a resolution of the Corporation's Board of Directors.

## ARTICLE IX

## Investment and Distribution of Income and Prohibitions.

All income of the Corporation for each taxable year shall be managed, invested, distributed and maintained in such a manner, and shall be distributed at the appropriate time and manner so as to not subject the Corporation to tax under Section 4942 of the Code, as amended, or any other tax. The corporation is prohibited in engaging in any act of self dealing (as defined in Section 4941(d) of the Code, as amended, from obtaining any excess business holdings as defined in Section 4943(c) of the Code, as amended, from taking any investments in such

manner as to subject the Corporation to tax under Section 4944 of the Code, as amended, and for making any taxable expenditures as defined in Section 4945(d) of the Code, as amended.

## ARTICLE X

## Amendments

These By-Laws may be altered, amended, or repealed in any regular or special meeting of the Board of Directors in which a quorum is present by the affirmative vote of at least two-thirds (2/3) of those directors present. At least ten (10) days advanced written notice of proposed changes and of the time and the place of the meeting to amend the By-Laws shall be required. Said notice shall state that the purpose of the meeting is to consider proposing amendment to the By-Laws. Additionally, the notice must contain or be accompanied by a copy of a summary of the amendment(s) or state the general nature of the amendment(s) to the By-Laws of the Corporation.

These By-Laws shall be reviewed by a committee appointed by the Chair~~man~~ of the Board of Directors not less than every three (3) years beginning with 1994.

These By-Laws were approved at a meeting of the Board of Directors on the 6th day of July, 1978, were first amended by the Board of Directors on the 18th day of September, 1990, amended a second time by the Board of Directors on the 17th day of May, 1994, amended a third time on the 24th day of March, 1998, amended a fourth time on the 19th day of September, 2000, amended a fifth time on the 16th day of September, 2003, amended a sixth time on the 19th day of April, 2005, amended a seventh time on the 20th day of May, 2008, amended an eighth time on the 16th day of February, 2011, amended a ninth time on the 23rd day of October, 2013, ~~and~~ amended a tenth time on December 16, 2015, and amended an eleventh time on the 28th day of November, 2018.

* * * * *

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## CERTIFICATE

The undersigned hereby certifies that the foregoing By-Laws of the Corporation were duly approved and adopted by action of the Board of Directors of the Corporation to be effective as of the 28th day of November, 2018.

THE CENTER FOR HOSPICE AND PALLIATIVE CARE, INC.

By: _____
Mark Murray, President/CEO

Center for Hospice Care
choices to make the most of life

# CHAPTER THREE

# PRESIDENT'S REPORT

**Center for Hospice Care**
**President / CEO Report**
**November 28, 2018**
***(Report posted to Secure Board Website on November 21, 2018)***

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:15 AM. This report includes event information from August 16 – November 28, 2018. The Hospice Foundation and GPIC Board meetings follow immediately in Conference Room C.

## CENSUS

Average Daily Census (ADC) has been challenging since its 2018 high in July. There have been many reasons for this, but the most obvious is that at the end of July the Admissions Dept. left marketing and went back under clinical. I was under the impression this was temporary while new staff were hired and trained. I was mistaken. However, as of Friday, November 16, Admissions is back under marketing where it had been for more than eleven years. Our Census Committee Meeting on November 15 was encouraging, and we have many opportunities for a census turnaround. Complicating factors for non-admitted patients year-to-date (YTD) compared to 2017 include a 42% increase in referred patients going to a Medicare A skilled nursing home for "rehab" (a 77% increase in referrals from hospitals) where we cannot see them. A terminally ill patient going to a skilled Medicare A bed to receive unnecessary therapy at end of life is a significant problem. Having identified hospice patients die on "rehab" seems to be wrong from every conceivable standpoint. Some have even suggested it accelerates a patient's decline (see attached recent NYT article, "*Costly Rehab for the Dying Is on the Rise at Nursing Homes"*). We also had a 36% increase in referred patients/families refusing hospice services, partly because frequently no realistic conversations are taking place until we get there. "*Mother had a better day today, so we don't need hospice now.*" We have also had a 12% increase in patients dying before admission (a 25% increase in referrals from hospitals) compared to last year. October 2018 was particularly unfortunate compared to October 2017. Referrals were down 9%, the conversion rate was down 11%, and the number of new admissions was the lowest month of 2018. However, YTD our ADC is up 2.39% from last year and the case mix of hospice to home health is much better than last year. But due primarily to October, patients served YTD is down -2.33% and YTD original admissions are down -1.69% compared to 2017. Again, I believe having Admissions back under marketing will improve our overall census, sense of urgency, and speed-to-care. Additional training for new Admission RNs regarding overcoming common patient/family barriers to admission should also make a positive difference. This topic will be the focus of the Board Education section.

| **October 2018** | **Current Month** | **Year to Date** | **Prior Year to Date** | **Percent Change** |
|---|---|---|---|---|
| Patients Served | 454 | 1,761 | 1,803 | -2.33% |
| Original Admissions | 113 | 1,393 | 1,417 | -1.69% |
| ADC Hospice | 357.52 | 377.83 | 356.31 | 6.04% |
| ADC Home Health | 24.42 | 17.28 | 29.59 | -41.60% |
| ADC CHC Total | 381.94 | 395.11 | 385.90 | 2.39% |

## CHC HOSPICE INPATIENT UNITS

| October 2018 | Current Month | Year to Date | Prior Year to Date | Percent Change |
|---|---|---|---|---|
| SB IPU Pts Served | 33 | 298 | 307 | -2.93% |
| SB IPU ALOS | 5.21 | 5.28 | 5.23 | 0.96% |
| SB IPU Occupancy | 79.26% | 73.87% | 75.47% | -2.12% |
| | | | | |
| Elk IPU Pts Served | 32 | 228 | 250 | -8.8% |
| Elk IPU ALOS | 3.63 | 4.49 | 4.49 | 0.00% |
| Elk IPU Occupancy | 53.46% | 48.12% | 52.73% | -8.74% |

## 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 | **2018** Oct | **2018** Nov | **2017** Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| S.B.: | 223 | 217 | 202 | 191 | 195 | 204 | 215 | 210 | 199 | 190 | | 221 |
| Ply: | 71 | 76 | 77 | 82 | 89 | 92 | 89 | 85 | 87 | 83 | | 72 |
| Elk: | 77 | 85 | 96 | 91 | 93 | 90 | 81 | 85 | 85 | 83 | | 79 |
| Lap: | | | 12 | 15 | 16 | 16 | 15 | 19 | 17 | 16 | | |
| SBH: | 5 | 54 | 6 | 4 | 4 | 5 | 6 | 6 | 4 | 6 | | 4 |
| EKH: | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 0 | 3 | 4 | | 4 |
| Total: | 380 | 387 | 392 | 387 | 402 | 411 | 410 | 406 | 394 | 382 | | 380 |

## PATIENTS IN FACILITIES

Of the 45 patients served in October 2018, 150 resided in facilities. The average daily census of patients served in nursing homes, assisted living facilities and group homes in October 2018 was 131 and year-to-date October was 127.

## FINANCES

Karl Holderman, CFO, reports the year-to-date October 2018 Financials are in the Board packet. The Finance Committee approved October 2018 year-to-date summary is presented on the next page. On 10/31/18, at the HF, intermediate investments totaled 4,509,886. Long term investments totaled $19,193,415. The combined total assets of all organizations, including GPIC, on October

31, 2018 totaled $54,455,504MM on 10/31/18 an increase of just over $5.6MM from October 2017. Year-to-date investments showed a loss of -$431,355. From a budget standpoint, CHC alone is over budget on operating revenue by $298,231 and under budget on operating expenses by just over $1.8MM.

Year to Date October 2018

| October 2018 Year to Date Summary | Center for Hospice Care | Hospice Foundation | GPIC | Combined |
|---|---|---|---|---|
| CHC Operating Income | 18,638,126 | | | **18,638,126** |
| MADS Revenue | 384,044 | | | **384,044** |
| Development Income | | 1,051,374 | | **1,051,374** |
| Partnership Grants | | | 439,936 | **439,936** |
| Investment Income (Net) | | (431,355) | | **(431,355)** |
| Interest & Other | 29,829 | 63,171 | 13,442 | **106,442** |
| Beneficial Interest in Affiliate | (1,582,835) | (15,416) | | |
| **Total Revenue** | **17,469,164** | **667,774** | **453,378** | **20,188,567** |
| **Total Expenses** | **16,435,902** | **2,250,609** | **468,794** | **19,155,305** |
| **Net Gain** | **1,033,262** | **(1,582,835)** | **(15,416)** | **1,033,262** |
| *Net w/o Beneficial Interest* | *2,616,097* | *(1,567,419)* | | |
| *Net w/o Investments* | | | | ***1,464,617*** |

## 2019 CHC BUDGET ON THE AGENDA FOR NOVEMBER MEETING

The Finance Committee also reviewed and approved the 2019 CHC Budget at their meeting on November 16th. The 2019 budget is included as an attachment to this report. CHC's budget alone is nearly $24 million dollars for next year. To continue business into the new year, it is very important that we have a quorum at our next board meeting. Please plan to attend the board meeting on Wednesday, November 28.

## CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

We continue to see reductions in the total Optum drug cost per patient day. From January 1 through September 30, 2018 our total drug cost per patient day was $4.44. For the month of September CHC hit an all-time low of $3.71 total drug cost per patient day. These reductions are a result of the medical staff utilizing the least expensive, but most effective drugs in providing quality patient care. Again, the pharmacists at Optum are amazed at our progress and have indicated we are probably in their top four national client performers on this metric.

Drs. Gregory Gifford and George Drake both took their Board recertification exams in Hospice and Palliative Medicine on November 19 and 20.

Karissa Misner, D.O., M.P.T., has now signed a contract to begin working with us fulltime on September 1, 2019. Over the next year she is completing her Hospice and Palliative Medicine Fellowship training at a program in Macon, Georgia. It is in conjunction with this that she will be rotating through our facility for training during the last two weeks of March and the first week in April of 2019.

Sandra Roland, M.D., an Interventional Radiologist at Saint Joseph Regional Medical Center in Mishawaka, has signed a contract to start doing face-to-face visits with us beginning in the latter part of November. She wants to make a career transition from Interventional Radiology to Hospice and Palliative Medicine. In mid-February, she will begin doing face-to-face visits and eventually be working with us up to 24 hours a week doing face-to-face visits, patient care, clinical evaluation and symptom management services.

We are in early discussions with Ahsanul Haque, M.D., to contract with the Elkhart Clinic to provide services to their clinic. If negotiations continue, Dr. Haque would become about a half-time hospice physician for CHC representing the Elkhart Clinic and providing care to their patients under this arrangement.

We have completed plans for expansion of a new office in LaPorte and anticipate moving to the new location around April 1 of 2019. The new location is across the street from the current location. You may recall that the current location has always been temporary until the new office construction is completed.

Bethany Lighthart, MSW, has been hired to fill the vacancy of Social Work Coordinator. She started October 8 and comes to us from Concerto Health in Kalamazoo and has also worked with Grace Hospice in Kalamazoo as a Social Worker. Previously, she has also worked with Select Health in South Bend and with Hospice at Home in Buchanan, Michigan.

In preparation of plans for opening the new Mishawaka Inpatient Unit, in October a team of personnel visited the Hill-Rom hospital bed factory, located in Batesville, Indiana to learn about what is available in the latest in hospital beds and nurse call systems.

We signed a contract with Settler's Place in LaPorte to provide hospice services to their patients. A new Goshen assisted living facility, Greenhouse Village, has also requested a contract.

We participated in a community-wide "table top" disaster drill on November 7. The disaster scenario was a blizzard entitled "Operation Northern Iceberg." The exercise involved our personnel having ongoing communications for two hours with the District 2 central command about different potential occurrences. The drill did not involve deployment of personnel or resources.

What does a hospice nurse practitioner do in her spare time? Medical staff member, Cathie Whitcroft, DNP, FNP-BC, ACHPN, recently volunteered and opened her heart and home to become a foster parent to a terminally ill dog which was diagnosed with breast cancer. After receiving excellent hospice and palliative care from Dr. Whitcroft, the dog had what is termed a "good hospice death", peaceful and without pain. We are extremely honored at Center for Hospice Care to work with some very exceptionally talented and loving people.

**DIRECTOR OF NURSING UPDATE**

Sue Morgan, DON, reports…

All the 2018 Nursing Goals have been met except for "Preceptor Program is to be revised and updated." This goal will continue into 2019.

Ancilla College in Plymouth has requested to complete their clinical rotations for their RN students at CHC beginning in January 2019. The contract is presently being reviewed.

There will be three RN's completing their CHPN (Certification Hospice and Palliative Nurse) exams between October 1 and December 31, 2018.

Dr. Gifford, CMO, and Sue Morgan, DON, presented an educational program "Hospice and Palliative Care" at Saint Joseph Regional Medical Center – Mishawaka's Medical Staff CME education on October 17, 2018.

An educational program was given to CHC nurses on "Various Religious Views on Death and Dying" by La Verne Blowers, former associate professor, missions and theology, division chair Bethel College.

We are supposed to be surveyed every three years for our home health state licensure and Medicare home health certification. The third anniversary of our last survey was November 10, 2018. Sue Morgan reports that CHC continues to be "survey ready" in preparation for Indiana State Department of Home Health Surveyor. We periodically remind the staff of the Conditions of Participation (COP's) in preparation of the survey. The Mock Surveys to prepare the staff were completed in October.

The nursing department is continuing to evaluate the triage program and to improve the process related to the response to calls. Two areas of improvement will be 1.) Incoming phone calls will rotate as they come into triage allowing the families and patients not to wait or be on hold. 2.) We have identified high call volume times and will be allocating staff to the high-volume times adjusting their work hours.

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

| | **2014** | **2015** | **2016** | **2017** | **2018** |
|---|---|---|---|---|---|
| January | 51,685.37 | 82,400.05 | 65,460.71 | 46,552.99 | 37,015.96 |
| February | 109,724.36 | 150,006.82 | 101,643.17 | 199,939.17 | 93,912.90 |
| March | 176,641,04 | 257,463.89 | 178,212.01 | 282,326.61 | 220,485.17 |
| April | 356,772.11 | 419,610.76 | 341,637.10 | 431,871.55 | 310,093.61 |
| May | 427,057.81 | 635,004.26 | 579,888.08 | 574,854.27 | 505,075.65 |
| June | 592,962.68 | 794,780.62 | 710,175.32 | 1,066,118.11 | 633,102.69 |
| July | 679,253.96 | 956,351.88 | 1,072,579.84 | 1,277,609.56 | 767,397.15 |
| August | 757,627.43 | 1,042,958.42 | 1,205,050.76 | 1,346,219.26 | 868,232.25 |
| September | 935,826.45 | 1,267,659.12 | 1,297.009.78 | 1,466,460.27 | 994,301.35 |
| October | 1,332,007.18 | 1,321,352.39 | 1,421,110.26 | 1,593,668.39 | 1,074,820.86 |
| November | 1,376,246.01 | 1,469,386.01 | 1,494,702.09 | 2,443,869.12 | |
| December | 1,665,645.96 | 1,757,042.51 | 2,018,630.54 | 2,730,551.86 | |

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

| | **2014** | **2015** | **2016** | **2017** | **2018** |
|---|---|---|---|---|---|
| January | 51,685.37 | 57,971.60 | 52,156.98 | 31,552.99 | 37,015.96 |
| February | 43,038.99 | 67,572.77 | 36,182.46 | 35,125.58 | 56,896.94 |
| March | 66,916.68 | 107,457.07 | 73,667.84 | 79,387.44 | 113,969.42 |
| April | 180,156.07 | 162,146.87 | 163,425.09 | 149,569.94 | 87,978.18 |
| May | 100,285.70 | 160,178.34 | 93,318.98 | 142,982.72 | 182,601.92 |
| June | 97,258.66 | 159,776.36 | 127,315.24 | 146,200.17 | 46,947.92 |
| July | 38,243.88 | 93,586.27 | 52,394.52 | 61,505.45 | 64,243.53 |
| August | 79,015.87 | 86,606.54 | 97,470.92 | 63,593.03 | 61,803.98 |
| September | 84,011.71 | 99,931.45 | 92,459.02 | 120,261.01 | 117,984.73 |
| October | 55,208.68 | 53,693.27 | 71,323.54 | 127,208.12 | 79,852.69 |
| November | 44,238.83 | 46,870.62 | 66,490.16 | 75,809.56 | |
| December | 193,065.45 | 161,519.80 | 138,328.11 | 286,687.74 | |
| **Total** | **1,033,125.99** | **1,257,310.96** | **1,064,532.86** | **1,319,883.75** | **849,295.27** |

Cornerstones for Living: The Crossroads Campaign

Campaign-related work in August, September, and October 2018 included meetings with donor prospects, donor stewardship meetings, additional donor cultivation, follow up activities, and scheduling meetings with major gift donor prospects. As we move through the second year of the public phase of our comprehensive campaign, which is in its 51st month, (7/1/14 thru 10/31/18) cash, pledges and documented bequests now total $11,256,708. We continue to remain intently focused on securing additional funding for two underfunded priorities, which include an additional $1.3 million for the new inpatient facility and $582,000 to match the $1 million challenge grant to fully endow the Vera Z. Dwyer Fellowship in Hospice & Palliative Medicine. In addition to campaign presentations and donor cultivation activities, we shared a Final Year Plan with the Campaign Cabinet at its October 2 meeting. Following are the plan goals: 1) Add $1.3 million (or more) to capital funding; 2) surpass the Annual Giving aggregate goal of the campaign; and 3) meet the Dwyer Challenge Match of $1,000,000 by raising the additional $582,000 in matching dollars. We've concluded a process of evaluating existing and prospective donors as we tighten our focus on the most likely sources of major gifts in the concluding months of the campaign. This group includes physicians and targeted businesses. A blend of donor prospects resulted in the creation of the Crossroads Campaign Final Year Prospect List. This serves as our work plan and road map to secure gifts in the campaign's final months.

Planned Giving

No estate gifts were received since the previous board meeting. We continue to field requests from financial advisors and attorneys about planned giving options and bequests from their clients.

Annual Giving

Our Friends of Hospice Appeal, which was mailed late May is focused on the Vera Z. Dwyer Fellowship, and is underway through November. Our Annual Appeal will be hitting mailboxes during Thanksgiving week and will focus on the remaining underfunded priorities of the Crossroads Campaign. The annual appeal mailing list will be subdivided with the same brochure going to everyone, but with two different letters. One letter will go to the small subset of donors who have already made a significant campaign gift, and another will be included in the mailing to the rest of our annual appeal list.

Special Events & Projects

We hosted several events during the 3rd quarter celebrating a few milestone anniversaries. Events included celebrations around the 25th anniversary of Camp Evergreen (8/9), Okuyamba Fest and 10th anniversary of the PCAU partnership (7/31), and the 10th anniversary of the Elkhart Campus (8/16) where we rededicated the inpatient care facility as "Esther's House." We also held a combined Bike and Walk event on our Mishawaka Campus on 9/23. More than 500 riders, walkers, staff and volunteers participated in this event. Though we had approximately half the number of participants as last year's event, the net revenue result was greater than last year's two separate events combined. Finally, we held the annual Veterans Tribute Ceremony on 10/16, where we also rededicated the memorial as the "Captain Robert J. Hiler Jr. Veterans Memorial." More than 150 people attended the event and reception.

Palliative Care Association of Uganda (PCAU)

We received a grant of $37,434 from the Community Foundation of St. Joseph County at the request of an anonymous donor to help support the sustainable scale-up of the Palliative Care Association of Uganda's mHealth surveillance system. The grant will allow us to provide support and strengthen palliative care services by assisting PCAU in collecting the necessary aggregate data on palliative care in a timely manner. This data is needed to understand the current state of palliative care, identify gaps, and provide evidence for decision making to enhance the availability and use of palliative care services in Uganda. This phase of the project focuses on project sustainability – primarily through integration with the Ministry of Health's data information system – and scale up to additional facilities throughout Uganda. Funding from the grant will support Cynthia Kabagama's salary as PCAU's data quality officer, as well as providing some funding for Mark Mwesiga for project management. It also provides funding for the foundation to provide support and oversight.

The 10th anniversary partnership report is in production and covers activities through the partnership exchange visit this summer, as well as providing an update on the Road to Hope program and other partnership initiatives.

Road to Hope

In September we received a 2nd quarter update from the Road to Hope program coordinator, Lydia Nakawuki. She noted that candidates in primary seven and senior six started their mock exams during the summer and that these will be completed at the start of the third trimester in preparation for the final exams. In July, the PCAU team visited George Bazaire (our very first child sponsored on the Road to Hope program) at Bishop Cyprian Nursery and Primary School and met with George's class teachers who informed the team about his progress at school. They reported that George is a completely changed person both in class and at school; he is disciplined, obedient and consults teachers with his challenges. In addition, his English has greatly improved which has improved his performance.

We continue to work 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. We now have an intern from Bethel College, Keenen Boyce, who is creating the framework for the program and adapting RISE's curriculum. He is meeting with Roberta Spencer to learn more about the empowerment retreat and talking with PCAU via Zoom conference calls.

Education

We have given end-of-life presentations to groups throughout the community. Those requesting presentations include Notre Dame, Indiana University South Bend, Valparaiso University and Mishawaka neighborhood associations. The college classes in which we presented were diverse in topics with Notre Dame offering a course on Medical Anthropology and IU South Bend offering Health Communications. We have been invited back for each semester that the course at Notre Dame is offered. We will be speaking at Valparaiso University on November 13th in two courses. These courses are focused within the field of sociology and discuss health and end-of-life issues.

A physician- and nurse practitioner-focused version of IU Talk, a workshop designed to teach clinicians effective communication skills for difficult patient conversations, took place on September 12 at the Mishawaka Campus. The workshop was taught by Lyle Fettig, MD and Erin Newton, MD. Both are board-certified hospice and palliative medicine physicians. Fettig is the director of the IU School of Medicine's hospice and palliative medicine fellowship. Newton is a faculty member at the school.

Our Introduction to Hospice and Palliative Care course took place on Saturday, September 22nd, preceded by two mandatory evening classes on Wednesday and Thursday at the University of Notre Dame. The course included a shortened version of "Death by Chocolate" to help break up the afternoon discussions with a more interactive piece. The course was taught by CHC and HF staff who each spoke on their area of expertise. The course had 80 students in attendance.

We have a new seminar called "Cupcakes to Die for" coming up on December 4th at our Mishawaka Campus. This event will bring members of our community together to discuss end-of-life-issues, as well as holiday trivia as they indulge in holiday themed cupcakes. The goal of this event is to normalize the conversation of end-of-life-issues in a peer setting involving companies in our surrounding area.

The National Alliance of Grieving Children aired a webinar on November 8th that addresses grief in students during tragedies. We hosted this webinar at our Roseland office. The webinar had CE credits available for multiple professions. We strive to include opportunities such as this one for our community, as well as webinars available from the Hospice Foundation of America. We will be purchasing the series for 2019 from HFA and will have the monthly live viewings during the day as well as evening opportunities to view the webinars. The evening opportunities will be aired monthly as well in both Elkhart and Mishawaka. We have had great success offering these CE credit webinars to our staff and hope to include the community as we schedule more in the evenings in 2019.

2019 will also include panel discussions with trusted advisors in Elkhart, Mishawaka, South Bend and Plymouth. Beginning in Mishawaka, we will invite experts in the surrounding area to speak to community members about what they do and what questions they run into. This panel will be a rotating group of experts in the area as we continue to offer panels each year.

Technology

Following a one-year trial of a new donor database management system for Global Partners in Care, the Foundation is now in the final stages of converting our entire 142,000-record HF donor database to that same system. The new solution, called Bloomerang, was developed by an Indianapolis-based company, and will take the place of the Raiser's Edge (RE) system we've had in place for many years. Over those years, Blackbaud, the company that owns RE, has continued to increase its fees with each 3-year renewal. The most recent proposal included a 15% price increase that would drive our hosting and maintenance fees to just over $39,000 annually. After negotiating a 10% prepayment discount, our entire three-year contract with Bloomerang totals $44,936, which includes a one-time conversion fee of $4,750. Not only will this conversion save us a significant amount of money each year, the new software will provide a much more user-friendly experience for data entry, reporting and data management. The conversion is expected to be completed by the end of November.

Honoring Choices Indiana – North Central

One of the strategic priorities outlined in our 2016-2018 strategic plan, "The Envisioned Future," is to serve as the principle resource, leader and voice of hospice and palliative care by being the convener to engage key community stakeholders in the design of what end-of-life care looks like in our community. The HF has taken the lead role in shepherding this goal. One of the final pieces in the puzzle has now been filled in by creating Honoring Choices Indiana – North Central (HCI-NC), which has been registered with the Indiana Secretary of State's office as an additional dba of the HF. This community-based program will be the primary vehicle thru which we will work with the region's health systems, medical providers and faith communities to promote and facilitate the use of advance care directives throughout our community. This initiative began three years ago when a consortium of healthcare providers and community leaders undertook the task of ensuring that advance care planning becomes a part of the community's healthcare landscape. Mike Wargo and Cyndy Searfoss both serve on the steering committee, which has developed a business plan and successfully received initial grant funding from Beacon Health System, Goshen Health System and Saint Joseph Health System. With the necessary external funding in place, we have now hired a part-time Advance Care Planning Coordinator, Sr. Eileen Wrobleski, who joined the HF staff in early November.

Mishawaka Campus

Construction continues on the Clinical Staff Building. Electrical, plumbing and mechanical rough-ins are nearly complete and many of the windows have been installed. During the upcoming weeks, we'll be completing installation of insulation, drywall and elevator. We continue to anticipate construction will be completed in time for occupancy in Summer 2019. Since the last board meeting, we've made great progress on construction of our new 12-bed inpatient facility, the Ernestine M. Raclin House. Structural steel has been set and the roof bar joist and decking and they have begun the exterior wall framing. We still anticipate construction will be completed in time for a Fall 2019 occupancy. 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.

Since the last meeting, the Mishawaka Plan Commission and Mishawaka Common Council have approved rezoning the residential parcels we acquired over the past few years from R-1 to C-3, which gives us the ability to move forward with construction of the new parking area at the corner of what is currently Madison and Pine streets. We are working to obtain final approval for the vacation of those streets. At the recent council meeting, we were faced with some opposition from neighbors living at the top of Pine Street and at the corner of Edgewater and Cedar. The primary concern revolves around the fact that what is currently public parking on Madison Street east of the existing alley toward Cedar Street will now become our private property. Mike is talking with the neighbors and working with our engineers and the City Planner's office to arrive at a plan suitable to all parties. (NOTE: the parking issues were resolved, and the measure received unanimous approval on November 19th. See attached South Bend Tribune article. Despite what the article says, the solution was ours and not the City of Mishawaka's.)

Residential Housing

Construction on the first of two Helman Sechrist-designed homes, which began in early July, is right on track. Our builder, Devine Homes by Miller, is making great progress. We anticipate completion by mid-December and are currently in conversation with a prospective buyer.

## GLOBAL PARTNERS IN CARE UDPATE (GPIC)

In the past, I haven't included a specific update for GPIC. However, so much has been going on and we've made such significant progress that I'm including this section in this, the last President's Report for the year. For information purposes, here is an update from GPIC.

Administrative

The Financial Sustainability Task Force will hold its first meeting during the third week of November. This group will provide guidance on our strategy and activities to grow GPIC financially. In addition to Advisory Council members, Karl Holderman, GPIC CFO, and, Chris Taelmen, Chief Development Officer, will join the discussion.

Fundraising

End of year fundraising activities are ramping up and will include the following:

- Annual Appeal: GPIC will send email letters this year to our database.
- Giving Tuesday: GPIC is participating in Giving Tuesday this year with a focus on raising funds to further develop our scholarship program with the African Palliative Care Association.
- Scholarship Donor: we remain in conversation with our largest donor about growing his engagement within and hopefully beyond the scholarship program. Next call with donor is on November 15th. He also requests anonymity.
- End of year partner letters: US partners who have yet to send any funds for their international partner have received a letter reminding them of their required commitment. We expect this will remind most to send in money but a handful of these are those we believe will likely dissolve. And we are fine with that.

Website update

We continue to make progress on the new GPIC website and expect it to launch before the end of the year. The new website will not only contain new and improved content, but will also reflect the branding of the Hospice Foundation's website from layout and color pallet.

Partnerships

We are still following up individually with each partnership. Some partners are quite active and need little attention, but many are asking for help reengaging or guiding their partnership. Currently we have 49 partnerships in 12 countries and 20 states. We continue to follow up with several of the partnerships that are still uncertain. By the end of this year we will determine all current partnerships as either dissolved or moving ahead. Our newest partnership between

Snowline Hospice in California and Hospice Ethiopia has gotten off to a great start. The director of Hospice Ethiopia, Ephrem Abathun, met with his US partners, CEO Michael Schmidt and CMO, Jeanine Ellinwood in Montreal. See 'Conference' section below for more detail. One of our other newer partnerships between Caring Circle in Michigan and Our Lady's Hospice in Kenya is also doing quite well. Global Partners in Care was invited to Michigan in September as the director of Our Lady's Hospice visited Caring Circle. This was a brief visit but allowed the partners to discuss plans for the coming year. In March, Caring Circle will host other staff from Kenya for a longer visit. In September, VITAS Chicagoland held its annual fundraiser for Matthew 25 House in Ghana. Mike Wargo attended the well-organized and fun event. Monsignor Bobby Benson from Matthew 25 House was in attendance and this was a wonderful opportunity for us to interact with partners. A goal of our attendance at the recent conferences was to recruit new US and perhaps Canadian partners. We had many good conversations, which seems to have generated lots of interest that we believe will turn into a few solid leads for new partners. See 'Conference' section below for more detail. In September, we met with Dr. Rajagopal from Pallium India while he was visiting James Cleary, MD, of IU Health Physicians in Indianapolis. We discussed possibly working with Pallium India to develop partnerships in India and are keen to pursue this idea further. Dr. Cleary is a member of the GPIC Advisory Council. In January, we will send out a partnership survey to all current partners to capture data and stories on our partners. We are redesigning the previously used survey to ensure we are gathering useful information that will help us measure the impact of our partnerships. We will also work with national associations and other regional partners to help encourage partner organizations to submit their surveys.

Global Partnership Award

With the input of our Advisory Council, we are making improvements to the process of awarding the Global Partnership Award. For 2018, we have identified four partnerships that meet the basic criteria and have asked them to submit materials that the Advisory Council will consider in naming a winner. The award will be presented at the NHPCO Leadership and Advocacy Conference in April 2019.

Research and Education

We are currently in discussions with Bluegrass Care Navigators, Lexington, KY, and the African Palliative Care Association (APCA) to develop an initiative to establish Palliative Care Leadership Centers in Africa. Bluegrass is one of a handful of centers in the U.S. and the CEO is a member of the National Hospice Executive Roundtable with me. Both partners are very excited about piloting this initiative. Our next call is at the end of November and we anticipate launching this project in 2019.

Conferences

The 22nd International Congress on Palliative Care, hosted by Palliative Care McGill (at McGill University) was held in Montreal October 2-5, 2018. There were 1,800 in attendance, with 67 countries represented. GPIC had very good visibility as a sponsor, exhibitor, and oral presenter. We had the opportunity to interact with participants interested in GPIC's work from Spain, Cote d'Ivoire, Rwanda, Sweden, New Zealand, Australia and many other countries. Our exhibit was well attended, and we are following up with people and organizations who are interested in partnerships or learning more about GPIC. At the conference Lacey Ahern, GPIC Program

Director, presented "Enhancing Access to Palliative Care Globally: 19 Years of Global Partnerships" as a high-level overview of GPIC's work. Four partnerships were highlighted through oral or poster presentations. This was a worthwhile use of our resources and we hope to participate in this Congress moving forward. We have a few potential Canadian organizations interested in a partnership, and we made a few connections with people in Francophone countries to be a resource for APCA.

As part of our strategy to recruit new U.S. partners, we plan to work with state hospice associations to reach out to their members and possibly even engage them in partnership. The Missouri Hospice and Palliative Care Association (MHPCA) extended an invitation to exhibit free at their Midwest Conference on Palliative and End of Life Care in Kansas City, MO Oct. 7-9. The CEO of the state association serves with me on NHPCO/HAN boards. We exhibited with the goal to highlight GPIC's work and recruit new US partners. It was a very good use of our time and we had at least ten organizations express an interest in partnerships. We also met with our partner Sandy Kuhlman, CEO of Hospice Services, Inc. in western Kansas. Sandy serves on NHPCO/HAN boards with me. They are partnered with Marangu Lutheran Hospital in Tanzania. Hospice services, Inc. has a tele-hospice program with Kansas University Medical Center (KUMC) extending hospice services in rural Kansas. We met with the research coordinator from KUMC and discussed possibilities to share their work in Tanzania. Hospice Services, Inc. is planning a trip in January and KUMC may join. Sandy is an ardent supporter of GPIC and was available to share her experiences as a US partner with other attendees. We met the faculty advisor of a medical student from Mercy Hospital in St. Louis who is working on a project in India – we made contact to see if there are any synergies there. The Missouri Hospice & Palliative Care Association is interested in a partnership. We are beginning discussions and considering partnering with them with the national association. Their CEO explained that she would like to broaden the experience and worldview of her board which includes leaders from a variety of not-for-profit and for-profit hospices in Missouri. This is exactly what we want to hear from our partners and we are beginning the process of finding a suitable partner.

Advisory Council Update

We held an excellent meeting of our GPIC Advisory Council in late October via a Zoom conference call. Twelve of thirteen members made the call and we continue to be impressed by the leadership and knowledge this group brings to GPIC. The members of the GPIC Advisory Council are:

Bob Clarke
CEO, Furst Group, NuBrick Partners and Salveson Stetson Group, Rockford, IL

Jim Cleary, MD
Director of the Walther Supportive Oncology Program at Indiana University School of Medicine, Indianapolis, IN

Stephen Connor, PhD
Executive Director of the Worldwide Hospice and Palliative Care Alliance, London, UK

Robin Fiorelli, MSW
Senior Director of Bereavement and Volunteer Services at VITAS Healthcare, San Diego, CA

Liz Gwyther, MD
CEO of the Hospice and Palliative Care Association of South Africa, Cape Town, South Africa

Cathy Hamel, MA
President of Gilchrist Services at Greater Baltimore Medical Center, Baltimore, MD

Fatia Kiyange, MA
Program Director at the African Palliative Care Association, Kampala, Uganda

Sharon Lutz, BSN
Executive Director of Hospice of the North Coast, Carlsbad, CA

Dan Maison, MD
National Medical Director at Seasons Hospice and Palliative Care, Grand Rapids, MI

John Mastrojohn, MBA
Chief Operating Officer at the National Hospice and Palliative Care Organization, Alexandria, VA

Lisa Motz-Storey
Former Chaplain at The Denver Hospice, Denver, CO

Faith Mwangi-Powell, MSc, PhD
Global Director, The Girl Generation, Nairobi, Kenya

Stacy Orloff, PhD
Vice President, Innovation and Community Health at Suncoast Hospice (Empath Health), Tampa/Clearwater, FL

Lori Williams, RN
National Vice President of Hospice Clinical Practice and Quality at Amedisys, Naples, FL

**COMMUNICATIONS, MARKETING, AND ACCESS**

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

Referral, Professional, & Community Outreach

Our Professional Community Liaisons continue to contact doctor's offices, clinics, hospitals, group homes and extended care facilities to build relationships and generate referrals. In August through October our Liaisons completed 1,247 visits to current and potential referral sources within our service area.

We had some staff turnover with our Professional Community Liaisons. Barb King, who has been our Marketing Assistant and has nine years of CHC experience, will be our newest Liaison replacing a terminated staffer. Barb will continue to serve as CHC's Diversity Officer and was just named as board member for the Michiana Institute for Successful Aging (MISA). Barb has

completed her orientation and is focusing on long-term care facilities. We've also hired Dorothy Jones as our new power weekend Admissions Representative. Dorothy comes to us from Real Services where she's worked for eight years.

Access

For the months of August - October, the Referral Specialists received 806, 782, and 766 incoming phone calls respectively to the Admissions Department. Our 'Deaths Before Admission' (DBAs) are running 11.5% above the same time in 2017. Although our YTD referrals from our major hospitals have increased by 7.45% over the same period in 2017, there has been a 20% increase in their DBA's. We're responding quickly to referrals with 52.75% of our admissions being within 24 hours from receiving the referral. In October alone our 24 hours or less response time was 63.06%. Most of the referrals that go beyond the one day or less time frame are due to family requests to accommodate their schedules, waiting for input from other family members, and an inability to decide.

Website

During the months of August - October, CHC's website hosted 8,305 new users, which is a 25% increase over the same period as last year. The overall number of users to our website also increased by 26%. In April - July 34.2% of visitors found us by entering our website address or through a search engine such as Google which is a 23.25% increase over the same period in 2017. Our page on Career Opportunities continues to be 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 193,664 people for the August - October, and had 5,660 reactions, comments and shares. Overall, our paid ads reached 150,745 Facebook users. We recently began adding more video with the intention of educating and focusing on what makes us different than competitors. From August - October, the most watched video was the Camp Evergreen 25th Anniversary which was viewed 2,700 minutes, followed by Bike Michiana for Hospice with Steve Peterson, owner of Trek Bicycle Shop – Granger, at 670 minutes and Okuyamba Fest 2018 at 233 minutes. We also continue to share content through Twitter, Instagram and LinkedIn.

Digital Overview

During August through October, the digital campaign focused on delivering our ad to the proper audience at the proper time. For these three months it generated 219 telephone calls. Google industry benchmarks show an average click-through rate in the Health & Medical field of 1.79% and we continue to be extraordinarily high at 9.9%.

## CLINICAL POLICIES ON THE AGENDA FOR APPROVAL

There are several policies on the agenda for approval. For hospice, they are related to existing policies that are being cleaned up for current practice and are: Standing Orders, Discharge Criteria, and Death Procedure. There is one new hospice policies, "Alerts in the Electronic Medical Record," which is a policy related to proper utilization of the "alerts" function of the Cerner electronic medical record. There is one new home health policy related to Quality Assessment and Performance Improvement due to the new Medicare home health regulations and CMS state operations manual.

## CHC BYLAWS CHANGES ON AGENDA FOR NOVEMBER BOARD MEETING

According to the Bylaws, the CHC Bylaws are to be reviewed every three years. 2018 was the year for this review. A Bylaws Committee is on the list of available committees for CHC board members to join and participate. A list of available committees is published and distributed frequently within CHC board packets along with verbal reminders at board meetings. Over the last three years, there have been no volunteers to participate on this committee. Therefore, the CHC Executive Committee reviewed the bylaws and is recommending a few changes which will be on the agenda of the November board meeting. These changes are "clean-up" to reflect current practice, counties served, gender neutral titles, and federal regulatory changes for home health care which eliminated the need for a committee. A red-lined copy of the Bylaws and the changes are included in your board packet.

## CHC's FEDERAL FISCAL 2019 (10/18 - 9/30/19) HOSPICE MEDICARE REIUMBURSEMENT RATES DISSAPOINTING

The 2019 federal fiscal year began on October 1, 2018. This is when CHC receives its new reimbursement rates for the Hospice Medicare Benefit which makes up about 77% of all CHC revenue. Reimbursement rates are based on the location of the patient and in larger metropolitan areas they are based upon a Core Based Statistical Area wage index multiplier of the national rates, meaning that CHC has four different rate structures (St. Joseph, Elkhart and LaPorte counties) for the four levels of care as well as a "rural Indiana" rate structure for all of our other service areas. Under the routine level of care alone there are two additional rate structures based upon patient length of stay from 1-60 days and then from 61+ days. All rates are then further cut by the 2% Congressional Sequester from several years ago. After experiencing a slight increase across the board for FY2018, CHC's FY2019 rates are basically flat based upon our case mix and level of care experience. Looking at the Routine Level of Care which is about 95%+ of all our claims, and looking at the rates for just the first 60 days, for FY2019 CHC is seeing a -0.95% cut to St. Joseph County patients, a -0.16% cut to Elkhart County patients, a +0.30 increase to LaPorte County patients, and a +1.16% increase to all other "Rural Indiana" patients. Running the numbers based upon our experience at the time when the rates were released in August, we estimated an annualized total increase of $37,000 out of nearly $24 million in revenue, not even coming close to covering basic inflationary increases.

## NATIONAL HOSPICE EXECUTIVE ROUNDTABLE MEETS IN OCTOBER

The National Hospice Executive Roundtable met at member program The Elizabeth Hospice in Escondido, CA October 7 – 9. Topics included program updates, positioning for the potential Medicare Hospice Managed Care carve out, and looking at the challenges and future of hospice care in America with special in-person guest, Edo Banach, Pres/CEO of the National Hospice and Palliative Care Organization. Additionally, we toured the Center for Compassionate Care of the Elizabeth Hospice, a freestanding bereavement facility for grief counseling, specializing in children's programming. The program has contracts with the San Diego and surrounding school systems to provide children's grief and crises counseling programming for a fee.

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

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

Because all NHERT programs are non-profit and have fundraising departments, a new development roundtable has been formed. They meet by conference call several times a year and will also meet in-person one time per year.

## NEW BOARD MEMBERS FOR 2019 TO BE ELECTED AT NOVMEBER 28TH MEETING

We have two new board members who will be on the slate to be elected for 2019. One has ties to the Elkhart area and the other from the greater South Bend area. Brief bios are included as an attachment to this report. We also need to re-elect Jen Ewing to a second three-year term. The CHC Officers and Executive Committee will change in 2019. The slate of officers is also included on the attachment to this report.

## BOARD COMMITTEE SERVICE

Committee service by all board members is encouraged by the Executive Committee. A listing of the Committees of the Board and a brief description of each is attached to this report for your review. Also, please note the "Specialty Committees" section which is open to all board members.

**ANNUAL GOALS AND STRATEGIC PLAN(S) UPDATE**

Like we do every year, at the February 2019 meeting we will be presenting the final status report on the 2018 Annual Goals as well as the 2019 Annual Goals. The goals are tied directly to the four overarching strategic goals of the Strategic Plan and presented in that format. Additionally, at the February 2019 meeting we will be presenting a final report on the current strategic plan, "The Envisioned Future 2016-2018. We are also planning on having our next three-year strategic plan available at that meeting for 2019-2021. One of the items I'm considering is a new position, Director of Strategic Initiatives. If this position becomes an addition to the Administrative Team – which I am also considering – it would be the first addition since I added the VP/COO in 2006, replacing myself as VP/COO after waiting nine years after becoming CEO in 1997. We have many items we would like to accomplish, but time and freedom is a precious commodity for our Admin Team of six. CHC has grown and we have taken on new entities like a separate corporate foundation, an adult day care program, an international partnership corporation, and a program specializing in advance directives, Honoring Choices Indiana – North Central. My hope is this new position would be able to, by a singular focus, accomplish items that many of us simply don't have the time to do, including some business development activities. Currently, I am considering functions for this position, and they may include, but would not be limited to:

- Work collaboratively with the CEO and Administrative Team to develop business strategy and strategic priorities. Must understand the difference between a "set of features" and "value propositions."

- Develop and maintain a framework and process for strategic decision making, oversee periodic review and refresh of strategic priorities and translate them into actionable plans and timelines.

- Monitor execution of the plan and ensure that individual departmental strategic plan projects align with CHC's strategic priorities.

- Communicate CHC's strategy internally and externally to key stakeholders and measure response to the value propositions.

- In collaboration with CEO and Administrative Team, actively pursue new partnerships, contracts, and business opportunities within health systems, payers, community organizations, value based purchasing and alternative payment models.

- Leverage innovation through new programs or program enhancements to create differentiation strategies to maintain a competitive edge.

- Utilize data analysis and market research to determine market behavior, demand for services, monitor emerging needs, and competitive activity.

- Keep current with ACA, MACRA, CMMI, population health and Medicare & Medicaid rulemaking. Assist with applying for CMS demonstration projects or program grants when they make sense for CHC.

- Oversee public policy, government affairs, and external affairs activities.

- Assist with planning, implementing, and/or expanding a community-based palliative care program.

- Collaborate with clinical services to foster positive, strategic relationships with providers and facilities by helping to discover previously unnoticed value propositions.

- Manage CHC's relationships with post-acute care networks, Medicare/Medicaid MA plans, ACOs, and other networks while seeking opportunities for CHC to participate in new network opportunities with payors, healthcare systems, and other providers.

- Continually monitors internal and external trends related to CHC's role as a provider throughout its service area and demonstrate an understanding of the implications of these trends and effectively develop strategies to assist CHC to excel in its broader market share and grow its census, access to care, and brand awareness.

Again, this new position is currently under development, but I hope to include it in the next strategic plan. I also plan on using the same format on the 2019-2021 plan that is the basis of the current plan.

**2018 BOARD OF DIRECTORS SELF-EVALUATION**

Every other year, at the last meeting prior to the seating of new officers and board members, we take an opportunity to complete a Board of Directors Self-Evaluation. At the 11/28 board meeting, we will be distributing hard copies of the bi-annual Board of Directors Self Evaluation along with a postage paid return envelope. We ask that you complete the evaluation and return the form by December 31, 2018. Aggregate results will be included in the February 2019 board meeting packet. Please remember this is a Board Self-Evaluation requesting your opinion regarding the operations of the Board of Directors itself. This is not an evaluation of Center for Hospice Care as an organization, its programming, or its staff.

**HOW DOES CHC RESPOND TO TRAGEDIES WITHIN THE COMMUNITIES WE SERVE?**

Rochester, IN is in Fulton County and within CHC's service area. The school bus tragedy made national news. I recently inquired with our Bereavement Department if we had offered services. Holly Farmer, MA, LMHC, Bereavement Coordinator responded by letting me know that one of our bereavement staff has a relationship with personnel in the Rochester school system. She contacted one of the counselors and provided support and reminded her of our services. For the immediate response at the schools, the school counselor reported that 4County Counseling Agency and Bowen Center provided personnel. The school counselor is aware of our services and CHC is included on a resource list provided to families when a tragedy happens. Most school systems and businesses have a critical incident response within their school district/company plans (sometimes through their EAP). We are not aware that CHC is not a part of any school's immediate response (the one that happens within 24-48 hours). This type of response requires availability 24/7 due to the need to respond to the scene and ability to cancel/reschedule usual work load. Currently, two

CHC bereavement counselors have the CISM (Critical Incident Stress Management). We have utilized this training with different groups over the years, usually within the week after an incident. For example, we have gone to agencies to meet with staff within a week after a colleague has died, multiple residents dying in a short period of time, a family member of a colleague has died. The agency has provided the immediate support and then we have been asked to meet with staff to provide education and support. In the past when there has been a tragedy and we don't already have a relationship with someone, we have, after the immediate response time had passed, sent a letter or called the school or workplace informing them of our services for the care of the grieving individuals.

## 2018 HOLIDAY MEMORIAL ATTENDANCE SECOND HIGHEST IN LAST FIVE YEARS

CHC's Annual Time of Remembrance Memorial Service was held on Sun., November 18 at the Kroc Center in South Bend at 2:00 p.m., Trinity UMC on Jackson in Elkhart at 2:00 p.m., and Christos Banquet Center in Plymouth at 4:00 p.m. Attendance this year was the second highest of the last five years. Every surviving family member who lost a loved one through CHC over the last year are invited to attend these free services that feature reflections and music. Singers, harpists, pianists and others take part in the program. A candle was provided as a memorial gift to all in attendance. 2018 attendance by location was:

South Bend = 365
Elkhart = 214
Plymouth = 86

Total 2018 Attendance = 665

Bereavement staff received numerous verbal comments from attendees during the gathering time after the service. Comments included:

*Thank you so much for the beautiful service.* (Many people said this.)
*Thank you for the candle, we appreciate it.* (Many people said this.)
*We appreciated being able to gather and remember her. She was so active in our community.*
*We didn't have a service for him and this was a way to have a service and was very meaningful.*
*Thank you for doing this, the music was so beautiful.*

One bereaved shared that she plans to put the candle with a picture of her spouse on the table at Thanksgiving. She was so appreciative for the candle.

There is no requirement that CHC produce an annual event like this. Bereavement services are required for Medicare hospice patients only and there is no reimbursement for them. CHC opens its doors and hearts to everyone in our service area who are dealing with the loss of loved one, regardless of whether they had a prior experience with CHC. We are proud of this important differentiator and know of no other local hospice program that has an event like this, or one close to being on this scale.

**OUT AND ABOUT**

Staff including Chris Taelman, Chief Development Officer, Hospice Foundation attended the groundbreaking for the new La Porte Hospital on August 23rd.

Several staff attended the 2018 Mishawaka Heritage Festival where we were a sponsor on September 2nd.

I attended the National Hospice Executive Roundtable meeting in Escondido, CA September 7-9.

Several staff, including Mike Wargo and Dave Haley attended the annual Medicine Ball for the Indiana University School of Medicine on October 21st.

Several staff, including Sue Morgan, Dave Haley, and Mike Wargo went to Batesville, IN to review hospital beds and nurse call systems for the Ernestine M. Raclin House and the Elkhart inpatient unit on October 29 and 30. All expenses were paid by Hill-Rom.

I attended the Hospice Action Network board meeting and the NHPCO combined issues session which were adjacent to the NHPCO Interdisciplinary Team Conference in New Orleans on November 3 and 4.

I continue to participate on the eight-member NHPCO/HAN Advisory Committee for the "MyHospice" campaign via monthly conference calls with Schmidt Public Affairs, the Alexandria, VA based firm who won the account. We have been meeting since early 2017.

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

Dave Haley's Census Charts.

South Bend Tribune front-page non-news article regarding "Hospice Campus Seeks More Parking" from 10/21/18

Follow-up article from 11/9/18 "Hospice Center, Neighbors Still Seek a Parking Solution in Mishawaka"

South Bend Tribune front-page news article regarding, "Mishawaka Finds Solution to Parking on Hospice Campus" from 11/20/18

ABC57 News website version of their news story on a CHC hospice RN, "Real Michiana: A life devoted to peaceful deaths

Wrap up press release "A Gorgeous Day for Bike Michiana and Walk for Hospice"

Modern Healthcare magazine article, "Nearly half of hospices surveyed might not survive a federal audit"

# Center for Hospice Care

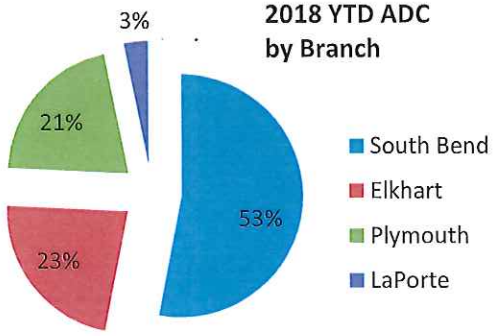
## 2018 YTD Average Daily Census (ADC)

(includes Hospice House and Home Health)

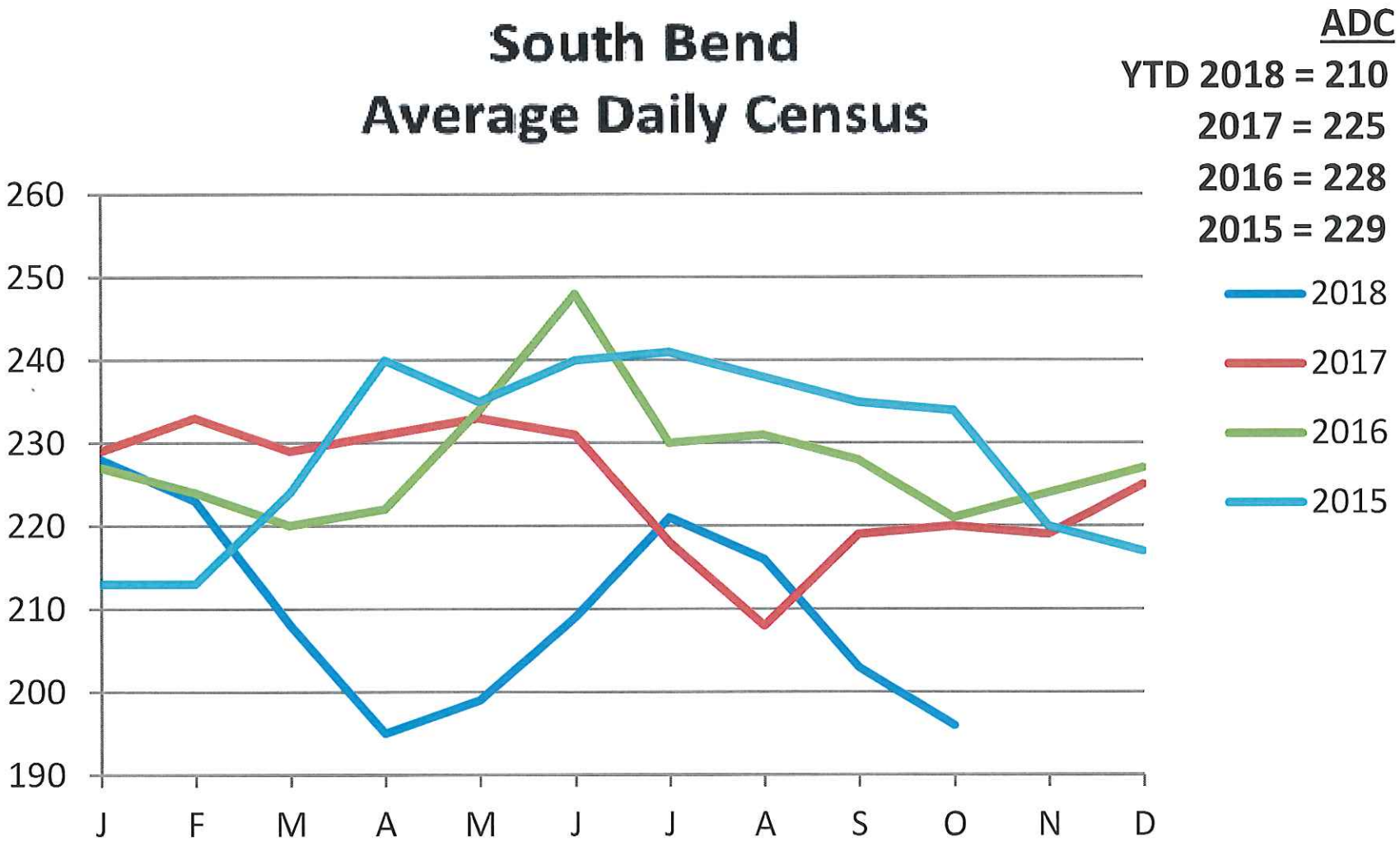
| | All | South Bend | Elkhart | Plymouth | LaPorte |
|---|---|---|---|---|---|
| J | 380 | 228 | 81 | 71 | 0 |
| F | 387 | 223 | 89 | 76 | 0 |
| M | 392 | 208 | 95 | 77 | 12 |
| A | 387 | 195 | 96 | 82 | 15 |
| M | 402 | 199 | 97 | 90 | 16 |
| J | 411 | 209 | 94 | 92 | 16 |
| J | 410 | 221 | 85 | 89 | 15 |
| A | 405 | 216 | 85 | 85 | 19 |
| S | 394 | 203 | 88 | 87 | 17 |
| O | 382 | 196 | 87 | 83 | 16 |
| N | | | | | |
| D | | | | | |
| 2018 YTD Totals | 3950 | 2098 | 897 | 832 | 126 |
| **2018 YTD ADC** | **395** | **210** | **90** | **83** | **13** |
| 2017 YTD ADC | 386 | 225 | 92 | 68 | 0 |
| YTD Change 2017 to 2018 | 9 | -15 | -2 | 15 | 13 |
| **YTD % Change 2017 to 2018** | **2.3%** | **-6.8%** | **-2.5%** | **22.4%** | **NA** |

**2018 ADC by Branch**

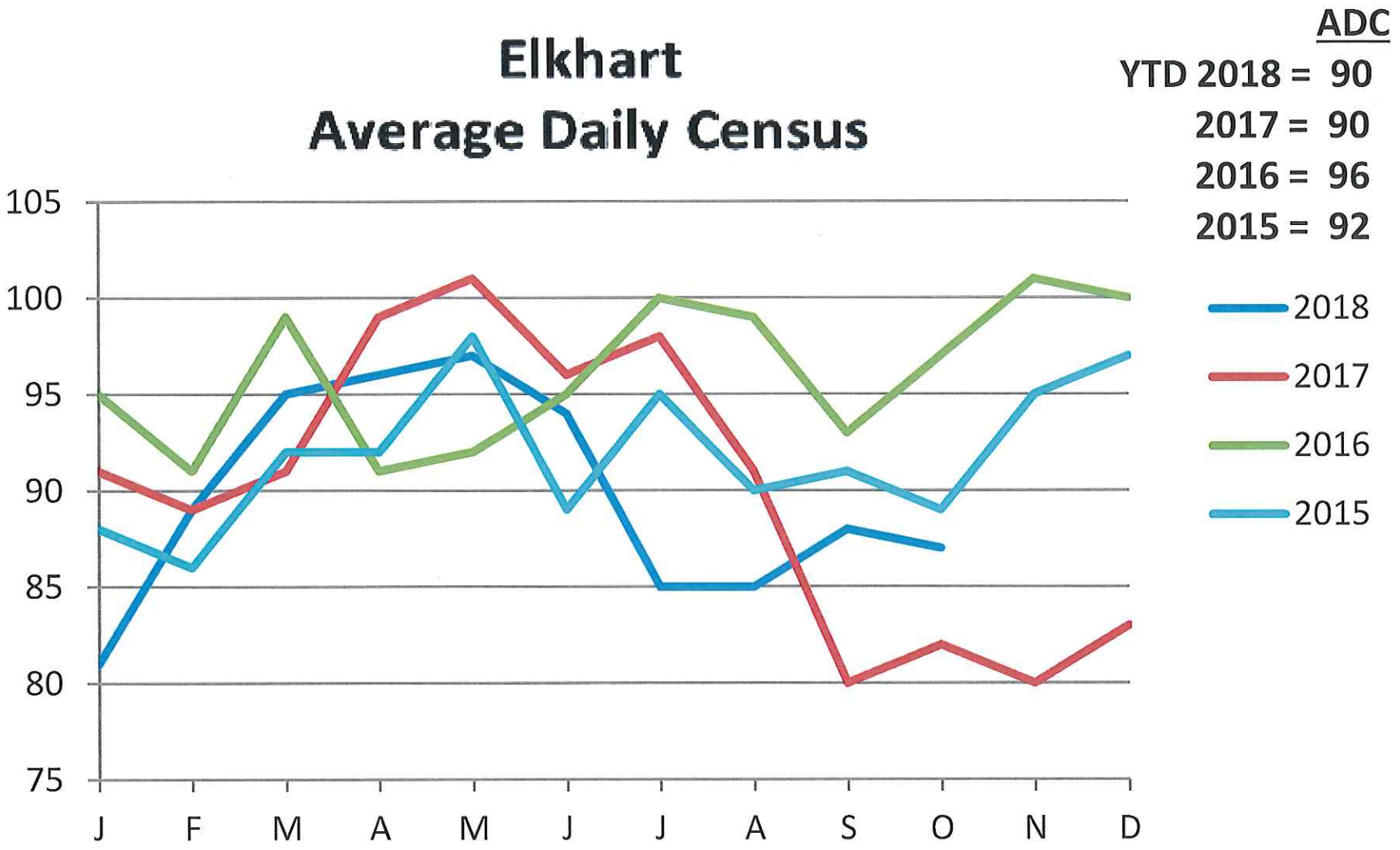
| | |
|---|---|
| South Bend | 53% |
| Elkhart | 23% |
| Plymouth | 21% |
| LaPorte | 3% |
| All | 100% |



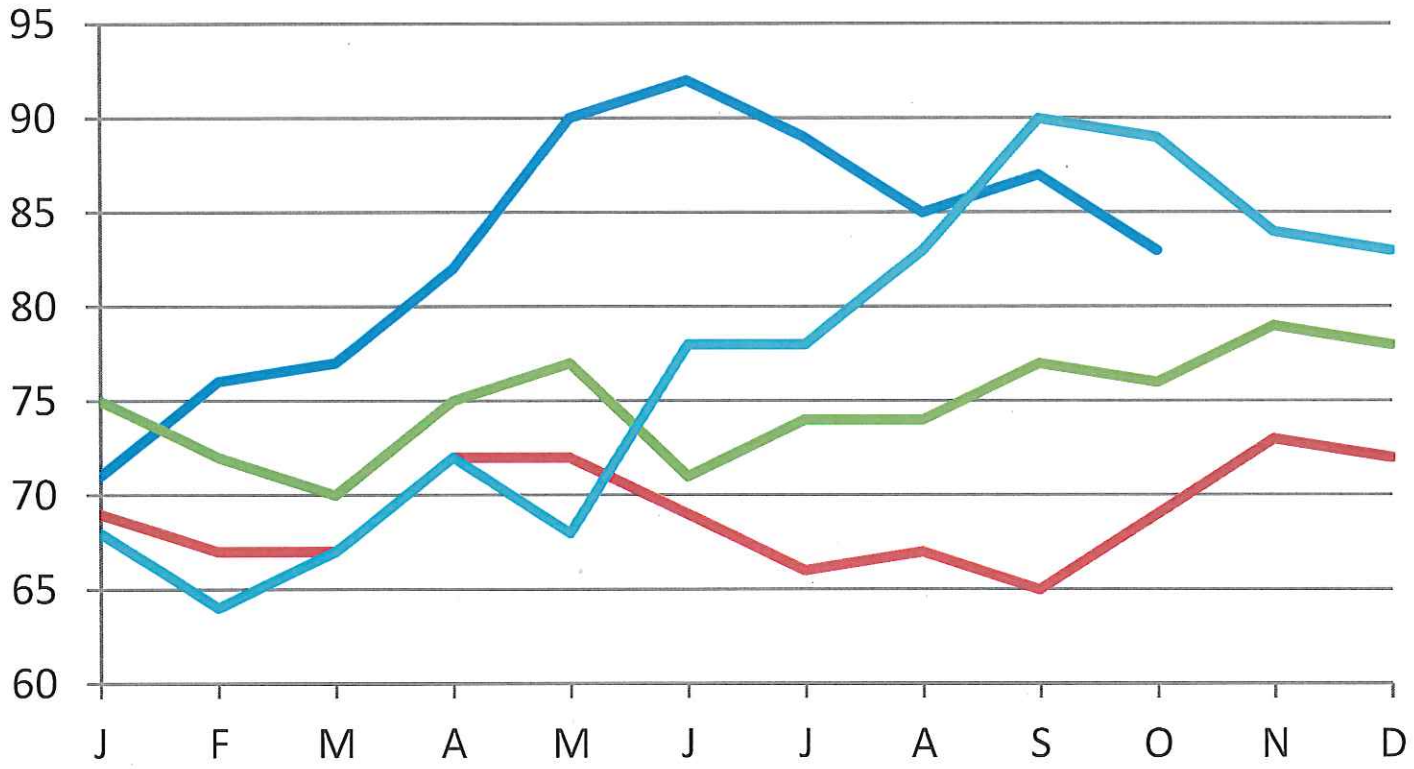
# South Bend
# Average Daily Census



# Elkhart
# Average Daily Census



# Plymouth
# Average Daily Census



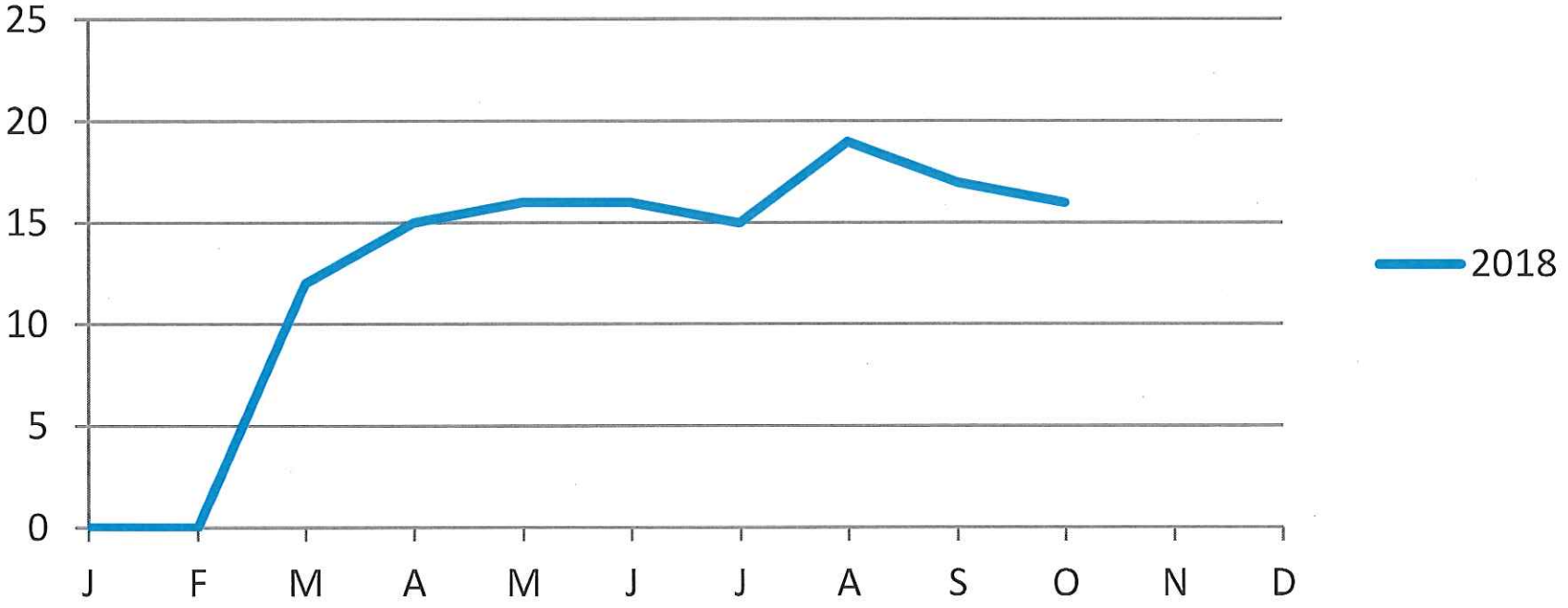

**ADC**

**YTD 2018 = 83**
**2017 = 69**
**2016 = 75**
**2015 = 77**

2018
2017
2016
2015

# LaPorte
# Average Daily Census

**ADC**
**YTD 2018 = 13**
**2017 = 0**



SB Tribune
10-21-18

# Hospice campus seeks more parking

## Squeezed neighbors hope for compromise

By Joseph Dits
South Bend Tribune

MISHAWAKA — Center for Hospice officials say they need more parking for its growing campus next to Central Park. Neighbors do, too. They're hoping for a compromise — at least a few on-street parking spots — as the organization looks to grow again, with a proposal to pinch off parts of Pine and Madison streets and turn a residential block into a parking lot.

Pine would become an access drive to the campus. Madison would be a one-way alley exiting onto Cedar. The only real through street, between Cedar and the park, would be Comfort Place along the northern edge of the campus.

Cedar Street neighbors Erica Campbell and Ken McCleary said they rely on Madison for overflow parking since their own homes have such limited street parking. But in the end, McCleary said he and his wife are happy with the improved look that the campus has brought to the neighborhood.

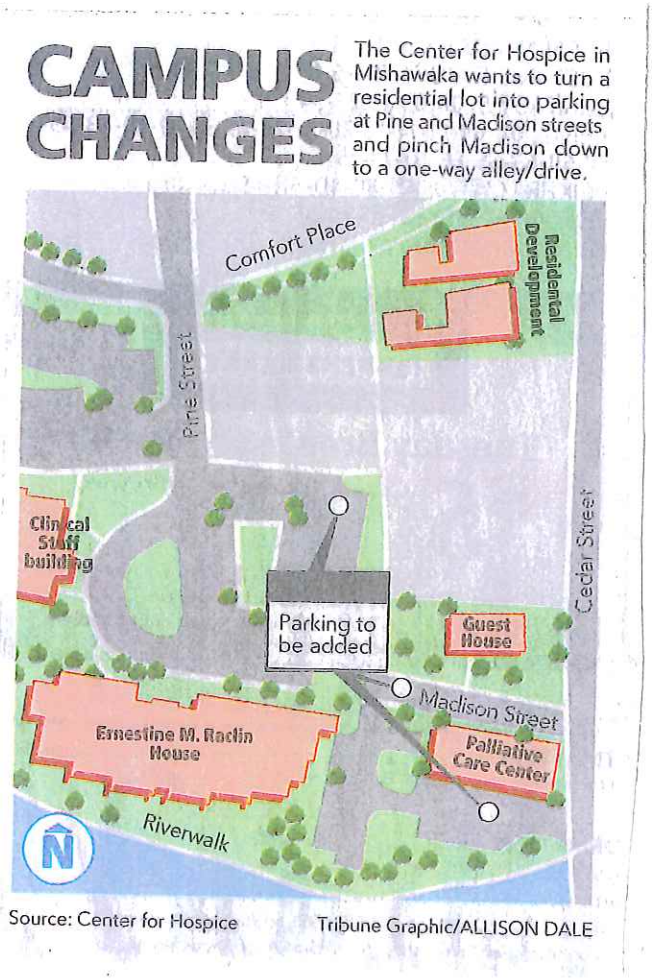
Mike Wargo, chief operating officer for the Hospice Foundation, said it's on his to-do list to look at their concerns.

Measures that will allow the street changes, including a rezoning and replatting of the land, will come to the city council at its meeting at 7 p.m. Nov. 7 at City Hall, 600 E. Third St.

The Center for Hospice needs the extra parking as it adds two buildings, now under construction, Wargo said. The organization hopes to create parking in a square plot of land that it owns at the northeast corner of Pine and Madison.

Owners had asked the center, one at a time, to buy their homes over the past

See PARKING, A5



FROM PAGE A1

# Parking

four years, he said. Only one out of the three homes stands, now used as a construction office and scheduled to be razed as well.

The street changes, he said, will also mean "not having to worry about someone flying around the corner," an ongoing issue when people have used Pine and Madison as through streets. That's now halted by construction fences.

The Center for Hospice started to actually build its campus here five years ago, on what had been a time-worn Moose lodge and vacant land, partly to consolidate offices from rented spaces.

It also is accommodating 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.

The Center for Hospice is currently building a two-story clinical staff building, next to its similar-looking main building, that Wargo said should be finished next summer, along with a single-story inpatient care facility for up to 12 terminally ill patients that would be done next fall. The street changes, if approved, would be made next year, too.

The Center for Hospice is also building the first of two houses at Cedar and Comfort Place, to be sold.

Meanwhile, the city plans to reroute the Riverwalk straight east by the riverbank to Cedar, now that it has acquired and demolished a house at the corner.

Asked if the Center for Hospice will grow even more, Wargo noted a small buildable lot at Pine and Comfort Place but said, "We have no immediate plans."

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# Hospice center, neighbors still seek a parking solution in Mishawaka

- By Joseph Dits South Bend Tribune


The Center for Hospice's new clinical staff building rises in the distance beyond a house on Madison Street, due to be razed. The charity wants to pinch off part of this street and make it a one-way drive exiting onto Cedar Street.

MISHAWAKA — Officials at the Center for Hospice Care say they don't want to get into the public parking business. If they started towing cars, that would be a "bad neighbor," and they don't want that, said Mike Wargo, chief operating officer for the center's Hospice Foundation.

Still, as the charity's campus grows, he said, he's looking for a way so that a few neighbors can continue to park on Madison Street to provide the overflow parking they lack by their homes.

The answer isn't quite there, even after a long discussion at the city council's meeting last week. The council is facing a vote on whether to vacate a small portion of Madison, which the Center for Hospice Care would turn into a one-way drive with seven angled parking spots, linking to Cedar Street.

The measure also calls for vacating Pine Street, too — but only the part south of Comfort Place — though no one has issues with that.

The idea is to stop public traffic from cutting through the campus and causing safety issues. The public would still have Comfort Place to drive to nearby Central Park.

So, the council delayed the vote to its Nov. 19 meeting, to allow the center to come up with more specific answers.

Cedar Street neighbors Erica Campbell and Ken McCleary said they rely on Madison for overflow parking. In fact, Campbell parks on Madison daily and has cleared snow there in the winter, too.

Wargo said the center would use the angled parking on Madison only during daytime business hours Monday through Friday, but Campbell said she'd need it more than the off hours.

She and Wargo discussed the notion of parking passes just for those neighbors, but they hadn't figured out a way to make it work.

Council members said they were torn between balancing the needs of the charity with the neighbors. Bryan Tanner, D-at large, suggested vacating Pine, then waiting a few years to see if the city needs to vacate Madison.

You can't drive more than a short block into Madison now before hitting a construction barricade. The center is currently building a two-story clinical staff building, next to its similar-looking main building, along with a single-story inpatient care facility for up to 12 terminally ill patients.

It's part of the more than $20 million that the center has invested, Wargo said, transforming what had been a rough-looking area and an aged Moose lodge. To further improve the neighborhood, the charity built a house at Cedar and Comfort Place that it is putting on the market for $349,000, he said. The center hopes to build another house next to it, all on a corner where the city had removed a blighted industrial building. Once those projects and extra parking is built next year, he said, the campus may be complete.

Kathy McCleary, a neighbor on Cedar who has used Madison for parking, affirmed that the center has been a good neighbor, saying that it spent "thousands of dollars" to upgrade a guest house next door.

"Everything they told us they were going to do, they have done," she said.

# Mishawaka finds solution to parking on hospice campus

- By Joseph Dits South Bend Tribune


The Center for Hospice Care's 12-bed inpatient facility in Mishawaka, on the left, rises next to the center's new clinical staff building by Madison Street, which the charity wants to pinch down to a one-way alley with angled parking.

By Joseph Dits South Bend Tribune

MISHAWAKA — The city's staff came up with a plan to satisfy neighbors who'd wanted to continue parking on Madison Street as the Center for Hospice Care moves ahead with plans to grow its campus. The city council voted 8-0 to approve the plan Monday.

At least two neighbors have told the council they rely on Madison for overflow parking. Among them, Erica Campbell, said she was "pleased" with the outcome even though she wasn't involved in crafting the solution. That's a change from the last council meeting, which drew a long discussion about how the center could accommodate the neighbors.

The nonprofit center originally proposed to convert a half block of Madison from a two-way street — specifically, between Cedar Street and the alley right behind the homes along Cedar, with angled

parking on the side. That much won't change. Rather than turning that all into a private alley and private parking, the new plan will leave it as part of the public right of way, meaning that the angled parking will be public; so neighbors could use it.

Also, consultants found a way to squeeze in 8 angled parking spaces along Madison, up from 7, to match the on-street parallel parking that has been on Madison until now.

Since it would be an alley, the city wouldn't plow snow on that section of Madison or the angled parking. The Center for Hospice Care and neighbors would be free to plow, though not required. Mike Wargo, chief operating officer for the center's Hospice Foundation, said the center will at least plow the alley to Cedar.

These are part of other street changes so the center can add parking on its campus, while it builds a two-story clinical staff building and a single-story inpatient care facility.
jdits@sbtinfo.com 574-235-6158

# Real Michiana: A life devoted to peaceful deaths

## By: Jess Arnold Facebook | Twitter

**Posted:** Sep 28, 2018 6:11 PM EST

BREMEN, Ind. -- This edition of Real Michiana hits on a touchy topic--death. We're introducing a hospice nurse who is devoting her life to helping her patients pass peacefully.

Abby Eicher's grandma died in hospice care; she tried it out in nursing school and loved it.

With six years of nursing under her belt, the 28-year-old is devoting her career to making the end of life as beautiful as the beginning.

“She knows what she’s doing. She likes what she’s doing and makes a nice entrance," said 90-year-old Sid Phillips, one of Abby's patients.

“I come here for compliments. I learn a lot from my patients. I’m a way better nurse than I was when I started four years ago," said Abby.

**“**I just can’t picture myself doing anything else, because I just love it so much. I get to meet amazing people all the time and take care of them when they’re most in need I think," said Eicher.

She's been taking care of Sid, who is more than 60 years her senior, for about a year.

Sid has idiopathic pulmonary fibrosis, for which there’s not a cure.

She says it’s basically scar tissue that’s in his lungs, and it  continues to grow, eventually causing the lungs to fail.

“One thing I really love about hospice...we’re more comprehensive than I think the rest of the healthcare system is. I think we tend to take care of people as a whole," said Abby.

Needless to say, after a life filled with love for his wife and his Lord, Sid isn't afraid of the end.

“I don’t need to be fearful, because I’m born again, I’m saved. Joanne’s saved, so if we die, we go to heaven," said Sid.

“I would say definitely my goal for all my patients is that they would be able to peacefully transition to whatever lies ahead for them...that they would be able to be surrounded by love at the time that they pass. And sometimes I’m the person there with them at that time and sometimes not," said Abby.

She says, though, that death can be a beautiful thing.

"I know some people feel like death is horrible, but I would say I’ve seen some beautiful deaths, so I don’t think it’s always a horrible thing," said Abby.

To nominate someone for our next Real Michiana feature, please email Jess at jarnold@abc57.com.

# A Gorgeous Day for Bike Michiana and Walk for Hospice!

September 23 turned out to be one terrific day. It started with a cool morning and continued into a bright, sunny day with a light breeze and 72 degrees. Not a bad start for the 10th Annual Bike Michiana for Hospice (BMFH) and the 33rd Annual Walk for Hospice. This year saw two exciting changes to these signature fundraisers: it was the first time the events were held on the same day, and it was the first time the bike event started and ended at CHC's Mishawaka Campus, adjacent to Central Park.

"We felt it was important to bring people together on our beautiful campus in Mishawaka and let them see all that is going on here," said Mike Wargo, chief operating officer of the Hospice Foundation. "By hosting BMFH on our own campus, along with Walk, we gave people the opportunity to connect more closely with the cause for which they are riding or walking."

The joint event, presented by *Trek Bicycle Store Grange*r, saw many other exciting changes. BMFH was revamped to include three new routes, new restaurant partners, and an easier check-in process. We were thrilled to have Y*esterday's Food & Spirits* return to host the after party, and are grateful for the ten-year partnership with this local gem. This was also the first year that registration in advance of these events was required – a practice which helped control costs and streamline the process.

"With any fundraiser, it's important to balance costs with revenue," said Peter Ashley, director of communications and annual giving for the Hospice Foundation. "By requiring advance registration, we were able to better plan for food and other elements of the event that ultimately made it a more effective fundraiser, while improving the day-of experience for registered participants."

More than 500 riders, walkers, staff and volunteers participated in the event, which raised 25% more than last year's event for Center for Hospice Care.

A post-event survey revealed that more than 94% of participants plan on returning to next year's event, which will take place on Sunday, September 8. Look for more details and registration information in the months ahead.

# Nearly half of hospices surveyed might not survive a federal audit

By Alex Kacik | October 24, 2018 Modern Healthcare

A significant number of hospice providers wouldn't survive an audit, according to a new survey.

Nearly half (46%) of 174 hospice agencies surveyed by Optima Healthcare Solutions said they aren't confident that they could sustain the financial impact of a federal audit. The proper technology and infrastructure to manage their clinical documentation was at the core of their concerns.

Ninety-four percent said their clinical documentation system or process needed at least some improvement. Only about a third said they are using software customized for hospices.

Eighty-four percent of the vast majority that said clinical documentation needs improvement reported that staff and clinician satisfaction has waned. Clinician efficiency and productivity has dipped (82%), clinician work-life balance has deteriorated (81%), reimbursement has slowed (60%), and compliance has faltered (59%). Nearly all (97%) of surveyed hospices indicated that clinicians document after hours, 94% sent papers back to clinicians for correction and 64% have had rejected Medicare claims.

Many providers that are concerned about surviving an audit are providing quality care and doing the right thing, but they don't have the proper infrastructure, said Mark Silberman, a partner at the law firm Benesch. It doesn't necessarily mean there is malfeasance, he said.

"There is no doubt that there are some people who are taking advantage of system, but the people who are concerned about their ability to survive an audit are the providers who have focused on providing

quality patient care," Silberman said. "They may be doing what the government wants, but the burden of evidencing it may be more than they can bear."

It's often a problem of the analytic-driven audit process, he said. The audits aren't designed to target organizations that are necessarily breaking the law, Silberman said, but often focus on companies that look and act like the ones that have already been caught.

Most hospice providers aren't equipped with the proper tools to retrieve the data requested in audits, according to the survey. Many still rely on a paper documents and compiling everything can cost at least tens of thousands of dollars.

Only 31% surveyed said they use hospice-oriented software for intake/referral, scheduling, clinical documentation, quality and billing. Sixty-two percent said that a lack of proper documentation reduces time clinicians spend with patients, and 54% said it reduces the quality of personalized care that clinicians can provide.

But spending money on new technology and boosting compliance doesn't increase reimbursement levels, Silberman said.

"Fixing the problem could directly be in contrast to our best interest—improving patient care," he said.

Mending a fragmented clinical documentation process requires taking a close look at the organization's underlying problems, said Josh Pickus, CEO of Optima Healthcare Solutions.

"Addressing this vulnerability requires evaluating how technology, best practices and other approaches can reduce risk," he said.

If the government can better communicate its expectations on what providers should be able to produce and in what format, it would give conscientious providers the ability to get out in front of it, Silberman said.

"The audit process as it currently exists has unintended punitive consequences for good providers to verify that they are good providers," he said.

# *Costly Rehab for the Dying Is on the Rise at Nursing Homes, a Study Says*

A new study of rehabilitation therapy for nursing home patients in New York State raises questions about the purpose of intensive services.CreditCreditDamon Winter/The New York Times

**By Tara Siegel Bernard**

- Oct. 12, 2018

Nursing home residents on the verge of death are increasingly receiving intense levels of rehabilitation therapy in their final weeks and days, raising questions about whether such services are helpful or simply a lucrative source of revenue.

That is the heart of a new study published in the Journal of the American Medical Directors Association, which found that the practice was twice as prevalent at for-profit nursing homes as at nonprofit ones.

More broadly, the study's findings suggest that some dying residents may not be steered to hospice care, where the focus is on their comfort.

Although the research is based on a relatively small number of patients in one state, it echoes what federal regulators have found in recent years.

It's also a fresh reminder that families should keep a close watch on, and ask questions about, the kind of care their relatives are getting in nursing homes.

"Some of these services are being provided in the last week and sometimes on the day of their death," said Dr. Thomas Caprio, one of the study's authors. Dr. Caprio, who specializes in geriatric medicine, hospice and palliative care, is an associate professor at the University of Rochester Medical Center.

Rehabilitation services — physical, occupational and speech therapy — are "a potential revenue source for these facilities," he added. "And when the plan of care shifts to hospice care and palliative care, that revenue stream disappears."

The study examined the level of rehabilitation therapy provided to nearly 55,700 long-term residents at 647 skilled-nursing homes in New York State in the 30 days before they died. The period analyzed was October 2012 through April 2016.

Nearly 14 percent of those residents, or 7,600, got some rehabilitation in the month before they died. Of that group, 2,667 received therapy at high (at least 325 minutes a week) to ultrahigh (at least 12 hours) levels.

Medicare often covers rehabilitation therapy for long-term patients, and nursing homes can bill Medicare at the highest rate for ultrahigh levels of treatment.

Among nursing home residents who got therapy, those receiving “ultrahigh levels” jumped 65 percent from 2012 to 2016, to 7.3 percent of those individuals — with most of the rehabilitation concentrated in the last seven days of their lives.

Daniel Ciolek, the associate vice president of therapy advocacy at the American Health Care Association, a nursing home trade group, said in a statement that its members had long supported redesigning payment models to be based on patients’ needs rather than the delivery of services.

But he said the group also took issue with the research for trying to “draw broad generalizations from what are very narrowly based study parameters.”

Helena Temkin-Greener, the study’s lead author and a professor at the University of Rochester Medical Center, disagreed.

“You can say it is not such a great number,” she said. “But it is a growing number. And this is just New York, not the whole country — and every year more and more Americans are dying in nursing homes.”

The analysis relied on patient data from the Minimum Data Set, which tracks the health status and other sociodemographic information of patients in all New York nursing homes.

A spokesman for the New York State Department of Health said nursing homes were required to follow their residents’ care plans, which are developed with their doctors.

“If actions taken by a nursing home were to cause patient harm,” the spokesman said, “the department would investigate and take appropriate actions.”

Rehabilitative therapy in nursing homes can provide significant benefits, even for patients who are not expected to recover. Speech therapy, for example, can help patients maintain their ability to swallow.

The study did not analyze the results of the therapy provided. But the researchers said their findings suggested that the “dosage” — or the scope and intensity — might be excessive, perhaps even making patients less comfortable.

Richard Mollot, executive director of the Long Term Care Community Coalition, a nonprofit advocacy group based in New York, said the study’s findings troubled him. He urged nursing home residents, their families and others who worked with them to be vigilant about the appropriateness of the care they receive, whether they believe it is excessive or inadequate.

“Residents should receive therapy and other services that can help them attain, and maintain, their highest practicable well-being,” Mr. Mollot said. “However, these services must always be tailored to the personal needs, goals and wishes of the individual.”

Some patient advocates expressed a concern that the potential overuse of therapy by nursing homes to pad profits would hurt efforts to get therapy for people who truly needed it, whether to maintain functions or to prevent or slow their decline.

"We need to be able to keep both perspectives," said Toby Edelman, senior policy attorney for the Center for Medicare Advocacy. "Nursing facilities are providing more therapy than needed in order to increase their reimbursement, and nursing facilities are not providing appropriate maintenance therapy to residents who need it — at the same time."

The study found that, broadly speaking, nursing homes with more registered nurses and licensed practical nurses on staff were associated with lower levels of therapy.

The Centers for Medicare and Medicaid Services plans to change the way they pay for many medical services, including rehabilitation therapy, which will no longer be based on the quantity of treatment provided but on a patient's personal traits.

But Dr. Caprio said the change would not affect how therapy services were billed for the type of patients he and his colleagues studied, who are typically covered by Medicare Part B.

Dr. Caprio, Professor Temkin-Greener and their colleagues said their results mirrored what federal regulators, including the Department of Health and Human Services' Office of Inspector General and the Centers for Medicare and Medicaid Services, have found: that the volume and intensity of therapy provided to residents may be more extensive than warranted.

And despite the study's being limited to New York, the researchers said they believed the problem could be much greater in others states with less-stringent regulations.

"I would think it is magnified in other states," Dr. Caprio said. "I think this is just tip of the iceberg, really."

# Global Partners in Care hoping to expand life-changing education in Africa this #GivingTuesday

November 16, 2018 | 0 Comments

Mishawaka IN – Global Partners in Care (GPIC), in collaboration with the African Palliative Care Association (APCA), are raising funds and raising awareness this #GivingTuesday, November 27 to expand palliative care opportunities for health care providers in Sub-Saharan Africa. Palliative care is the best – and often only – option available for individuals and families in this area of the world who are facing serious illness and death.

"The burden of diseases that need palliative care continues to increase and yet there are very few trained care providers. Your support is needed in order to expand service," said a recent scholarship recipient.

The partnership between the organizations typically funds three or four nurses and social workers to be trained per year, however, the need for such workers far exceeds that output. It is estimated that worldwide, only 14 percent of people in need of palliative care receive it. This number may be much lower in countries that face a critical shortage of healthcare workers in general. That is why on #GivingTuesday, both organizations are committed to raising funds for this life-changing cause.

The goal is to raise ten thousand dollars which will allow the program to double the amount of scholarships that will be funded in the next year. Each scholarship provides formal training in palliative care and equips each healthcare worker with the much-needed skills to handle patients with life-limiting illnesses such as HIV/AIDS and cancer. These scholarships align with GPIC's mission to expand the availability of hospice and palliative care in Africa and globally.

To donate: please visit the GPIC website.

**About GPIC:**
Global Partners in Care supports access to compassionate care by establishing collaborative partnerships, supporting research and education, and raising awareness of the global need for access to essential hospice and palliative care services. Driving all of our efforts is an unswerving commitment

to extending compassion and reducing suffering among those in need. For more information, visit GlobalPartnersinCare.org.

**About APCA:**
The African Palliative Care Association is  a pan-African organization that ensures that palliative care is widely understood, integrated into health systems at all levels and underpinned by evidence in order to reduce pain and suffering across Africa. They work collaboratively with existing and potential providers of palliative care services to help expand service provision (although they don't provide direct clinical care to people living with progressive, life-limiting illnesses). They also work with governments and policymakers to ensure the optimum policy and regulatory framework exists for the development of palliative care across Africa. For more information, visit AfricanPalliativeCare.org.

August 2018
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

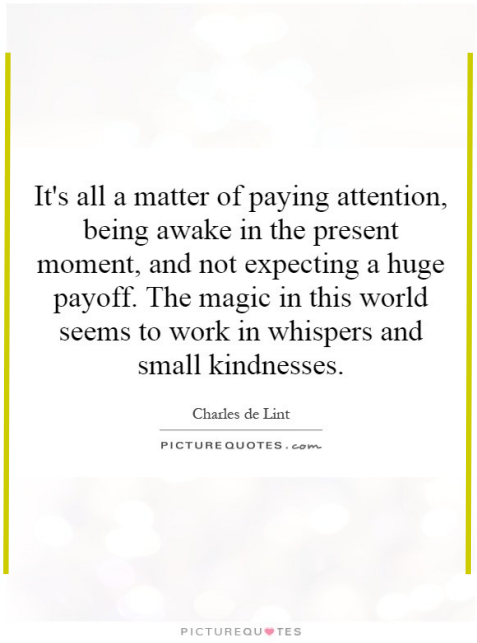
# Simply Being Present

*By Kristiana Donahue*

Probably one of the greatest gifts we give our families and patients is the ability to be present with them. In a world that doesn't seem to pause for their significant life situations, it's comforting to know some people do take that time. But it can be challenging. The nagging grocery list, grandkid shuttle schedule, dirty dishes and endless other distractions crowd the space in ourselves that allows us the freedom to be present. But as the saying goes, "Practice makes perfect." So, perhaps we can take a few steps... practice them...and allow these simple habits to usher us into that quiet, sacred space with our families and patients.

## Build in Time

Try to build in just a few extra minutes before a volunteer appointment. In that time, try to calm your mind, your thoughts, your endless lists. Breathe deeply. Turn your attention on the patient and family. Spend a few moments thinking about them, what they are going through and what they need at this time.




## Hide the Phone

Put the phone away. Phones are leeches that suck countless hours of our day. Out of sight, out of mind. There may be some instances where playing soothing music off a phone could be a great addition to a visit. However, more often than not, phones are simply a distraction.

## Be in Tune

Be observant. Be in tune with what is going on around you. Look for signs to guide you to the best care for the patient. Are there unopened cards and mail that could be read? Are their hands dry and chapped and in need of some lotion? Are they cold? Are they hot? Pay attention to the family members. Read their non-verbal cues. Are they doing okay? Do they need anything? Are the

*Continued on Page 6*


**Inside this issue:**

## Mark Your Calendars

Bike Michiana for Hospice & Walk for Hospice

Sunday, September 23, 2018

Contact Hannah Nichols at NicholsH@FoundationforHospice.org for more information.

NEW Volunteer Training

September 25, 27 & October 1

9:00am-12:00pm

October 4

9:00am-3:00pm

501 Comfort Place

Mishawaka, IN

Contact Kristiana Donahue at donahuek@cfhcare.org for more information.

Camp Evergreen Children's Day Camp Workshop

October 13, 2018

9:00am-2:00pm

501 Comfort Place

Mishawaka, IN

Contact Kim Mathews at MathewsK@cfhcare.org for more information.

## In Loving Memory

Our condolences and heartfelt sympathies go out to the family of the following CHC volunteer who served as a bereavement volunteer and helped facilitate a crafting group.

Pam Price, South Bend

Wednesday, August 15, 2018

## Welcome to the Team

Erica Cartwright
Plymouth CNA

Angela Hallman
South Bend Triage RN

Denny Miller
Elkhart IPU RN

Jill Miller
Elkhart IPU RN

Kim Ransbottom
Admissions Representative

Barbara Tinyszin
Elkhart IPU RN

## Birthdays

9/3
Joseph Donofry
9/7
Pamela Jentz
9/7
Mary Perron
9/8
Mary Adams
9/8
Barbara Adcock
9/9
Denise Johnson
9/9
Rebecca Watson
9/11
Kathleen Hojnacki
9/12
Becky Donahue
9/12
Nancy Whipple
9/14
Cheryl Barker
9/16
Sharon Leamon
9/16
Max Rarick
9/17
Matthew Huyvaert
9/21
Judith Atkinson
9/22
Rikki Norman
9/22
Jim Rahilly
9/24
Sylvia Ford
9/28
Valorie Eads

# Volunteer Spotlight
## Dan and Vera, Plymouth

### How long have you been a volunteer with CHC? Why do you volunteer with CHC?

Vera and Dan started volunteering for CHC about 17 years ago. After receiving a stage 4 cancer diagnosis in 2000, Vera decided to work with others who were facing life threatening illnesses. She wondered if this might be a frightening experience for her. Negative end of life images actually changed for Vera as she witnessed improvements in quality of life issues for her CHC patients.

### What volunteer work do you do with CHC?

Vera arrived home after her first training session to questions from her husband Dan. "Are there any men at that training?" "What would you do as a volunteer?" "Could l get involved?" He made up the missed session and completed his training. Between the two of us, we have been involved in patient visits to homes and nursing facilities, 11th hour, Tuck In calls, Caring Touch and Life Stories. We are proud to be part of the CHC team as we hear wonderful stories from our patients about their great nurses, physicians, counselors, social workers and, of course, volunteers.

### Favorite quote?

A favorite quote of Vera's is "Develop rituals, not will power, to change behaviors." She has been working on this one. Her collection of quotes are everywhere - over her desk, on the refrigerator, in her daily calendar, on sticky notes.

### Tell us a bit about your family.

Vera's father was born and raised in Italy and he married his surgical nurse (Vera's Mom) and had five children. Dan is an only child so visiting Vera's large/noisy/always-eating family took some getting used to. We have two children, six grandsons and two very large dogs. Dan is the videographer for Wild Rose Moon Performing Arts Center in downtown Plymouth. Dan's favorite music is Folk and Americana.

### What do you like to do in your spare time?

We are both avid kayakers, skiers, hikers and campers. Vera has been a ski patroller for 36 years. Vera loves to sing with the Marshall County Melody Makers and a small 4-part harmony group called The Rose Hips. Dan manages our 17 acre Wildlife Habitat and enjoys being outdoors as much as possible. Vera has to go out searching for Dan and remind him to eat and drink.

### Favorite movie and why?

Vera's favorite movie is Forrest Gump. She loves the many messages in that movie – especially recognizing the importance of focusing on what you love. Her favorite book is Siddhartha – seems this is also about focusing on what you love. Seems to be a continuing theme. Dan's favorite play is Man of LaMancha and his favorite author is James Lee Burke. Very scary, said Vera, who could ONLY stand to read one of Burke's novels.

"Dan and Vera are two of the kindest, and genuinely compassionate people I've ever had the pleasure of knowing. They form very special bonds with every patient that they see, and the patients and patients' families cannot say enough wonderful things about them. They are amazing people, and we are very lucky to have them as part of our team."

*Tara Minix,*

*Plymouth Volunteer Coordinator*

# Training Tips & Reminders

## Grief and Expectations for Yourself

The following, suggested by Therese Rando, is a list of appropriate expectations that you can have in grief, depending on the intensity of the loss. Evaluate yourself on each one and see if you are maintaining realistic expectations for yourself.

You can expect that:

- Your grief will probably take longer than most people think.
- Your grief will probably take more energy than you ever would have imagined.
- Your grief will probably involve many changes and be continually developing.
- Your grief will probably show itself in all spheres of your life: psychological, social, spiritual and physical.
- You will grieve for many things both symbolic and tangible, not just the death alone.
- Your grief will probably entail mourning not only for the actual person you have lost, but also for all the hopes, dreams and unfulfilled expectations you held for that person, and for the needs that will go unmet because of the death.
- Your grief will involve a wide variety of feelings and reactions, not solely those that are generally thought of as grief, such as depression and sadness.
- You may have some identity confusion as a result of this major loss and of the reactions you are experiencing that may be quite different for you.
- You may have a combination of anger and depression such as irritability, frustration, annoyance or intolerance.
- You may feel some anger and guilt, or at least some manifestations of these emotions.
- You may lack self-esteem.
- You may experience grief spasms; acute upsurges of grief that occur suddenly with no warning.
- You may have trouble thinking and making decisions.
- You may feel as if you are going crazy.
- You may find yourself having a number of physical reactions.
- You may find that there are certain dates, events, stimuli or even experiences that bring upsurges of grief.
- Society will have unrealistic expectations about your mourning and may respond inappropriately to you.
- You may begin a search for meaning and may question your religion and/or philosophy of life.

# Volunteer Needs

## Camp Evergreen Children's Day Camp Workshop Volunteers

We are looking for volunteers for our Camp Evergreen Children's Day Camp Workshop. It will take place on Saturday, October 13, 2018 from 9am to 2pm at the Mishawaka Campus (501 Comfort Place, Mishawaka, IN). Buddy volunteers will be paired up with a child (ages 6-9) to support them and listen to them as they participate in the day's activities. Activity volunteers are needed to help set up various activities for the campers. For more information, please contact Kim Mathews via email at MathewsK@cfhcare.org or phone at 574-255-1064.

## Inter-disciplinary Team Meeting (IDT) Volunteer

Elkhart Office

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

Plymouth Office

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

## Patient Home Visitors

We are in need of volunteers to go into homes to provide respite for caregivers and companionship and care to patients.

## 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 . For more information, please contact Hannah Nichols via email at NicholsH@FoundationforHospice.org or phone at 574-243-3119.

# Elkhart Fleece Blanket Making Party

Wednesday,
September 26, 2018

10:30am-1:30pm

Elkhart Campus

We need a few (five would be great) volunteers to assist. Please contact Marlane Huber at 974-0401 to RSVP. A light lunch will be served.

Bring your scissors!

# Comments from Our Families

- CHC was invaluable in helping us through the illness with the information provided, comfort and support and care during and after. They were very knowledgeable and in tune with the needs and comfort of our son.

*Continued from Page 1*

dishes piling up in the sink? Is there a small load of laundry that could be started? Follow what the care plan dictates, but communicate with our staff any needs you might notice.

## Don't Avoid Quiet

It takes a bit of practice to feel comfortable with quiet. We sometimes feel that we need to make sure there is no "awkward space." Quiet isn't bad. Allow it. Listen. If it's warm out, open the windows. Hear the lawn mowers, the kids getting home from school or the dogs barking in the neighbor's yard. Quality of life is often comprised of these little nuggets. We take for granted these bits. But most likely our patients enjoy those sounds. They connect them to the world around them. And if we listen, they might do the same for us.

## Let them Lead

Allow the patient and family to share what they need to share. We sometimes assume that they don't want to talk about the impending death, but that may not be true. They may be desperate for someone who will listen. They may not share with their own loved ones for fear that they will make them depressed. Allowing them a kind ear while they process their thoughts is a wonderful way to be present. Always be aware of distressing topics, such as suicide ideations, harm to others or spiritual pain. Listen and alert CHC staff in such situations.


## Set the Mood

If you are able to learn a bit about the patient, find out what things have always been important to them. While quiet times are good, sometimes soft music is appropriate too. Find out if they like Frank Sinatra, country music, hymns or a bit of rock ballads. Soft lighting and fuzzy blankets might feel comforting. Reducing TV noise and other distractions can provide an atmosphere that is relaxing.

## Physical Touch

If you are comfortable with it, physical touch can be such a comfort to our patients. Putting some lotion on their hands can feel so wonderful. Simply holding a hand for awhile assures them you're there and you're present.

Remember that all our volunteer opportunities work towards the same goal. If you are doing office work, Tuck-In calls or other duties, being present is still important.

There are many ways we can be completely present with our patients and families. Remember that you don't have to "look like another volunteer." You have your own gifts to give. Our patients and families need *you.*

September 2018
Volunteer Newsletter

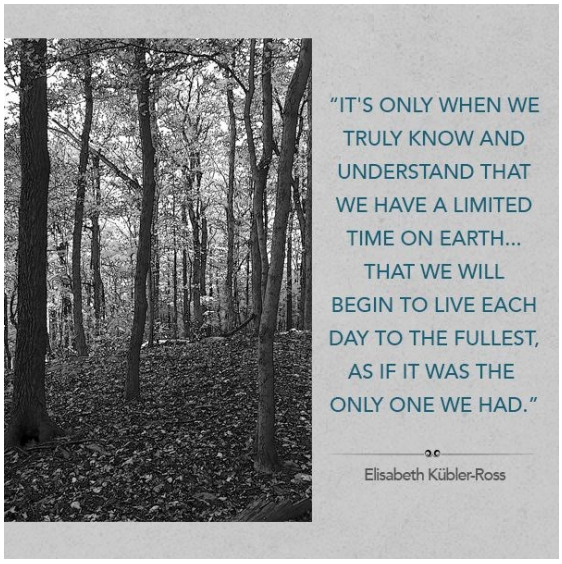
# Center for Hospice Care

choices to make the most of life™

## Why Get Hospice Sooner?

*"85% of Americans want to die at home and yet 50% die in the hospital."*

Patients and the family will benefit from an earlier referral to CHC. The patient and family will benefit more from hospice services if they are not referred during a crisis. The unique medical, psychosocial and spiritual support provided by CHC can assist patients and families as they navigate through all the difficult decisions that need to be made.




### Why earlier, before a crisis occurs?

Studies have shown that 85% of Americans want to die at home and yet 50% of Americans die in the hospital. If patients wait until they are hospitalized, it increases the likelihood that the patient will not die at home.

Patients and families who are coping with a life-limiting illness have practical issues to deal with:

- Business decisions
- Advance care planning
- Estates and wills
- Funeral arrangements, etc.

They also need time to have meaningful conversations and relationships with loved ones. The psychosocial and spiritual support provided by CHC can be a valuable resource for the patient and the family.

CHC's goal for patients is to relieve suffering and assist them to live life to its fullest. An earlier referral to CHC means that specialized pain and symptom management can begin earlier, not only managing current symptoms but also preventing others that may occur. It is ensuring optimal quality of life.

The National Hospice and Palliative Care Organization (NHPCO) 2009 state-of-the-industry report found that the median length of stay was only 21.3 days even though six months of care can be covered by Medicare. At the same time, family evaluations of hospice care remain high and often include comments like "Why didn't the doctor tell me about this sooner?" An earlier referral to hospice makes life easier for the patient and the family.

*Continued on Page 6*


**Inside this issue:**

## Mark Your Calendars

NEW Volunteer Training

September 25, 27 & October 1

9:00am-12:00pm

October 4

9:00am-3:00pm

501 Comfort Place

Mishawaka, IN

Contact Kristiana Donahue at donahuek@cfhcare.org for more information.

Camp Evergreen Children's Day Camp Workshop

October 13, 2018

9:00am-2:00pm

501 Comfort Place

Mishawaka, IN

Contact Kim Mathews at MathewsK@cfhcare.org for more information.

## In Loving Memory

Our condolences and heartfelt sympathies go out to the following CHC volunteer who lost a loved one recently.

Becky Donahue, Plymouth

Father, John Flora Jr. Sunday, September 9, 2018

## Welcome to the Team

Amber Crihfield
Elkhart CNA

Allison Smith
South Bend Resource Social Worker

Jennifer Ellsworth
Elkhart IPU CNA

Julie Taylor
South Bend RN

## Birthdays

10/1
Ann Baucus

10/2
Noreen Buczek

10/2
Sue Ermeti

10/4
Debra Janicki

10/7
Sophie White

10/10
Vicky Flanery

10/11
Donald Zimlich

10/13
Joan Hunt

10/15
Charles Lynn

10/15
Carolyn Tihen

10/16
Lora Tormanen

10/21
Ted Stanley

10/25
Janice Berger

10/27
Cindy Ward

10/29
Hatti Miller

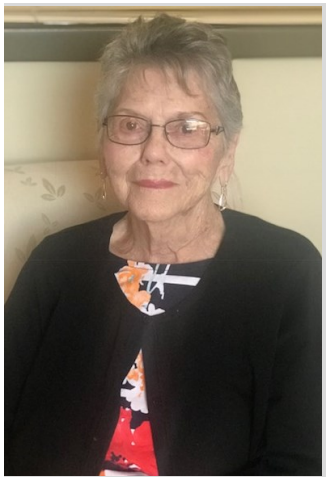
10/29
Elizabeth Stauffer

10/30
Sharon Marshall

10/30
Kay Swett

10/31
Robert Putnam

# Volunteer Spotlight
## Chrystal Snow-Schmatz, Elkhart



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

I started with CHC in 2000. I initially did patient and bereavement care. I hosted the bereavement picnics at my home for several years. When the group became too large, I was able to use the Elkhart Conservation building for the picnics. I volunteered at the Memory Wall at the Walk for Hospice event several years. I have helped in the inpatient care units and mass mailings. I currently make bereavement calls. With the help of my husband, granddaughter and my senior church group, we have purchased and completed over 100 fleece blankets and lap robes for hospice patients.

I volunteer because the Lord has blessed me and I try to be a blessing to others.

### Favorite quote?

"I can do all things through Christ who strengthens me." Philippians 4:13

"Praise be to the God and Father of the Lord Jesus Christ, the Father of compassion and God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves have received from God."
2 Corinthians 1: 3&4

### Tell us a bit about your family.

I have 5 children and 4 stepchildren. We have 37 grand and great grandchildren. They live all over the U.S. I have been married to my current husband for 17 years. My first husband died in 1997. We had hospice for only 17 hours. They were invaluable.

### What do you like to do in your spare time?

I enjoy reading, crocheting, sewing and traveling. I have visited 37 countries so far. I continue to have a desire to learn and try new experiences. Because of my hospice training, I have been able to assist family and friends with mental health and other health issues. I am a good listener. I have received much more than I have given through my years at CHC.

"Chrystal is one of the hardest working people I know.

She is inspiring to me and I'm sure to those who know her.

If you spend even a few minutes with Chrystal, you realize she uses just about every minute of her day doing something for someone.

In her service with CHC she is compassionate, thoughtful and caring. She is able to relate to the bereaved she calls on and is a wonderful, supportive listener. She also donates fleece, along with her church and coordinates volunteers from her church to make blankets for our patients.

Just this week Chrystal and a group of CHC and church volunteers made 14 blankets to give to our newly admitted patients through our Hospitality Program. Outside of her service with CHC, Chrystal writes notes of encouragement to those she knows that need a boost, she cooks meals for friends who are recovering from surgery, she takes friends and relatives to doctor appointments. She is also the caregiver for her husband and assists with her granddaughter, Katelyn, who was left disabled after being struck by lightning as a child. Chrystal does so many little things and big things for those she knows are in need emotionally, physically or spiritually.

She tells me God is her guide and she follows what He wants her to do. Her faith propels her forward at full speed most every day. "

*Marlane Huber,*

*Elkhart Volunteer Coordinator*

# Training Tips & Reminders

## How to Cope During the Grief Cycle

- Try to focus on one problem at a time.
- Try to keep control of your attitude.
- Look at your self-talk. Beware of always, never, can't in your thoughts. Use thought stopping to break out of negative thinking.
- Write your problem on paper. Seeing it in writing may help.
- Count your blessings.
- Reach out and talk to someone.
- Balance between feeling emotions and managing them.
- Keep a routine, especially on weekends and vacations.
- Try to see things from another person's view.
- Have a plan to handle bad days

⇒ Who will I talk to?

⇒ Where can I go?

⇒ What will I do to help get my mind off problems?

⇒ What new coping skills will I try?

⇒ Do I need to be with people or among them?

- Use good self-care

⇒ Sleep 7-8 hours every night

⇒ Eat balanced meals

⇒ No alcohol or other drugs

⇒ Cut amounts of sugar and caffeine

⇒ Practice relaxation

⇒ Exercise

⇒ Balance work and play

- Take one step at a time. Find one thing to control. No matter how small.

# You're Invited
## to CHC's Sixth Annual Soup's On Volunteer Gathering!

Enjoy hot soup, soft bread and great company
while listening to Volunteer Harold Yoder
as he speaks on his experience over the past year
with our Hospitality Program.

Visit with your fellow volunteers
and enter to win a door prize

**Saturday, November 10, 2018**
**11:00 am – 12:30 pm**

Center for Hospice Care Mishawaka Campus
501 Comfort Place
Mishawaka, IN 46545

Please RSVP by phone: 574-277-4100
by October 25, 2018

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

## Remember to chart in the ECFs

All volunteers (Pet Visitors, 11th Hour, ECF Volunteers) who make visits to our patients in the ECF must document their visit in the patient charts at the ECF. Just remember that each ECF may chart differently (ECF chart, electronic or separate CHC chart). Find out from your VC or the ECF RN how each ECF charts. There is a Miscellaneous Tab at the back of the chart where the Interdisciplinary Flow Sheets are located. You should be documenting on the Flow Sheets. Each discipline now has its own Flow Sheet, so you will not be documenting on a sheet shared by other CHC staff.

## Comments from Our Families

- Appreciate the Elkhart Hospice House so much! Seems he was brought there as a launching pad to heaven and he went so peacefully. Thank you!
- CHC staff at the Roseland facility are the best! So caring, so patient, so supportive, and very loving!
- CHC through all their contacts with us was a tremendous blessing. I am deeply grateful for everyone and everything that was done for my wife and me. Thank you all very much.
- Our nurses were absolutely amazing! My mother had the kindest aide who made my mother feel good about herself. We are truly grateful. Thank you.
- I think you people are strong and full of love to do what you do. Thank you.

*Continued from Page 1*

**Benefits to early referrals:**

- Intensive pain and symptom management which eliminates or reduces unnecessary hospitalizations/ER visits
- Medications, DME and supplies are provided, making the patient more compliant to their treatment plan
- Medication refills are ordered by CHC
- Family support and education relieves caregiver stress and exhaustion
- Ability to benefit from a full range of programs and services, including 24-hour access to care, psychosocial programs, volunteer services and grief counseling
- When the patient and family receive symptom control and emotional and spiritual support, their quality of life improves
- NHPCO stresses its concern over the increase in short lengths of service and strongly recommends that physicians, patients, and families learn about and discuss end-of-life care options before a health crisis occurs.

1 Robert Wood Johnson Foundation 2002

2 Center for Gerontology and Health Care Research 2004

# Volunteer Needs

## Camp Evergreen Children's Day Camp Workshop Volunteers

We are looking for volunteers for our Camp Evergreen Children's Day Camp Workshop. It will take place on Saturday, October 13, 2018 from 9am to 2pm at the Mishawaka Campus (501 Comfort Place, Mishawaka, IN). Buddy volunteers will be paired up with a child (ages 6-9) to support them and listen to them as they participate in the day's activities. Activity volunteers are needed to help set up various activities for the campers. For more information, please contact Kim Mathews via email at MathewsK@cfhcare.org or phone at 574-255-1064.

## Inter-disciplinary Team Meeting (IDT) Volunteer

### Elkhart Office

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

### Plymouth Office

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

## Patient Home Visitors

We are in need of volunteers to go into homes to provide respite for caregivers and companionship and care to patients.

## 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.

## Hospitality Volunteers

The Elkhart Office is looking for volunteers to deliver a small care packages to newly admitted patients.

October 2018
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

# Pam's Perspective

*By Kristiana Donahue*

*In memory of Pam Price, who crossed what she referred to as "the victory line" on August 18, 2018.*

When I greeted Pam a few months ago, I had a small armload of gifts to deliver, tokens of appreciation for her volunteerism at Center for Hospice Care. She extended her arms for a hug and pecked a kiss on the side of my cheek. Even with the nasal cannula and the pounds lost, her spunk and her smile were as strong as ever.

Pam was diagnosed with non-small lung cell carcinoma. We all chuckled at the lack of creativity in the name, but that nonetheless, is the correct term. This sort of cancer doesn't grow like a tumor, but rather like a lesion. It is inoperable. "My prognosis was 50/50 chance he could put it into remission," Pam explained. "90% chance it would come back—a week, a month, a day—they don't know. It's the type of cancer that is very fast moving." The oncologist laid out the chemotherapy plan to her. "It was daunting. It was unbelievable. It was mind-boggling," Pam said. She declined treatment and opted for palliative care.

Pam Price was quite familiar with Center for Hospice Care prior to her own diagnosis. She had utilized the bereavement groups and wanted to get more involved. "I was at a point I just said to God, *Okay, now where am I going from here? What is my purpose at this point in the game?*

Continued on Page 5

**Inside this issue:**

## Mark Your Calendars

Soup's On
November 10, 2018
11:00am-12:30pm
501 Comfort Place
Mishawaka, IN

## In Loving Memory

Our condolences and heartfelt sympathies go out to the following CHC volunteers who lost a loved one recently.

Ginny Russell, Elkhart
Father,
Paul (Lark) Lawler,
October 1, 2018

Linda Sullivan, Elkhart
Husband,
Gerald Sullivan,
September 18, 2018

## Welcome to the Team

**Sarah Contreras**
Elkhart IPU RN

**Barb King**
Professional Relations Liaison

**Katie Sweet**
Coding & Verification Billing Representative

**Julie Fairchild**
Marketing Assistant

**Bethany Lighthart**
Social Work Coordinator

**Dorothy Jones**
Admission Representative

**Marcia Miller**
South Bend IPU RN

## Birthdays

11/1
Nancy DeMaegd
11/7
Martha Jones
11/7
Kristie Sherburn
11/8
Karen Goodnough
11/8
Mary Murphy
11/10
Ruth Anne Gray
11/10
Kathleen Griffin
11/11
Rebecca Lanning
11/17
Jenny Cowsert
11/18
Nancy Jackson
11/18
Helen VanGundy
11/20
Karen McCormick
11/22
Elizabeth Basket
11/22
Bill Singler
11/23
Kathy Fuchs
11/23
Diane Huwaldt
11/25
Jennifer Lutz
11/25
Nellie Vels
11/28
Elizabeth Kuntz
11/29
Phyllis Hong
11/29
Bill Michalak
11/30
Phyllis Hutton Bowser

*"Even if it's a little thing, do something for those who have need of a man's help—something for which you get no pay but the privilege of doing it. For, remember, you don't live in a world all your own. Your brothers (and sisters) are here too." Albert Schweitzer*

# Volunteer Spotlight
## Paul Go, South Bend

Family wedding in Crested Butte, Colorado, altitude is 10,000 feet. Paul is two right from the groom.

### What volunteer work do you do with CHC?

I volunteer at the inpatient care unit (Hospice House) in South Bend. I've been there the past six years, since I retired from Notre Dame. It was my first choice of what I wanted to do when I retired.

### Why do you volunteer with CHC?

My aunt, who was from Indonesia and was like a mom to me, was diagnosed with pancreatic cancer at the end of 2006. She had hospice care for about 2 weeks. My aunt expressed the desire to die at home and we were able to make that happen. The care that she got from CHC was really amazing. They knew what they were doing and they kept the family informed. It was because of the amazing care she received that drew me to want to volunteer here.

### Favorite quote?

People may not remember exactly what you did, or what you said, but they will always remember how you made them feel.

### Where are you originally from?

I was born in Indonesia and lived there until I moved to Australia at age 16 where I completed my undergraduate degree. After graduation, I moved to Chicago where I went to DePaul to study Physics. I then moved to this area to continue my studies at Notre Dame. I ended up retiring from Notre Dame after 37 years.

### Any talents or hobbies?

I play the piano. I'm not very good, but I remember playing during my college years in Australia. No one else could play, so I was designated. Much of what I played were the 1960's folk songs. Friends would join in and we'd enjoy hootenannies.

### Where would you like to travel to?

I have been able to travel to places like London, Ireland, France, Italy as well as return to Indonesia a couple times. Two years ago, we traveled to Australia to visit my host family. After 50 years it was so great to reconnect. We traveled to most of these places to visit people we hosted in our South Bend home, many of them grad students. Next year my wife and I are celebrating our 50th wedding anniversary. We are planning a road trip along the West Coast of Michigan all the way up to Mackinac. We are looking forward to that!

"Paul's energy and personality never stop! He has a true passion for humanity and exemplifies our hospice mission. He is thoroughly appreciated by patients, families and staff at CHC."

*Debra Mayfield,*

*South Bend Volunteer Coordinator*

# Training Tips & Reminders

## Documentation: What to do and What not to do

Volunteer Report and Time Sheets

The Volunteer Report and Time Sheet is an actual part of the patient's medical record and is placed in their chart. Because of that, please remember the following:

- Any notes that you need to give to your Volunteer Coordinator (requests for more time sheets, patient concerns, or other comments) need to be on a separate piece of paper. Do not put these comments on the time sheet itself.
- Avoid these words: appeared, seemed, looked, feel/felt, think/thought. They are generally used when making judgement calls. Remember that we are always to document what we observe only. Facts. No judgements.
- Make no comparisons from one visit to the next. We are to observe one visit at a time and document what we observe at that visit only.

# Welcome New Volunteers!

Please join us in welcoming these new CHC volunteers! They completed volunteer training on October 4, 2018.

Front to back, left to right: Michelle Lothamer, Erin Norton, Janey Almaraz, Donna Kooy, Tracey Eagleton, John Dendiu, Tom Vickers, Hugh O'Donnell and Reilley Knott

Not pictured: Barb Reasor

Continued from Page 1

*What am I supposed to be doing?"* Pam remembered. "The next day Michele calls me and wants to know if I would consider volunteering in the bereavement department." Michele told her to think about it and let her know. But Pam knew it was the answer to her questions, so she agreed immediately.

Pam quickly got involved with compassionate and creative pursuits. She co-facilitated the Crafting Memories group with her friend and fellow CHC volunteer Marilyn Kay. Laura Lord, Bereavement Assistant, said of Pam, "Pam was a free spirit and full of life and love. She greeted everyone with a *Hi, Sweetheart* and a teddy-bear hug." Her creativity was often displayed through her ever changing colors of hair and her meaningful ideas for the crafting group. Her desire to do something with her life, to give of herself so that those who were grieving could find a friend on their journey, drove her daily decisions. "If I could say one word, give one smile, to one person in the group that day…to give them hope, then I was good," she shared. "I had accomplished my goal for that day…and I was good."

When Pam decided that she wanted to pursue palliative care instead of the chemotherapy, it wasn't easy. Choosing not to proceed with treatment doesn't always receive supportive responses. Friends, family and even medical personnel don't always know what to do with this reality. Pam's daughter and caregiver, Ericka, knew that her support would be best for her mom. Ultimately, she knew what her mother's response would be. "You've chosen that way before your diagnosis," Ericka explained, knowing that the decision wasn't flippant or uncalculated. But Ericka had been through this before, with her mother-in-law. She had learned a lot during that time and used her experience to help her ask the difficult questions she knew had to be addressed. Most families don't ask those questions and most likely don't even know what to ask. Having the support of her daughter allowed Pam the ability to obtain peace with her decision. "Once I made the decision, this is *my* decision…it was a peace and comfort," Pam said. "I don't care how long I have. It doesn't matter. Do I have control over that? Do you? So, whether I have a day, a month, two months…I just want it to be the best quality I can have. I want to be with my children, my grandchildren and my friends."

That's exactly what happened. Family continued to respond with care, visits and as much quality time as possible. Pam's granddaughter, Maya, had asked a few years ago if she would ever entertain another relationship. "At my age, that's a lot of work," Pam answered. "I'll tell you what. He'd have to be a Harley man with a Harley bike. Or, he could be a real cowboy with a real horse." Maya had teased her about this since then, but she didn't forget.

*Continued on Page 6*

## Comments from Our Families

- Our family was very grateful for the care given to our father during his short stay. Thank you all very much.
- Mom's nurse was the best, helped me in so many ways. Was always available to answer any questions. Would not have gotten through this without her.
- I have been so thankful, both for the excellent care mom received from your staff, but also the compassion that you have shown to me. Thank you and may God bless you.

*Continued from Page 5*

A few months ago, family came over for a picnic pizza party. The grandkids and family were all gathered together outside. Then all of a sudden, the roar of multiple motorcycles interrupted the gathering. They made their way up the rather lonely street and stopped right in front of Ericka's home. Maya had arranged for the Patriots, a local motorcycle group, to visit her grandmother. It wasn't one Harley man with a Harley bike, but rather a group of around twenty men and women wanting to see the smile on Pam's face. "I have official membership," Pam smiled at me, as she continued her story. "I rode in the side car. They took me for a ride and it was so incredible. I could just feel that freedom. I think that is what the final victory is going to feel like. It's freedom."

With Center for Hospice Care providing care to focus on her comfort, these moments were possible. "We brought Center for Hospice Care on board immediately when I made the decision," Pam shared. "And they've been beautiful, which I knew they would. You guys have been more than supportive." Knowing that her desire was to spend time with those she loved the most, CHC worked toward that end, making sure her level of comfort was at its best so she could savor every moment. "The thing is," Pam continued. "If I had chosen treatment, I know in my heart the parties wouldn't have happened. It couldn't have happened, because I wouldn't have been able to do it."

Supporting someone at the end of life is anything but easy. It's a journey of goodbyes and grieving. Pam's family showed her such loving support, yet it was mixed with emotion and difficult realizations. Pam's birthday bash idea was born out of such bittersweet realities. The idea started when one of her younger grandchildren (aged nine) asked if grandma was going to be here for Christmas. The family wisely had been honest with the kids, allowing them to process their grief along the way. They told her that they didn't know, but it wasn't likely she would be here for Christmas. She paused while the thoughts whirled in her young mind. Her birthday was in November, which was close to Christmas. "Then that means I'll never have a birthday party with my grandma again," she said. The party idea was born.

The birthday party wasn't for Pam, but for her grandchildren. There were party hats and decorations. As well as desserts, seven desserts to be exact: cake, pudding, Rice Krispy treats, ice cream, brownies, blueberry pie and cheesecake. There was definitely enough sugar to energize the kids for the presents. These presents were especially picked out for them, from Pam's home. Their mom had asked ahead of time if there was anything they wanted from her home, and they all had some ideas. The youngest one had asked for the blanket from Pam's bed. "When he opened the blanket…he just lit up," she shared. "*This is just what I needed grandma,* he said to me. *Now when you're gone I will still be able to smell you and wrap myself up in this and I can feel your comfort."* Pam was so grateful for these moments. She realized that it was a gift to be able to plan things, just the way she wanted it. "Thank you, God," she said. "You have given me this very short time, whether it's two weeks, three weeks, a month, to actually end and see my grandchildren and children and be able to give them things, know what they want and help them."

Pam's perspective can teach all of us. Purposeful and mindful moments should be a part of all of our days, but somehow that clarity is best revealed when time is short. Pam spent her time exactly as she wished, and she responded to those questions she asked years ago. "God said, '*Here is your purpose, take it or leave it.'"* Pam leaned in and said softly. "*But it's your purpose. Go your way."*

**Center for Hospice Care**
**Compliance Committee Meeting Minutes**
**August 30, 2018**

| | |
|---|---|
| *Members Present:* | Craig Harrell, Dave Haley, Karl Holderman, Vicki Gnoth, Becky Kizer |
| *Absent:* | Sue Morgan |

| Topic | Discussion | Action |
|---|---|---|
| **1. Call to Order** | • The meeting was called to order at 3:00 p.m. | |
| **2. Minutes** | • The minutes of the 02/20/18 meeting were approved by consensus. | |
| **3. Committee Members** | • We suggest adding Tammy Huyvaert, ADON, to represent admissions and the IPUs. We should also add someone from the medical staff since Dr. Kubley has retired. Mark will discuss that with Dave at their next meeting. | |
| **4. Hospices & Opioids** | • Article reviewed from Hospice Compliance Letter May 2018. The administrative team has talked about some issues of possible shortages and the government purposefully reducing manufacturing of opioids. HAN has addressed with legislatures the disposal of meds in the home at the time of death. Right now it is up to the family but our RNs offer to assist. We cannot destroy them or remove them under the law. The meds are the patient/family's property even if we have paid or them through Medicare, etc. The article talks about making sure hospice staff understand addiction, diversion, and related issues. Drug diversion is discussed in the IDTs, and the medical staff has switched medications for some patients to a non-opioid. Patients have been brought to the IPU to make that switch. We have also have occasionally and discharged patients for cause due to a pattern of missing opioids. We are doing more lockboxes in the home. We feel we are doing a fairly good job to prevent drug diversion.<br>• We feel staff is very aware of drug diversion. We have heard that in some areas doctors may not want to serve as a hospice medical director because of the dilemmas and controversies of opioid prescribing. If NHPCO is able to get legislation through, it may change again so the nurses can dispose of meds in the home. It's been reported that some hospices wants legislation to continue to have families dispose of the meds, because the agency didn't want the liability or responsibility of having to deal with it. We offer to assist the family in disposing and we document that. | |
| **5. Hospice Care to** | • Article on providing quality hospice care to sexual and gender minorities in Hospice | |

| Topic | Discussion | Action |
|---|---|---|
| **Sexual & Gender Minorities** | Compliance Letter June 2018. Barb King will be doing a presentation on diversity at the 09/26 staff meeting. We did LGBTQ training for all administrators and coordinators this year. The article talks about having welcoming materials in the admission packet. We could include information that we partner with the LGBTQ Center. Barb is working on diversity at the NHPCO level. They have been waiting for a couple months for information from a panel or committee that is working on some formal verbiage that could be put in a packet. This issue relates to Patient Rights and nondiscrimination. | |
| **6. Patient Rights** | • Hospice Compliance Letter July 2018 article on honoring patients' rights. They will be looking at hospice compliance plans and the CoPs each month starting with patient rights. We want to make sure we are still on track and meeting our obligations as a compliance committee. The article provides an overview for providers on how to ensure the patients' rights are honored. We could review some of these pearls at a staff meeting. Vicki will monitor the compliance letters and forward them to the committee, and at the next meeting we can look at a couple of them to see what they are highlighting. | |
| **7. Other Business** | • We had our hospice survey in June, and are due for a home health survey later this year. | |
| **Adjournment** | • The meeting adjourned at 3:30 p.m. | Next meeting TBA |

# 2019 CHC Board of Directors Elections

## 2019 CHC Slate of Officers and Executive Committee Members

Chair = Mary Newbold

Vice Chair = Carol Walker

Treasurer = Tricia Luck

Secretary = Jennifer Houin

Immediate CHC Past Chair / 2019 Hospice Foundation Chair = Wendell Walsh

Hospice Foundation Immediate Past Chair = Amy Kuhar Mauro

## Candidates for 2019 Board Members and Brief Bios

**Andy Murray**, Chief Sales Officer, Lippert Components, Inc., Elkhart, IN. Murray became Chief Sales Officer in May 2018. His previous role with the Company had been Vice President of RV Sales where he provided leadership and direction to the Company's many RV product and RV sales teams. In his current role, he maintains those responsibilities while working closely with the international RV markets as well as the Company's aftermarkets, marine markets and other important leisure and mobile transportation markets. Since joining LCI 15 years ago, Murray spent his early years on the operational side of the business, working with several of the Company's manufacturing divisions and product development. He is currently on the board of directors for Child and Parent Services (CAPS) in Elkhart and is a past board chair of CAPS.

**Mark Wobbe**, Principal, Risk Advisor – Commercial Risk Management, Gibson Insurance, South Bend, IN. Wobbe's insurance career has included time in underwriting and management within property/casualty insurance companies, and in sales and consulting roles while a partner/owner at Gibson. He provides risk management and insurance services to business clients throughout Northern Indiana and Southwest Michigan. Wobbe leads one of Gibson's commercial risk management teams from its South Bend office and is a senior member of several management committees at Gibson. Mark is a member of the board for The Scholarship Foundation of St. Joseph County, has been a Campaign Coordinator for the United Way, has coached youth basketball for several years, and is a graduate of Leadership South Bend/Mishawaka.

## Re-Elect to Second Three-Year Term

**Jennifer Ewing**, RN, MSN, NP-C, AOCNP

# # #

**Center for Hospice Care**
**Committees of the Board of Directors**

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

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

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

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

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

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

Center for Hospice Care
choices to make the most of life

# CHAPTER FOUR

# FINANCE COMMITTEE

## Center for Hospice Care
## Financial Summary
## October 31, 2018

Assets now total over $51.2 million. Our only significant liabilities are our trade accounts payable, accrued payroll, and accrued payroll taxes.

| Octoberr 2018 Year to Date Summary | Center for Hospice Care | Hospice Foundation | GPIC | Combined |
|---|---|---|---|---|
| CHC Operating Income | 18,638,126 | | | 18,638,126 |
| MADS Revenue | 384,044 | | | 384,044 |
| Development Income | | 1,051,374 | | 1,051,374 |
| Partnership Grants | | | 439,936 | 439,936 |
| Investment Income (Net) | | (431,355) | | (431,355) |
| Interest & Other | 29,829 | 63,171 | 13,442 | 106,442 |
| Beneficial Interest in Affiliate | (1,582,835) | (15,416) | | |
| Total Revenue | 17,469,164 | 667,774 | 453,378 | 20,188,567 |
| Total Expenses | 16,435,902 | 2,250,609 | 468,794 | 19,155,305 |
| Net Gain | 1,033,262 | (1,582,835) | (15,416) | 1,033,262 |
| *Net w/o Beneficial Interest* | *2,616,097* | *(1,567,419)* | | |
| *Net w/o Investments* | | | | *1,464,617* |

| Octoberr 2017 Year to Date Summary | Center for Hospice Care | Hospice Foundation | GPIC | Combined |
|---|---|---|---|---|
| CHC Operating Income | 17,484,169 | | | 17,484,169 |
| MADS Revenue | 374,983 | | | 374,983 |
| Development Income (Net) | | 1,432,807 | | 1,432,807 |
| Partnership Grants | | | 225,987 | 225,987 |
| Investment Income (Net) | | 2,634,762 | | 2,634,762 |
| Interest & Other | 25,471 | 14,472 | 129,287 | 169,230 |
| Beneficial Interest in Affiliate | 1,938,701 | 129,942 | | |
| Total Revenue | 19,823,324 | 4,211,983 | 355,274 | 22,321,938 |
| Total Expenses | 16,187,833 | 2,273,282 | 225,332 | 18,686,447 |
| Net Gain | 3,635,491 | 1,938,701 | 129,942 | 3,635,491 |
| *Net w/o Beneficial Interest* | *1,696,790* | *1,808,759* | | |
| *Net w/o Investments* | | | | *1,000,729* |

| Difference | Center for Hospice Care | Hospice Foundation | GPIC | Combined |
|---|---|---|---|---|
| CHC Operating Income | 1,153,957 | 0 | 0 | 1,153,957 |
| MADS Revenue | 9,061 | 0 | 0 | 9,061 |
| Development Income (Net) | 0 | (381,433) | 0 | (381,433) |
| Partnership Grants | 0 | 0 | 213,950 | 213,950 |
| Investment Income (Net) | 0 | (3,066,117) | 0 | (3,066,117) |
| Interest & Other | 4,358 | 48,699 | (115,845) | (62,788) |
| Beneficial Interest in Affiliate | (3,521,536) | (145,358) | | |
| Total Revenue | (2,354,160) | (3,544,209) | 98,105 | (2,133,370) |
| Total Expenses | 248,069 | (22,673) | 243,462 | 468,858 |
| Net Gain | (2,602,229) | (3,521,536) | (145,358) | (2,602,229) |
| *Net w/o Beneficial Interest* | *919,307* | (3,376,178) | | |
| *Net w/o Investments* | | | | *463,888* |

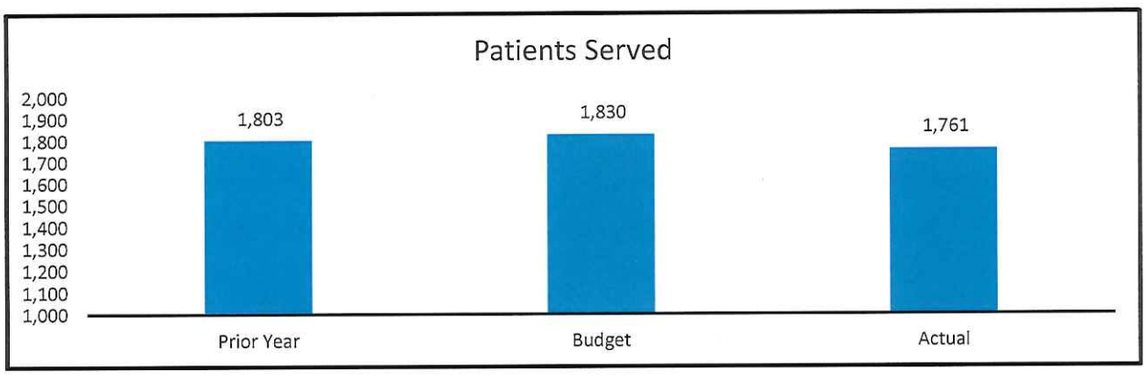
Reviewed

Karl Holderman, VP / CFO — Date: 11-14-18

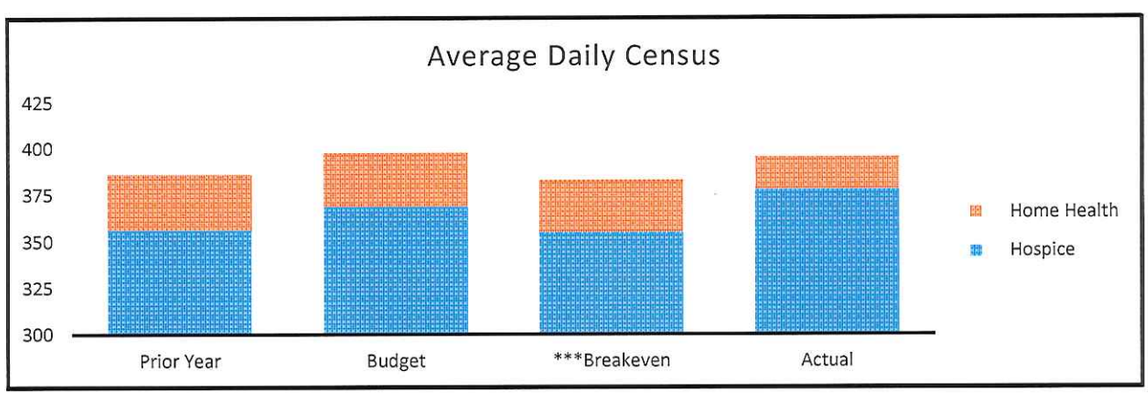
Mark Murray, President / CEO — Date: 11/14/18

# Center for Hospice Care
# October 2018 Summary

| | Prior Year | Budget | Actual |
|---|---|---|---|
| **Patients Served** | **1,803** | **1,830** | **1,761** |

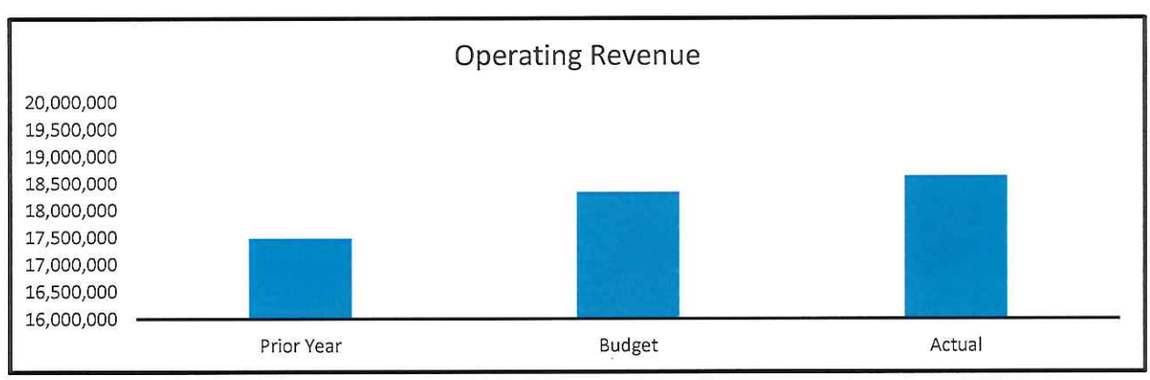



| **Average Daily Census** | **Prior Year** | **Budget** | *****Breakeven** | **Actual** |
|---|---|---|---|---|
| Hospice | 356.31 | 368.65 | 354.98 | 377.83 |
| Home Health | 29.59 | 28.97 | 27.90 | 17.28 |
| **Total Average Daily Census** | **385.90** | **397.62** | **382.88** | **395.11** |

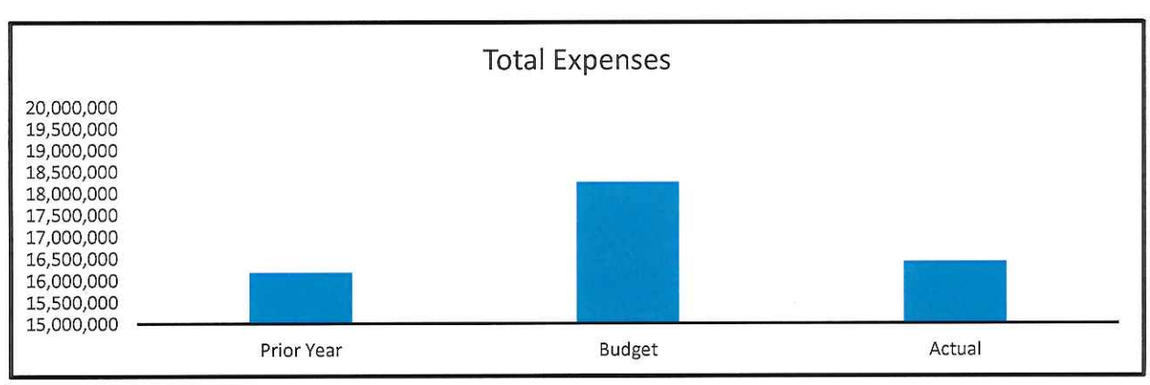



**** Budgeted Breakeven*

| | Prior Year | Budget | Actual |
|---|---|---|---|
| **Operating Revenue** | **17,484,169** | **18,339,895** | **18,638,126** |




| | Prior Year | Budget | Actual |
|---|---|---|---|
| **Total Expenses** | **16,187,833** | **18,259,995** | **16,435,902** |



**Summary Balance Sheet**
**Center for Hospice Care**
**October 31, 2018**

| Assets | August 31, 2018 | September 30, 2018 | October 31, 2018 | October 31, 2017 | Net Change |
|---|---|---|---|---|---|
| Cash and Equivalents | 5,071,565.35 | 5,176,607.76 | 5,090,768.90 | 4,856,358.45 | 234,410.45 |
| Intermediate Cash | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Long Term Cash | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Other Investments | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Accounts Receivable | 3,797,584.18 | 4,020,542.26 | 4,457,846.30 | 3,027,788.75 | 1,430,057.55 |
| Due from Affiliate | 15,823,430.53 | 15,956,466.00 | 16,084,098.55 | 14,577,300.60 | 1,506,797.95 |
| Prepaid Assets | 296,974.56 | 260,309.43 | 276,656.34 | 364,655.19 | (87,998.85) |
| Plant, Property & Equipment | 4,235,548.42 | 4,307,273.02 | 4,307,273.02 | 4,326,554.70 | (19,281.68) |
| Accumulated Depreciation | (3,400,190.74) | (3,426,388.12) | (3,452,585.50) | (3,257,063.59) | (195,521.91) |
| Other Assets | 26,002,585.62 | 25,800,957.57 | 24,468,476.56 | 24,847,048.82 | (378,572.26) |
| **Total Assets** | **51,827,497.92** | **52,095,767.92** | **51,232,534.17** | **48,742,642.92** | 2,489,891.25 |
| **Liabilities** | | | | | |
| Accounts Payable | 393,861.01 | 545,026.51 | 692,105.45 | 669,178.83 | 22,926.62 |
| Due to Affiliate | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Accrued Payroll | 1,047,916.93 | 1,149,172.54 | 1,245,232.93 | 1,161,618.39 | 83,614.54 |
| Payroll Taxes | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Payroll Deductions | 1,684.58 | 12,239.73 | 2,738.68 | 15,102.01 | (12,363.33) |
| Other Liabilities | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Long Term Liabilities | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| **Total Liabilities** | **1,443,462.52** | **1,706,438.78** | **1,940,077.06** | **1,845,899.23** | 94,177.83 |
| **Fund Balance** | | | | | |
| Unrestricted Funds | 48,247,566.27 | 48,247,566.27 | 48,247,566.27 | 43,249,627.74 | 4,997,938.53 |
| Temporarily Restricted Funds | 11,629.33 | 11,629.33 | 11,629.33 | 11,629.33 | 0.00 |
| Permanantly Restricted Funds | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Retained Earnings | | | | | 0.00 |
| Year to Date Net Income | 2,124,839.80 | 2,130,133.54 | 1,033,261.51 | 3,635,486.62 | (2,602,225.11) |
| **Total Fund Balance** | **50,384,035.40** | **50,389,329.14** | **49,292,457.11** | **46,896,743.69** | 2,395,713.42 |
| **Total Liabilities and Fund Balance** | **51,827,497.92** | **52,095,767.92** | **51,232,534.17** | **48,742,642.92** | 2,489,891.25 |

# Center For Hospice Care
## Summary Income Statement

| | January | February | March | April | May | June | July | August | September | October | November | December | YTD Actual | YTD Budget | YTD Variancce |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Operating Revenue** | | | | | | | | | | | | | | | |
| Hospice Medicare Benefit | 1,584,623 | 1,556,444 | 1,749,863 | 1,616,117 | 1,684,597 | 1,742,287 | 1,878,858 | 1,817,258 | 1,680,058 | 1,669,927 | | | 16,980,031 | 16,925,339 | 54,692 |
| Medicaid Hospice Benefit | 13,002 | 12,429 | 17,693 | 28,995 | 20,974 | 15,465 | (7,153) | 10,656 | 22,469 | 22,290 | | | 156,819 | 238,492 | (81,673) |
| Private Ins Hospice Benefit | 144,364 | 108,885 | 148,217 | 144,681 | 132,258 | 154,322 | 131,595 | 120,318 | 65,655 | 98,154 | | | 1,248,448 | 889,219 | 359,229 |
| Self-Pay Hospice Benefit | | 5,119 | 14,661 | 4,754 | 16,363 | 6,215 | 977 | 3,537 | 9,591 | 9,015 | | | 70,232 | 39,141 | 31,091 |
| Hospice House R&B | | | | 2,373 | | | | | | 650 | | | 3,023 | 4,344 | (1,322) |
| Medicare Home Health | 24,170 | 9,523 | 19,799 | 15,485 | 10,112 | 22,111 | 18,940 | 21,968 | 6,208 | 16,324 | | | 164,639 | 178,185 | (13,546) |
| Medicaid Home Health | 622 | | | | | | | | | | | | 622 | 9,987 | (9,365) |
| Private Ins Home Health | 5,170 | 27 | 545 | 3,150 | 4,371 | (1,483) | 764 | 27 | 2,102 | (693) | | | 13,980 | 46,249 | (32,269) |
| Self-Pay Home Health | | | | 156 | 176 | | | | | | | | 332 | 8,939 | (8,607) |
| **Total Operating Revenue** | **1,771,951** | **1,692,427** | **1,950,778** | **1,815,711** | **1,868,851** | **1,938,917** | **2,023,981** | **1,973,764** | **1,786,083** | **1,815,667** | **0** | **0** | **18,638,126** | **18,339,895** | **298,232** |
| **Development Income** | | | | | | | | | | | | | | | |
| **Other Income** | | | | | | | | | | | | | | | |
| Interest Income | 848 | 1,089 | 1,064 | 1,063 | 1,474 | 1,359 | 1,418 | 1,362 | 1,201 | 1,012 | | | 11,889 | 10,000 | 1,889 |
| Change in Ben Int in Foundation | 640,532 | (821,039) | (258,783) | (156,150) | 219,588 | (120,045) | 302,408 | 144,762 | (201,628) | (1,332,481) | | | (1,582,835) | 376,579 | (1,959,414) |
| CADS Income | 40,687 | 36,604 | 40,934 | 44,043 | 45,968 | 35,273 | 33,382 | 37,632 | 32,429 | 37,092 | | | 384,044 | 375,000 | 9,044 |
| Miscellaneous Income | 1,959 | 192 | 291 | 2,466 | 1,635 | 4,595 | 3,356 | 533 | 816 | 2,096 | | | 17,940 | 20,832 | (2,892) |
| **Total Other Income** | **684,026** | **(783,154)** | **(216,494)** | **(108,578)** | **268,665** | **(78,818)** | **340,564** | **184,289** | **(167,182)** | **(1,292,281)** | **0** | **0** | **(1,168,962)** | **782,411** | **(1,951,373)** |
| **Total Revenue** | **2,455,977** | **909,273** | **1,734,284** | **1,707,133** | **2,137,516** | **1,860,099** | **2,364,545** | **2,158,053** | **1,618,901** | **523,386** | **0** | **0** | **17,469,164** | **19,122,306** | **(1,653,141)** |

# Center For Hospice Care
## Summary Income Statement

| | January | February | March | April | May | June | July | August | September | October | November | December | YTD Actual | YTD Budget | YTD Variancce |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Operating Expenses** | | | | | | | | | | | | | | | |
| Salary & Wages | 840,171 | 759,522 | 1,019,006 | 895,783 | 927,086 | 866,209 | 911,254 | 890,669 | 888,442 | 901,088 | | | 8,899,230 | 9,774,198 | 874,968 |
| Temporary Staff | 17,127 | 8,266 | 3,215 | 8,360 | 12,366 | 10,301 | 11,590 | 11,597 | 8,805 | 6,955 | | | 98,581 | 85,000 | (13,581) |
| Employment Expenses | 219,383 | 179,027 | 211,360 | 197,768 | 189,119 | 255,028 | 186,354 | 181,563 | 198,130 | 183,136 | | | 2,000,868 | 2,411,306 | 410,438 |
| Education | 1,822 | 2,809 | 3,330 | 7,335 | 7,733 | 6,037 | 1,511 | 6,629 | 978 | 8,951 | | | 47,136 | 119,150 | 72,014 |
| Travel | 21,821 | 28,306 | 40,192 | 31,104 | 32,299 | 32,888 | 30,631 | 38,329 | 35,617 | 32,958 | | | 324,146 | 374,795 | 50,649 |
| Supplies Inventory | 29,857 | 17,211 | 38,664 | 23,639 | 27,767 | 25,020 | 33,190 | 26,892 | 27,632 | 34,007 | | | 283,878 | 249,625 | (34,253) |
| HMB Direct Care | 223,419 | 173,153 | 229,347 | 202,374 | 230,187 | 233,677 | 218,990 | 233,872 | 211,546 | 225,185 | | | 2,181,750 | 2,232,746 | 50,996 |
| MHB Direct Care | 1,090 | 2,104 | 2,580 | 5,687 | 2,824 | 2,586 | 3,477 | 4,233 | 4,115 | 3,267 | | | 31,963 | 16,517 | (15,446) |
| PHB Direct Care | 12,649 | 16,546 | 13,838 | 26,469 | 21,975 | 18,008 | 28,695 | 26,184 | 18,711 | 11,451 | | | 194,527 | 151,930 | (42,597) |
| SHB Direct Care | 6,415 | 6,094 | 5,217 | 6,803 | 8,412 | 8,145 | 6,524 | 4,664 | 4,563 | 4,551 | | | 61,388 | 36,339 | (25,049) |
| Hospice House Expenses | 1,306 | 1,277 | 2,195 | 2,213 | 1,936 | 2,698 | 1,488 | 1,579 | 2,378 | 2,132 | | | 19,202 | 26,336 | 7,134 |
| Hospice Outreach | 95 | 3,105 | 2,050 | 812 | 2,878 | 6,601 | 476 | 1,076 | 890 | 5,467 | | | 23,451 | 64,000 | 40,549 |
| Office Costs | 13,455 | 9,875 | 20,820 | 14,789 | 14,289 | 24,301 | 13,914 | 20,449 | 27,523 | 17,863 | | | 177,277 | 249,450 | 72,173 |
| Dues | 6,949 | 5,726 | 5,726 | 5,726 | 5,726 | 7,075 | 6,129 | 6,896 | 6,248 | 6,036 | | | 62,236 | 77,918 | 15,682 |
| Insurance | 25,972 | 17,820 | 25,519 | 31,677 | 10,135 | 25,728 | 17,911 | 17,911 | 10,135 | 8,729 | | | 191,535 | 184,166 | (7,369) |
| Public Awareness | 21,459 | 25,588 | 22,417 | 15,454 | 15,777 | 22,692 | 17,803 | 33,409 | 16,902 | 23,107 | | | 214,608 | 400,998 | 186,390 |
| Professional Fees | 12,243 | 1,143 | 14,067 | 1,750 | 11,706 | 11,915 | 8,691 | 1,195 | 3,648 | 3,666 | | | 70,024 | 118,002 | 47,978 |
| Software Maintenance | 19,838 | 18,160 | 16,877 | 19,591 | 19,146 | 20,842 | 21,605 | 17,923 | 19,860 | 20,625 | | | 194,466 | 237,250 | 42,784 |
| Volunteer Awards & Expenses | 158 | 78 | 3,904 | 5,375 | 75 | 1,282 | | | 2,418 | 286 | | | 13,577 | 30,000 | 16,423 |
| Building & Grounds | 27,686 | 29,597 | 26,365 | 30,932 | 35,049 | 24,359 | 35,317 | 34,658 | 30,949 | 25,665 | | | 300,577 | 336,586 | 36,009 |
| Telephone | 22,862 | 19,224 | 26,866 | 28,778 | 35,328 | 24,268 | 22,983 | 30,073 | 28,300 | 28,804 | | | 267,487 | 311,868 | 44,381 |
| Depreciation | 26,197 | 22,268 | 22,268 | 22,268 | 22,268 | 22,268 | 22,268 | 22,268 | 22,268 | 22,268 | | | 226,607 | 276,252 | 49,645 |
| Bad Debt | 12,738 | 37,005 | 21,976 | 8,517 | 36,615 | 7,706 | 40,594 | 40,381 | 16,081 | 16,713 | | | 238,324 | 183,399 | (54,925) |
| Miscellaneous | 10,350 | 6,992 | 9,147 | 5,045 | 6,957 | 6,768 | 9,737 | 8,247 | 6,273 | 7,734 | | | 77,248 | 83,340 | 6,092 |
| CADS Expenses | 23,000 | 26,318 | 16,769 | 21,328 | 27,633 | 29,044 | 24,000 | 26,914 | 21,197 | 19,614 | | | 235,816 | 228,824 | (6,992) |
| **Total Operating Expenses** | **1,598,062** | **1,417,214** | **1,803,715** | **1,619,577** | **1,705,286** | **1,695,446** | **1,675,132** | **1,687,611** | **1,613,609** | **1,620,258** | **0** | **0** | **16,435,902** | **18,259,995** | **1,824,092** |
| **Total Expenses** | **1,598,062** | **1,417,214** | **1,803,715** | **1,619,577** | **1,705,286** | **1,695,446** | **1,675,132** | **1,687,611** | **1,613,609** | **1,620,258** | **0** | **0** | **16,435,902** | **18,259,995** | **1,824,092** |
| **Net Gain** | **857,915** | **(507,941)** | **(69,431)** | **87,556** | **432,230** | **164,653** | **689,413** | **470,442** | **5,292** | **(1,096,872)** | **0** | **0** | **1,033,262** | **862,311** | **170,951** |
| **Beneficial Int in Foundation** | **640,532** | **(821,039)** | **(258,783)** | **(156,150)** | **219,588** | **(120,045)** | **302,408** | **144,762** | **(201,628)** | **(1,332,481)** | | | **(1,582,835)** | **376,579** | **1,959,414** |
| **Net w/o Beneficial Interest** | **217,383** | **313,098** | **189,352** | **243,706** | **212,642** | **284,698** | **387,005** | **325,680** | **206,920** | **235,609** | **0** | **0** | **2,616,097** | **485,732** | **2,130,365** |

| | | CHC 10/31/18 | CHC 10/31/18 Pct | CHC 12/31/18 Proj | CHC Proj 12/31/18 Pct | Overall 2019 Budget | Overall 2019 Budget Pct | Overall 2018 Budget | Overall 2018 Budget Pct |
|---|---|---|---|---|---|---|---|---|---|
| 41100 | Hospice Medicare Benefit | 16,980,031 | 97.20% | 20,250,000 | 92.51% | 20,451,001 | 85.59% | 20,340,765 | 87.11% |
| 41200 | Medicaid Hospice Benefit | 156,819 | 0.90% | 175,000 | 0.80% | 294,270 | 1.23% | 286,610 | 1.23% |
| 41300 | Private Insurance Hospice Benefit | 1,248,448 | 7.15% | 1,400,000 | 6.40% | 1,280,224 | 5.36% | 1,068,657 | 4.58% |
| 41400 | Self-Pay Hospice Benefit | 70,232 | 0.40% | 75,000 | 0.34% | 75,746 | 0.32% | 47,042 | 0.20% |
| 41500 | Hospice House Room & Board | 3,023 | 0.02% | 3,200 | 0.01% | 6,228 | 0.03% | 5,223 | 0.02% |
| 42100 | Medicare Home Health | 164,639 | 0.94% | 180,000 | 0.82% | 221,622 | 0.93% | 214,139 | 0.92% |
| 42200 | Medicaid Home Health | 622 | 0.00% | 625 | 0.00% | 0 | 0.00% | 12,003 | 0.05% |
| 42300 | Private Insurance Home Health | 13,980 | 0.08% | 17,000 | 0.08% | 17,993 | 0.08% | 55,582 | 0.24% |
| 42400 | Self-Pay Home Health | 332 | 0.00% | 500 | 0.00% | 1,756 | 0.01% | 10,744 | 0.05% |
| **Total Operating Revenue** | | **18,638,126** | **106.69%** | **22,101,325** | **100.97%** | **22,348,841** | **93.54%** | **22,040,765** | **94.39%** |
| 46000 | Contributions and Fundraising | | 0.00% | | 0.00% | | 0.00% | | 0.00% |
| 47000 | Planned Giving | | 0.00% | | 0.00% | | 0.00% | | 0.00% |
| **Total Development Income** | | **0** | **0.00%** | **0** | **0.00%** | **0** | **0.00%** | **0** | **0.00%** |
| 48000 | Investment Income | | 0.00% | | 0.00% | | 0.00% | | 0.00% |
| 49100 | Interest Income | 11,889 | 0.07% | 15,000 | 0.07% | 12,000 | 0.05% | 12,000 | 0.05% |
| 49200 | Beneficial Interest in Hospice Foundation | (1,582,835) | -9.06% | (686,800) | -3.14% | 1,042,430 | 4.36% | 821,871 | 3.52% |
| 49900 | Center for Adult Day Services | 384,044 | 2.20% | 440,000 | 2.01% | 465,000 | 1.95% | 450,000 | 1.93% |
| 49950 | GPIC Mgmt Revenue | | | | | | | | |
| 49951 | GPIC Grant Revenue | | | | | | | | |
| 49952 | GPIC Other Revenue | | | | | | | | |
| 49990 | Miscellaneous & Other Income | 17,940 | 0.10% | 20,000 | 0.09% | 25,000 | 0.10% | 25,000 | 0.11% |
| **Total Investment, Interest, and Other Income** | | **(1,168,962)** | **-6.69%** | **(211,800)** | **-0.97%** | **1,544,430** | **6.46%** | **1,308,871** | **5.61%** |
| **Total Revenue** | | **17,469,164** | **100.00%** | **21,889,525** | **100.00%** | **23,893,271** | **100.00%** | **23,349,636** | **100.00%** |

| | | CHC 10/31/18 | CHC 10/31/18 Pct | CHC 12/31/18 Proj | CHC Proj 12/31/18 Pct | Overall 2019 Budget | Overall 2019 Budget Pct | Overall 2018 Budget | Overall 2018 Budget Pct |
|---|---|---|---|---|---|---|---|---|---|
| 50000 | Salary & Wages | 8,899,230 | 54.15% | 10,750,000 | 54.58% | 11,520,366 | 52.32% | 11,735,448 | 53.60% |
| 50100 | Temporary Staff | 98,581 | 0.60% | 125,000 | 0.63% | 350,000 | 1.59% | 100,000 | 0.46% |
| 50200 | Employment Expenses | 2,000,868 | 12.17% | 2,350,000 | 11.93% | 2,689,258 | 12.21% | 2,895,153 | 13.22% |
| 50300 | Education | 47,136 | 0.29% | 65,000 | 0.33% | 142,500 | 0.65% | 138,250 | 0.63% |
| 50400 | Travel | 324,146 | 1.97% | 390,000 | 1.98% | 434,000 | 1.97% | 450,000 | 2.06% |
| 51000 | Supplies Inventory | 283,878 | 1.73% | 325,000 | 1.65% | 345,000 | 1.57% | 300,000 | 1.37% |
| 51100 | HMB Direct Care Costs | 2,181,750 | 13.27% | 2,500,000 | 12.69% | 2,691,693 | 12.22% | 2,683,298 | 12.26% |
| 51200 | MHB Direct Care Costs | 31,963 | 0.19% | 40,000 | 0.20% | 31,390 | 0.14% | 19,847 | 0.09% |
| 51300 | PHB Direct Care Costs | 194,527 | 1.18% | 230,000 | 1.17% | 188,340 | 0.86% | 182,591 | 0.83% |
| 51400 | SHB Direct Care Costs | 61,388 | 0.37% | 70,000 | 0.36% | 70,628 | 0.32% | 43,663 | 0.20% |
| 51500 | Hospice House Expenses | 19,202 | 0.12% | 25,000 | 0.13% | 25,000 | 0.11% | 31,600 | 0.14% |
| 51600 | Hospice Outreach | 23,451 | 0.14% | 30,000 | 0.15% | 84,000 | 0.38% | 69,000 | 0.32% |
| 52000 | Office Costs | 177,277 | 1.08% | 200,000 | 1.02% | 265,774 | 1.21% | 299,334 | 1.37% |
| 52100 | Dues | 62,236 | 0.38% | 80,000 | 0.41% | 93,500 | 0.42% | 93,500 | 0.43% |
| 52200 | Insurance | 191,535 | 1.17% | 240,000 | 1.22% | 242,250 | 1.10% | 221,000 | 1.01% |
| 53000 | Public Awareness | 214,608 | 1.31% | 250,000 | 1.27% | 420,444 | 1.91% | 463,775 | 2.12% |
| 54000 | Professional Fees | 70,024 | 0.43% | 100,000 | 0.51% | 137,250 | 0.62% | 137,750 | 0.63% |
| 54100 | Software Maintenance | 194,466 | 1.18% | 240,000 | 1.22% | 245,700 | 1.12% | 284,700 | 1.30% |
| 55000 | Volunteer Awards and Expenses | 13,577 | 0.08% | 15,000 | 0.08% | 17,500 | 0.08% | 30,000 | 0.14% |
| 56000 | Building & Grounds | 300,577 | 1.83% | 400,000 | 2.03% | 545,733 | 2.48% | 414,038 | 1.89% |
| 56100 | Telephone | 267,487 | 1.63% | 325,000 | 1.65% | 354,150 | 1.61% | 374,250 | 1.71% |
| 56200 | Depreciation | 226,607 | 1.38% | 325,000 | 1.65% | 535,900 | 2.43% | 331,500 | 1.51% |
| 57000 | Bad Debt | 238,324 | 1.45% | 260,000 | 1.32% | 223,488 | 1.01% | 220,408 | 1.01% |
| 58000 | Miscellaneous | 77,248 | 0.47% | 90,000 | 0.46% | 90,000 | 0.41% | 100,000 | 0.46% |
| 58100 | CADS Expenses | 235,816 | 1.43% | 270,000 | 1.37% | 275,000 | 1.25% | 275,000 | 1.26% |
| 58110 | Interest | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% |
| **Total Operating Expenses** | | **16,435,902** | **100.00%** | **19,695,000** | **100.00%** | **22,018,862** | **100.00%** | **21,894,103** | **100.00%** |
| 59000 | Fundraising | | 0.00% | | 0.00% | | 0.00% | | 0.00% |
| **Total Expenses** | | **16,435,902** | **100.00%** | **19,695,000** | **100.00%** | **22,018,862** | **100.00%** | **21,894,103** | **100.00%** |
| **Net Gain** | | **1,033,262** | **5.91%** | **2,194,525** | **10.03%** | **1,874,409** | **7.84%** | **1,455,532** | **6.23%** |
| **Beneficial Interest in Foundation** | | **(1,582,835)** | **-9.06%** | **(686,800)** | **-3.14%** | **1,042,430** | **4.36%** | 821,871 | 3.52% |
| **Net w/o Beneficial Interest in Foundation** | | **2,616,097** | **13.73%** | **2,881,325** | **12.76%** | **831,978** | **3.64%** | **633,661** | **2.81%** |
| *Capital Expenditures* | | | | *150,000* | | *675,000* | | ***369,150*** | |